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Military Sexual Trauma in Female Veterans: Psychoeducation and Treatment Approaches

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MILITARY SEXUAL TRAUMA IN FEMALE VETERANS: PSYCHOEDUCATION
AND TREATMENT APPROACHES

General Master's Proficiency Project

Submitted to the
Faculty of Dominican University of California
Counseling Psychology Department

In Partial Fulfillment of the Requirements for the Degree of
Master's Degree in Counseling Psychology with a General Concentration

By

Jeanne M Spence

May 2017

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General Master's Program Advisor

April 10, 2017

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Faculty Member Reader

April 10, 2017

General Master's Proficiency Project Manual

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May 2017

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Abstract

This informative guide was created to help civilian therapists, interns and trainees work with military personnel, specifically with female veterans who are survivors of a Military Sexual Trauma (MST) and present with Post Traumatic Stress Disorder (PTSD). When becoming a therapist, cultural awareness is always important. When working with military or veteran clients, learning about military culture is equally important. Some military personnel, active duty and/or veterans prefer a military therapist because they perceive he or she understands the culture and the language and will save the client hours trying to explain military life. This guide will provide civilians with psychoeducation on sexual assaults in the military; how common they are, how often they go unreported, and why. It will also explain how the military culture can both amplify the psychological impact of a sexual assault and impede the recovery process. Finally, this guide will outline the negative ramifications of MST and PTSD in female veterans, such as avoidance and substance problems, and enumerate multiple treatment options. Some are evidence based, some are not; however, all are described in this manual.

Preface

When I was in the army, I saw a couple of therapists to help deal with basic army issues that many enlistees experience. When I became a veteran, I continued therapy at the VA. As helpful as most of the therapists were to me, I learned repeatedly that civilians lack quality knowledge about military life. Of course, they have no reason to understand a life style which has no effect on them. And many therapists who have no personal experience with depression, high anxiety, or drug problems can still successfully assist clients who do. Civilian therapists can help their military clients. But I believe the process can be hastened and improved if the therapist has some education on military culture and how military life is very different from civilian life.

I chose to write an educational manual about female veterans who have experienced a MST and who have a PTSD diagnosis because I am a female veteran and want women to have the best therapeutic care possible. For that to happen, I aim to provide the civilian therapist with a fundamental education on military culture, and how things are done. I remember spending so much time explaining so many things to my therapist when we could have been addressing more important issues, and I despised that. Based on my experience, and my objective to become a therapist who works with military clients, I have created this manual to help provide psycho-education for civilians in this field.

Introduction

This guide will educate a therapist, or one becoming a therapist, on sexual trauma in the military, and how it can lead to PTSD within female veterans. It will explore how common sexual assaults are in the military, with statistics on assaults and reporting. It will explain a woman's options for reporting the assault to the proper chain of command; how sexual harassment is tolerated throughout the military; and the impact it can have on women who serve or have served our country. PTSD is one of the most pressing concerns facing female veterans today. A wide range of helpful information has been included: the symptoms and prevention of PTSD from an MST; protocols for reporting; the specific effects of trauma; negative outcomes and ramifications; and potential positive treatment options tailored to each veteran's individual needs. Also included is a convenient list of common military terms to help the therapist understand more of what the client is saying.

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Terms and Definitions Used Throughout Manual

Military Sexual Trauma (MST) – An incident of sexual assault or recurring, threatening sexual harassment that the veteran experienced during his or her military service. Rape, forcible sodomy, offensive assault, and any attempts of these violations are considered sexual assault (Williams & Bernstein, 2011). Although there are multiple definitions for MST, this is the one used in this manual.

Post-Traumatic Stress Disorder (PTSD) – a mental health problem that develops after undergoing or witnessing a life-threatening event, such as combat, a natural disaster, a car accident or sexual assault. (US Department of Veterans Affairs, 2016).

Veterans Affairs (VA) – The department of government that oversees veterans services, including healthcare.

Absent Without Official Leave (AWOL) – when a member of the armed forces who, with no authority, fails to go to his/her appointed place of duty at the time given; goes from that place; or absents himself/herself or remains absent from his/her unit, organization, or place of duty at which he/she is required to be at the time given. Punishable via military court-martial. (GI Rights, 2016).

Operation Iraqi Freedom (OIF) - U.S. military conflict with Iraq

Operation Enduring Freedom (OEF) – U.S. military conflict with Afghanistan

Operation New Dawn (OND) - During Operation New Dawn, the remaining 50,000 U.S. military members serving in Iraq conducted stability operations, focusing on advising, assisting and training Iraqi Security Forces (ISF) (USF Iraq, 2016).

Literature Review

Abstract

This literature review explains the prevalence and impact of sexual assaults of female soldiers and how these incidents can lead to post-traumatic stress disorder (PTSD.) Although current estimates suggest that up to 40% of active duty females experience military sexual trauma (MST), most incidents go unreported based on the fear of negative outcomes and stigma around reporting an assault. Many female veterans who experience a MST while serving their country now have PTSD, accompanied by negative coping mechanisms such as substance use and self-harm. This paper will discuss the psychological barriers that come with an MST, personal stories from female veterans, and different treatment options.

Sexual assaults of females within the military are more common than one may think. And PTSD from an MST is one of the most persistent mental health concerns currently effecting female veterans. When a female has been attacked, the fear of being attacked again can have a major effect on her day-to-day and overall quality of life (David, Simpson & Cotton, 2006). MST, as defined by the Department of Veterans Affairs (VA), covers both experiences of sexual assault as well as repetitive, threatening sexual harassment during active military service (U.S Department of Veterans Affairs, 2015). Experiencing an MST increases the risk of PTSD, which is the most common diagnosis within the population of female veterans seeking mental health services (Ferdinand, Kelly, Skelton, Stephens, & Bradley, 2011). Diagnostic criteria for PTSD includes a history of exposure to a traumatic event and symptoms from each of the four

symptom clusters: avoidance, intrusion, negative alterations in cognitions and mood, and modifications in arousal and reactivity (U.S Department of Veterans Affairs, 2016).

Active duty military fear the stigma of reporting, the negative consequences that can happen, and fear their life and/or career will get worse if they report an assault.

There are associations between PTSD symptoms, the involvement of an MST, and the prospects for alcohol use and coping skills that predict drinking behavior (Creech & Borsari, 2014). A person with an MST can have significant emotional and physical distress often manifested in feelings of hopelessness, shame, and/or betrayal (Conrad, Young, Hogan, & Armstrong, 2014). This paper will also include evidence of research based studies on female veterans who have experienced an MST and now have PTSD and the different treatment methods.

Female Veterans and Sexual Trauma

Literature Review

Joining the military service, whether it was forced or voluntary, involves the expectation of absolute obedience, uniform appearance, disengagement from family and a potential threat for physical injury and mental stress as well as the requirement for responsibility beyond the needs of the individual. Between the years of 2000-2010 the average age of female recruits was roughly 20-22, which is considered early adulthood. The early adult soldier is forced to achieve within new situations that have their own rules, new demands and challenges that associated with a competitive atmosphere, and constant feelings of being tested (Northcut & Kienow, 2014).

In a 2016 Pentagon report, the military acknowledged more than 6,000 sexual assault reports in the previous year. Out of those, approximately 250 were directed to a court-martial and conviction, which means only about four percent of sexual assault complaints led to a conviction (Tilghman, 2016). Those are just the reported assaults. Many active duty and veterans do not report because they perceive that no good will come from reporting. The fears are endless and the stigma around reporting as well as the fear of being labeled in a negative way is considerable. In 2011, the Pentagon estimated that 80% to 90% of MST experiences are unreported and 97% knew the person who assaulted them. Victims of MST still tend to pursue treatment even if they did not report the assault while on active duty. The Department of Veterans Affairs has a strong treatment program with trained clinicians for female veterans with MST and PTSD (O'Brien, Keith, & Shoemaker, 2015). The most common complaints are, but not limited to: headaches, gastrointestinal symptoms menstrual problems, pelvic pain and back pain, and chronic fatigue (Conrad, Young, Hogan, & Armstrong, 2014).

How Common Military Sexual Assaults Occur and Stories from Female Veterans

The experiences of an MST are alarmingly common. Traditional estimates indicate that almost 20% of female veterans requesting mental health treatment from the Veterans Health Administration (VHA) were sexually assaulted while serving in the military. Another 20% experienced repetitive threatening sexual harassment (Ferdinand, Kelly, Skelton, Stephens, & Bradley, 2011). Recently published Pentagon data estimates that, in 2012 alone, 26,000 military personnel were sexually assaulted, reflecting an increase of 7,000 victims of MST from the prior year (Northcut & Kienow, 2014).

In 2009 sexual harassment increased 11% in all military branches and 16% were in combat sectors of Afghanistan and Iraq. Between 2003 and 2008, 48,106 female veterans were screened at the VA for experiencing sexual assault during their service. Females in the military who have a high level of combat stress paired with an MST have a higher likelihood of PTSD even without combat exposure. One study found 71% of female veterans with PTSD requesting disability from the VA had experienced MST (Cater & Leach, 2011). Women who have experienced an MST have a higher rate of PTSD than women with other military-related disturbances (Sufis, Malcolm, Chard, Ahn & North, 2013).

Military sexual assaults do happen to both male and female populations. In 2013, 13,900, or 1.16%, of the 1.2 million men on active duty status suffered sexual assault, although 12,100, or 5.26%, of the 203,000 women who serve experienced the same crime (Northcut & Kienow, 2014). Military sexual trauma survivors with PTSD are different from those veterans suffering PTSD from his/her exposure to death and/or violence.

MST/PTSD trauma is unique because of the massive personal and professional damage, frequent participation in self-injurious behavior, and enduring traumatization long after the initial trauma occurred, when seeking treatment (Northcut & Kienow, 2014).

As hard as it is to negotiate a world that feels unsafe, research has shown the effects of trauma on the entire person and not just the psychological effects such as dissociation, anger, and shame. Researchers proposed that the sense of identity is not reducible to just a “psychological” sense of self. Rather there are composite factors reshaping the mind, body, and behavior (Northcut & Kienow, 2014).

The following are examples of what a female may experience while serving her time in the military. One female soldier shared her story of joining the Army at age 19, getting deployed to Iraq, and having her unit leader announce in front of her platoon that she was going to be his sex slave for the next twelve to fifteen months. The soldier went AWOL (Absent Without Official Leave) because she could not deal with his repeated sexual assaults. She was put in military prison for twenty-one days until she was transferred to a new unit (Cater & Leach, 2011).

A second female veteran told her story once she left active duty. During basic training a drill sergeant called her outside, told her not to look around, then blindfolded her and raped her multiple times. He said if she told anyone he would kill her. Although she never reported her sexual assault to anyone, the soldier did her best to finish basic training, continue to her job training, then move on to her duty station. The veteran stated that she used alcohol and cocaine to cope with the emotional numbing and that she ended up “running drugs” to feed her addiction (Ferdinand, Kelly, Skelton, Stephens, & Bradley, 2011).

A third female military member was sexually assaulted by a fellow soldier. When she reported the assault to her superiors, the focus of their investigation was not on the man who assaulted her, but on her. She was questioned about her drinking, her motives for visiting his room, and subsequently blamed for her own assault. She channeled her feelings by writing them in a journal. When her room was searched and the journal found, she was then hospitalized for a psychiatric evaluation. When she received the diagnosis of borderline personality disorder. The military discharged her as unreliable. By reporting the events that had happened to her in accordance with her mental health status, she lost the opportunity for advancement or to even stay in the military (Northcut & Kienow, 2014). In her mind, she let her squad down, as well as her country and professional and personal self. (Northcut & Kienow, 2014).

These forms of trauma are often inflicted by someone well known to the victimized person, and comprise a betrayal of trust. Numerous aspects specifically associated in an MST can be traumatizing. Being mistreated by a military associate can increase the sense of betrayal. Victims may assume that escape is not possible and fear negative consequences for revealing their sexual assault (Ferdinand, Kelly, Skelton, Stephens, & Bradley, 2011).

Fear of Reporting

Reporting of sexual assaults within the military rose nearly 88% between 2007 (2,688 reports) and 2013 (5,061 reports). The Department of Defense (DOD) has recognized that less than 15% of military sexual assault victims report the assault to a military authority. More recently, a 2015 research review on MST specified that between 9.5% and 33% of women report undergoing a rape or an attempted rape while

serving (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015).

Most survivors are intimidated to report for fear of retribution and fear that the perpetrator will not be punished (Northcut & Kienow, 2014).

Culture Shock from Civilian to Military Life

Joining the military, no matter what the reason, changes one's personal identity and demeanor. Military training protocols are intended to convert an individual civilian into a group oriented soldier functioning at peak performance physically and mentally (Northcut & Kienow, 2014). Society may have their own thoughts and opinions on basic training, also known as boot camp, but for young civilians, the transformation is not just physical training. Basic training is also designed to remove societal restraints and convert recruits into instruments of war. The process destabilizes individual needs, feelings, thoughts, desires and behaviors and replaces them with unquestioning loyalty to one's platoon and branch of military service (Northcut & Kienow, 2014). Contained within the changed identity of the physical self is significantly changed psychological and sociological functioning as well (Northcut & Kienow, 2014).

Personnel entering military culture are taught that the mission comes first. Additional non-negotiable values include: selfless service, courage, honor, respect, discipline and the refusal to accept defeat. Trained acceptance of these values may create the belief that reporting an individual MST somehow disrespects the group's values. Therefore, sexual harassment is tolerated in work environments where males and females live together 24 hours a day (Cater & Leach, 2011).

Stigma of Reporting an MST

Generally, most sexual assaults in the military go unreported because the victims fear social and professional retaliation. Military culture teaches that service to country demands suppression of individual pain and emotions. The soldier's attention must, at all times, be focused on more important elements such as completing the mission. Unit cohesion is highly enforced and subsequent bonding helps everyone learn to trust, get along, and take care of each other. When a sexual assault happens, especially in cases when the perpetrator is in the same unit or, even worse, out ranks the victim, unit cohesion collapses and trust is broken (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015).

Barriers to seeking treatment at the VA are described in reports by veterans who believe the system has not been beneficial to them. Many have the perception that VA providers rely heavily on prescription medications instead of examining the influence of a trauma in a more holistic fashion. Victims report avoidance, lack of knowledge, stigma, and gender related concerns such as lack of support from a male dominated environment. Some may have issues with a male service provider (Northcut & Kienow, 2014).

It is important to understand how influential the military culture is in manipulating or downplaying the experience of trauma. In the progression from civilian to soldier to veteran, a female soldier's military experience alters the ways in which she views herself and how she relates to others throughout life (Northcut & Kienow, 2014). The existence of an MST may not be related to war and clearly goes against the values, honor codes and laws of the US military. However, any attempt of sexual assault against

a soldier's will, no matter where the location of the assault took place, is an MST (Conrad, Young, Hogan, & Armstrong, 2014).

PTSD based on MST

PTSD is one of the most demanding mental health concerns facing female veterans today. When a female has been attacked, the fear of being attacked again can have a major effect on every aspect of her health and quality of life. Psychological repercussions may include avoidance, emotional numbing and physiological hyperarousal (David, Simpson, & Cotton, 2006). In addition, sexual trauma correlates to multiple negative physical consequences, such as headaches, chronic pain, gastrointestinal and gynecologic disorders and an overabundance of physical symptoms (Ferdinand, Kelly, Skelton, Stephens, & Bradley, 2011). Sexual trauma can also lead to eating disorders, depression, dissociative disorder, personality disorder, substance abuse and panic disorder (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015). Research has shown that veterans of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) with an MST are more likely than those without an MST to have at least three comorbid mental health diagnoses (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015).

Having an MST may lower the veteran's self-esteem and motivation; produce undesirable views about one's self and others; create emotional dysregulation; increase risk of physical illness, self-harm, relationship issues and lead to substance abuse. It may also cause hyperarousal (insomnia, irritability and startle reactions), and elicit feelings of self-blame, guilt, loss and social alienation (Cater & Leach, 2011). Some trauma survivors can no longer experience the world as a safe place. Feelings of

disempowerment and disconnection from others are common in survivors of an MST. Because of this, recovery treatment needs to include empowering survivors and helping them create new attachments. MST can disrupt past patterns of effective functioning that contributed to the overall sense of self and uniqueness of the individual. The various aspects of self - biological, sexual, psychological, spiritual, behavioral, sociological - can become disconnected and, at the very least, the sense of continuity and feeling of identity is disrupted (Northcut & Kienow, 2014).

Emotional Stress and Coping Tactics

When comparing United States veterans to civilians, US veterans have higher rates of substance abuse and health problems. Alcohol use interacts with the coping style, emotional stress and the relationship with MST and PTSD (Creech & Borsari, 2014). Some reported experiencing depression. And more drinkers are reporting they experienced MST and/or sexual harassment while participating in the recent Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) conflicts. A study examined the relationship between coping style, beliefs about alcohol use, experience of MST, and symptoms of PTSD and alcohol consumption in female veterans who use the VA as their primary care (Creech & Borsari, 2014). The study found that one out of the nine participants who reported heavy irregular alcohol use in the past 30 days had also reported experiencing an MST (Creech & Borsari, 2014). The study also indicated that the experience of MST, rather than PTSD symptoms, tends to relate to alcohol use. MST was related to binge drinking, yet can go with other issues that can cause alcohol use and that MST does not affect an increased alcohol use (Creech & Borsari, 2014).

Understanding other effects of trauma is important. Self-injury, for example, often occurs with PTSD, and can involve cutting, burning, or starving oneself. Self-destructive behaviors can be different for everyone. Survivors frequently define the behavior as an attempt to reclaim some control in their confused world. Emotional states can range from shame, rage, sadness, anxiety, grief, and/or depression (Northcut & Kienow, 2014).

Multiple articles state that a female veteran with MST and PTSD may have an eating disorder. A study found that unhealthy eating patterns, such as overeating and binge eating, may emerge to cope with post-deployment stress (Northcut & Kienow, 2014).

One of the most frustrating aspects with MST occurs when the victim had to continue to work near, and sometimes live with, her offender. This situation can lead to debilitating emotional and physical distresses, such as shame, hopelessness and betrayal (Conrad, Young, Hogan, & Armstrong, 2014).

Sexual Trauma in Males

Over the years, the primary focus of sexual assault in the military was on females, even though data showed that 50% of sexual assault survivors are men. Cultural variables are correspondingly as important when investigating sexual assaults of men, specifically in the military setting. And more attention is needed to comprehend the impact of military culture on male survivors of a military sexual assault (O'Brien, Keith, & Shoemaker, 2015).

Research on adult male sexual assault is a moderately a new endeavor. There are minimal publications prior to 2000 on sexual violence against men (O'Brien, Keith, & Shoemaker, 2015). There is, however, an increasing awareness that sexual assault of males occurs throughout military service. The Veteran Administration's focus on MST

encompasses both female and male veterans; but there is negligible practical work that focuses on male MST. As of 2011, for example among the 74 peer reviews of articles published prior to December 2009 focused on MST, only two concentrated on men, with an additional 14 reporting gender-specific data. Most of the remaining articles focused exclusively on females (O'Brien, Keith, & Shoemaker, 2015).

In 2010 a study by the Defense Manpower Data Center found that 85% of military males who experienced unwanted sexual contact did not report the occurrence. The Department of Defense estimated that 67% of women and 81% of men do not report sexual assaults that happen to them while they are in the military (O'Brien, Keith, & Shoemaker, 2015). The Naval Inspector General estimates that 66% of sexual assaults against males go unreported. In 2013 there were 57,800 men (1.3%) and 77,000 women (24.3%) seen at the VA who experienced an MST. Regardless of the difference in percentages of MST between sexes, the total of males and females who report MST are moderately comparable, since there are more males than females in the military. Sexual assault is one of the most underreported crimes, and male sexual assault appears particularly underreported (O'Brien, Keith, & Shoemaker, 2015).

There is minimal information available on the specific causes for underreporting military sexual assault. In 2012, the Department of Defense surveyed active duty members about gender relations and decisions to not report sexual assaults. The response from males identified negative consequences of reporting, such as punishment for violations, decreased chance for promotion, and not being believed. Females reported feelings of discomfort and wanting to keep the sexual assault confidential (O'Brien, Keith, & Shoemaker, 2015). According to a later analysis of the 2012 survey, the

following information was not included in the questionnaire; it can be recognized that males in the military have concerns about their career, but the avoidance of the penalties of reporting may also reflect an awareness of cultural norms related to masculinity, male sexuality, and the delicate emphasis on the high expectations of being a male service member (O'Brien, Keith, & Shoemaker, 2015).

When males with an MST go to the VA for help, their symptoms can include suicidal behavior, personality disorders, PTSD, attention deficit hyperactivity disorder and conduct problems, dissociative disorders and bipolar disorders. A national study of 941 male and female sexual assault survivors discovered that males report significantly higher levels of distress, such as sexual concerns, dysfunctional sexual behavior, externalizing activities, anger, anxious arousal, impaired self-image and defensive avoidance. The National Comorbidity Survey found that the prospect of receiving a PTSD diagnosis following a sexual assault was higher for men (65%) than women (46%) (O'Brien, Keith, & Shoemaker, 2015).

Military culture exerts a major influence on men and women who do not report their sexual assaults. One military myth is that "real" men can fight off a rapist, and no man would let himself be raped without at least suffering serious injury. The military culture intensifies the strong will to take control of hostile conditions as the aggressor and the accompanying belief that military men are too strong and confident to be sexually assaulted (O'Brien, Keith, & Shoemaker, 2015). A persistent myth is that male-on-male rape is about homosexuality, and that homosexual men get raped only by homosexual men. A parallel myth is that rape is about sexual attraction. Both these myths influence the decision not to report a sexual assault (O'Brien, Keith, & Shoemaker, 2015).

Treatment Options

In 1995, the Veterans Health Administration made all MST-related care free and, in 2000, authorized universal screening. Currently, MST programs are available in 92% of VA health centers. In 2009, 590,000 health care outpatient visits were designated as MST related (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015).

Although there are multiple studies on treatment for PTSD, the proportion of studies related to MST and PTSD is small. Reports show that some veterans may not want to access Veteran's Affairs (VA) treatment because they believe the system has been unsuccessful for them. They perceive that VA providers rely heavily on prescription medicine and routinely avoid fully examining the impact of the trauma in a more extensive way (Kintzl et al, 2015).

A core treatment option offered at VA hospitals is cognitive processing therapy (CPT). This is a manualized cognitive-behavioral therapy by Resick and Schnicke for treatment of rape related PTSD which has been modified for treatment of MST and PTSD in veterans and active duty military (Sufis, Malcolm, Chard, Ahn & North, 2013). Cognitive processing therapy provides an outline for theorizing PTSD as a disorder of non-recovery from trauma. Initial interventions contain education, examination of thoughts through Socratic dialogue and skill building. The remaining five sessions challenge beliefs surrounding themes of safety, trust, power, self-esteem and intimacy (Sufis, Malcolm, Chard, Ahn & North, 2013). CPT is an evidence based, trauma focused therapy for PTSD and studies have shown that participants only need twelve sessions or

less to achieve remission. The focus is on why the patient believes the significant event happened, how it has affected his/her beliefs about him/herself and others, and how to differentiate thoughts from facts. Patients are taught to identify events, thoughts and subsequent emotions while the therapist helps them observe the facts and framework of the trauma through Socratic questioning. This treatment is done through talk therapy as well as using progressive worksheets. Over time, patients learn to examine their own thoughts and emotions and develop new and more balanced thinking about traumatic events. (Resick, Wachen, Mintz, Young-McCaughn, Roache, Dorah, & Peterson, 2015). CPT does not include a discussion of the traumatic event(s) because the emphasis is on helping manage the present symptoms through problem solving. (Resick, et al, 2015).

Another treatment option well known at the VA is prolonged exposure (PE). This is a manualized treatment delivered in an individual format over nine to twelve sessions. The therapy is set up in two core components: exposure to real-life, feared stimuli and imaginal exposure (exposure to traumatic memories). The imaginal sessions involve making intensely detailed auto-recordings of the patient's worst traumatic experience in the presence of the provider, followed by emotional processing, or discussing the traumatic events, for approximately seven to nine sessions. The goal of imaginal exposure is to overcome distress, and process the difficult emotions associated with the traumatic memory (Zoellner, Feeny, Cochran & Pruitt, 2003).

Another treatment option is present-centered therapy (PCT). This is a manualized therapy for PTSD without the cognitive-behavioral or trauma-focused aspects of CPT. In PCT, the therapeutic focus is purposely redirected away from discussion of traumatic events. PCT provides care and educational focus on current issues in the client's life with

the emphasis on problem solving and improving relationships, and the connections made between current problems and PTSD symptoms (Sufis, Malcolm, Chard, Ahn & North, 2013). PCT utilizes writing as a component in the form of daily journaling. PCT was extended from 10 to 12 sessions to match CPT (Sufis, Malcolm, Chard, Ahn & North, 2013).

Eye movement desensitization and reprocessing (EMDR), also evidence based, is another psychotherapy for PTSD. EMDR can help with processing upsetting memories, thoughts and feelings related to trauma. After a trauma, individuals with PTSD often have trouble making sense of what happened to them. EMDR helps process the trauma, and this can allow the healing to start. The client pays attention to back-and-forth movement or sound while they sit and think about the painful memory long enough for it to become less overwhelming. Some research says that the back and forth movement is an important part of treatment, but other research says the opposite. In the first stage, one learns about physical and emotional reactions to trauma. The client discusses if and when they are ready to focus on the traumatic memories in therapy and acquire new coping skills. The second step is to identify the upsetting memory the client wants to focus on, including negative thoughts, feelings, and physical sensations related to the memory. The client holds the memory in their mind while also paying attention to a back-and-forth movement of sound or light until the distress goes down. The average duration is about 30 seconds at a time. Eventually the focus will shift to a positive belief and feeling and, near the end of treatment, the client will be re-assessed for symptoms to gauge their progress (U.S Department of Veterans Affairs, 2016).

Treatment for MST and PTSD is key in getting through the trauma. Feeling safe and powerful can help, too. Personal safety helps empower women to cope with the threat of sexual violence. With all the findings on MST and its relation to PTSD, researchers questioned whether a therapeutic self-defense program may function as a heightened exposure therapy model for female veterans who experienced an MST and now have PTSD (Simpson & Cotton, 2006). Taking Charge is a program of self-defense and personal safety training for women with PTSD from an MST. Taking Charge is a 36-hour comprehensive behavioral intervention connecting psychoeducation, personal safety and self-defense. The results, from up to six months follow up, indicate significant reductions in behavioral avoidance, PTSD hyperarousal, and depression, plus significant increases in interpersonal activity and self-defense self-efficacy. This can be an added therapeutic tool with treatment of PTSD (Simpson & Cotton, 2006).

Conclusion

Research on MST and PTSD is ongoing for veterans, both female and male. This literature review discussed how frequently MST happens and how it can be difficult to document statistics when so many sexual assaults go unreported. It was discussed why these sexual assaults go unreported, and how the reasons for not reporting differ between male and female military victims. The focus of this paper was primarily on female veterans. But, of course, that does not mean that males do not experience sexual trauma as well. At this point, there is just much more information on female veterans than on their male counterparts.

Military culture is a major factor in why so many MSTs go unreported. Learning more about the culture, as well as the ways veterans cope with MST, and often develop

comorbid symptoms such as substance use and traits of personality disorder, is critical. A range of treatment options were described. Usually the veteran has a choice as to which treatment will be the best fit. EDMR is a relatively new treatment. Not every VA has personnel trained in EMDR, and there is a difference of opinions on how effective it really is, especially when compared to the other treatments offered by the VA for MST and PTSD. More research on active duty members experiencing MST and reducing any delay in getting them into treatment (so they do not end up with PTSD as well) is also key. In addition, continuing and expanded prevention programs, to stop military sexual trauma from even happening, must be further explored.

Section 1: How Common Are Sexual Assaults in the Military?

Most experts believe that the total number of sexual assaults that happen in the military is massively under-reported. In 2012, out of the 203,000 females in the military, 12,100 reported a sexual assault. However, in anonymous surveys, military members submit data that more than 20,000 military troops are assaulted every year (Tilghman, 2016).

In 2002, the Veterans Health Administration (VHA) instigated a standard screening program, in which every veteran seen for health care is asked whether he or she experienced MST. Since then, national data from nearly 4.8 million veterans reveals that about 1 in 4 women and 1 in 100 men responded “yes,” that they experienced MST. Importantly, this data speaks only for the veterans who have chosen to seek VA health care; but not for those who haven’t. (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016).

The data from other reports is equally startling: A 2008 survey says that 60% of females serving in the National Guard and Reserve had experienced an MST. More recently, in combining 21 studies on MST and PTSD, some results found that sexual harassment went from 55 to 70%, while sexual assault went from 11 to 48% in female veterans (Katz, 2016). Another combination of 25 studies discovered that MST of sexual assault went from 20 to 43% in female veterans. The studies focused only on females returning from combat (Iraq and Afghanistan) and range from 14 to 15.1 % for females screened at the VA.

Adding insult to initial injury, women suffering MST are four to nine times more likely to suffer from PTSD as well, then those women in the military who were not

sexually assaulted (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015).

As a consequence of the large number of active duty women reporting sexual assaults, and the larger number of veterans affirming unreported assaults, the VA has identified MST as a priority focus area for research. Reports of sexual harassment and assault among active duty service members have also raised public awareness of MST, prompting research aimed at understanding its effects (Yano et al., 2006).

Survivors of rape are considered the largest group suffering from MST with an assessed rate of 33 to 57% developing PTSD. Experiencing an MST does not always lead to PTSD. It can lead to other symptoms; hyperarousal, dysregulation, a profound sense of betrayal from the perpetrator as well as bystanders such as people in authority, lack of closure and a smothering sense of injustice and resentment, the unrealistic shame and self-blame as well as feeling excluded from peers and avoiding social connections (Katz, 2016).

Examples from female veterans who experienced MST

The following examples have been publicly posted by female veterans who experienced an MST:

In 2009, Katie joined the Army at the age of 17, to serve her country, earn money for college and to make a career from being a soldier. Katie's first duty station was in Germany. Within her first week, when she had not received her paycheck, her Staff Sergeant took her to the finance office to see what needed to be fixed. She was brought in to speak with a male Specialist about her issue and to get it resolved. Later that night Katie was invited out to a club with some people from her new unit. She ran into the

Specialist from that day and met his wife. An hour later, he asked her to come outside to talk about her paycheck. He walked Katie up three stories of the fire escape where he stopped her, turned her around, tried to kiss her aggressively, then bent her over the iron railing, and raped her. When she found an opening to push him away, she ran down the stairs, but he pushed her back. Her last alternative was to try and climb over the railing but, before she could, he pushed her. Katie fell, woke up a few minutes later, and managed to get home on her own, worried that the soldiers she had gone out with had no idea where she'd gone.

The next day, Katie fell out of her run because of major back and cervical pain, and bleeding. When Katie told another female soldier what happened, she was called a liar and told there is no way that Specialist would do something like that because her fellow soldier knew him personally. The female soldier told Katie's Staff Sergeant and he advised Katie to keep quiet. The next day, Katie went to the doctors and told the Major what happened. Although he documented her claim of sexual assault, he did nothing else but give her a few days off from physical training for her back. Later when she was walking into her room, the Specialist that had raped her had somehow gained access to her room and was demanding she take an AIDS test and show him the results. Katie told a female Sergeant, who told her male NCOIC. When he met with Katie privately, he said, "I know what you are claiming, and all this talk about rape just needs to be over or it's gonna get you in trouble." Although Katie stayed in the army for a year, she was continually harassed by peers, then discharged for not meeting fitness standards. At the VA clinic, Katie was treated for depression, addiction, and PTSD. Today, Katie works

with survivors from MST and addiction and continues to convince other survivors to get help (Protect Our Defenders).

A second example is Vanessa, who was sexually assaulted by her Navy recruiter during the time frame that Don't Ask Don't Tell was appealed. Vanessa had set up an appointment by phone to take the pre-test of the Armed Services Vocational Aptitude Battery (ASVAB). She met the recruiter outside the recruiting station to take the computerized pre-test, and felt uncomfortable because he was staring at her while she was taking the test. Once the test was over, he asked to take her back to the station in his car. Vanessa thought she could trust him because people in the military are usually trusted and have positive morals. At the station, he grabbed her and forced her to perform oral sex, then threatened her to keep it quiet.

Vanessa went forward and completed basic training at Ft. Jackson, South Carolina. One night during basic, a drill sergeant accused her of looking at other females while they were in the shower and told her it was inappropriate. Although she did not understand where such accusations were coming from, she stayed silent and did nothing. Then she was ordered to no longer shower with the other females and told she would have to wait and sometimes have an escort. This lasted for a few weeks though they told her it would be a few days. During a live fire exercise, a male soldier touched Vanessa in her genital area. She tried to kick him and move away and told him to stop, but did not want to bring any attention to herself or him. She just wanted to move but could not move because of lack of space. Vanessa reported the incident a few days later, but nothing was done. She did not want to press charges; she just wanted them to know and for it to stop. Her drill sergeants told her she was making it up and, if she wanted it to stop, she could

have stopped him. After Vanessa graduated basic training, she went on to Advanced Individual Training (AIT), for further instruction in her Army assigned job. While Vanessa excelled in every aspect, she was bullied by her peers and made the conscious choice to just keep going.

After graduation from AIT, Vanessa went to South Korea for her first duty station. She was highly motivated, did well, and got promoted. Then, she was assaulted again and went to the emergency room to be evaluated. The provider did a rape kit, kept her for three days, and investigators arrived to interrogate her. Vanessa was threatened by her commander to be chaptered out of the army based on failure to adapt to the military environment. Vanessa was sent to a new unit, was assaulted again, but was still able to overcome her assaults. She describes herself as demonstrating the power of being resilient and persevering (Protect Our Defenders).

The final example is from a retired female who graduated from West Point. “Every time you turn around,” she testified, “you are re-victimized and re-traumatized.” She also testified that she was raped in Kuwait by a noncommissioned officer. Although she reported right after the assault happened, her attacker was never punished, and she was discharged for PTSD (Cater & Leach, 2011). In another example, during a military hearing, a sexually assaulted female was asked questions along the lines of, was she wearing a bra or underwear to the party, if she “felt like a ho” after, and how she opens her mouth during oral sex (Lucero, 2015). These are just a few of the many anecdotal examples available of what some women may experience while serving in the military.

Statistics from the VA and the Pentagon

Women in the military are more likely to be sexually assaulted by other military members than killed in combat (Lucero, 2015). A 2010 Pentagon study disclosed that out of 19,000 unsolicited sexual assaults, only 3,158 were reported, 575 were processed, and 96 ended with a court martial. In 2012, of 26,000 unsolicited sexual assaults, only 302 went on to trial (Lucero, 2015). In fiscal year 2015, while the total number of assaults was not disclosed, there were 6,083 reported sexual assaults (almost double that of 2010), of which around 1,500 were restricted (victims did not participate in a criminal investigation but did pursue healthcare and support services) (Tilghman, 2016). Of the remaining 4,584 unrestricted 2015 reports, quite a few of the attackers were unknown, or had discharged from the military, or the attacker may have been a civilian and civilians are not tried in the military system (Tilghman, 2016). Once the remaining 2,783 cases were investigated and brought to military commanders, 770 were determined “not enough evidence,” 576 were validated “misconduct to sexual assault.” Of the remaining 1,437, 511 were taken care of with no court martial, and 926 went to court-martial proceedings against the alleged perpetrators. Of those 926 cases, 159 closed because the alleged perpetrator resigned from the military, and 111 cases were dismissed in pretrial proceedings (Tilghman, 2016). Out of the final 656 cases which went to court-martial, 130 led to not-guilty decisions, 413 perpetrators were convicted with a court-martial (161 resulted in charges unrelated to sexual assault, 254 of a sexual assault-related offense), and at the end of 2015, 113 cases were still pending (Tilghman, 2016).

In 2004, the Department of Defense (DoD) created the Sexual Assault Prevention and Response (SAPR) program. This program was designed for active duty members and required them to report details of a sexual assault in order to receive benefits. Based on

SAPR's 2009 annual report, out of all cases filed that year, 63.5% were dismissed. Of the remaining cases, only 26% led to court marital and disciplinary action. However, the DoD did acknowledge that, despite SAPR, only around 20% of all sexual assaults were reported (Cater & Leach, 2011).

Reporting Sexual Assaults

In the past, females in the military have been expected to adjust and adapt to the rules made for men by men. Women would complain because they felt powerless but would fear reporting (Cater & Leach, 2011). Prior to the last several decades, sexual assault and harassment was essentially ignored (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015). More recently, the decision to report a sexual assault is not an easy choice, and making the decision can be influenced by different motives and consequences. In fact, reporting an MST can increase sexual harassment and jeopardize a victim's military career (Cater & Leach, 2011).

To prevent and protect sexual assault victims, provide the services needed, and prevent future assaults, military sexual assaults need to be reported. Today, victims have two options: one is restricted and the other unrestricted. Although, based on other reports, these two ways are not always offered. The question that develops is "why do victims not report?" This question is asked much more now than in the past. Some of the main answers are fear of retaliation, career loss, and the culture of the military (Lucero, 2015).

Section 2: Stigma

Why most Military Sexual Assault Cases go Unreported

The negative after-effects of a sexual assault frequently interfere with the victim's ability to function within the military, and can ultimately cause her to leave the service. Reporting raises questioning of the victim's judgment and effectiveness. This may decrease her ability to advance within a culture that is all about advancing. Many females who have experienced an MST explain that, "If you want to keep your career, you don't say anything...you just deal with it" (Lucero, 2015). Like many other situations in life, people talk. When sexual assault victims in the military hear what other females have endured when they reported their assault, they often decide not to report because they don't want to go through what their friend experienced. The blame and re-traumatizing is too much to handle (Lucero, 2015).

Not only do MSTs go unreported; many members contemplate not staying in the military because of how traumatic the assault was. For 34 to 56%, the fear of losing benefits and career consequences changes their thought process. Further studies need to be done to examine the relationship between female personnel turnover and their feeling of military betrayal and psychiatric stress due to MST. This could provide valuable information regarding how the military perceptions color the response to MST and the veteran's emotional health. There is a high level of suicidal self-directed violence connected with MST. Preliminary research is studying the victims' perceptions of betrayal by the military associated with the symptoms of PTSD, as well as suicidal ideation and symptoms of depression after an MST (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016).

Military Culture

The military teaches recruits to conquer individual pain, refrain from showing emotions, and retain focus on the current mission. Establishing and maintaining the bonds within and between each unit is highly reinforced. Doing anything to shift the positive bond is not good (Kintzle, Schuyler, Letourneau, Ozuna, Munch, Xintarianos & Castro, 2015).

The military culture is dominated by the rarely-questioned core belief that soldiers are protected by their superiors (the officers and enlisted who outrank them). That promised level of support while serving reinforces a soldier's loyalty to and solidarity with the leadership and the rank structure, as well as his or her submission to individual emotional control for the greater good of the group. The commander is the person in charge of each company and everyone under him/her follows his/her orders in an equal manner. A commander is often regarded as a father figure who loves everyone in his/her unit and treats them all the same. When someone reports a sexual assault, leadership and the appropriateness of such behavior is questioned. The commander is required to respond quickly to diminish any upset to the company's cohesion. Often, the most expedient response is to deprecate the person who either was assaulted or who committed the assault. This process can range from a private request to "forget about it" for the sake of the unit, to granting of a transfer, to further investigation and military court action. When the commander emphasizes personal responsibility and submission to maintain unit strength, the original trauma is then compounded by the efforts of the company or squad to perpetuate the status quo (Northcut & Kienow, 2014).

Rape culture is a term created by feminists in the 1970s as a way of describing a culture whose prevailing social attitudes have the effect of normalizing or trivializing

sexual assault and abuse. Rape culture both excuses sexual assault and encourages male aggression, by blaming the victim. An example of victim blaming is attributing the assault to what she was wearing, level of intoxication, or perceived sexual behavior, then blaming and shaming the victim for her negative decisions. Sexual assaults create fear. Rape culture prolongs the fears and stops women from reporting (Lucero, 2015).

Sexual Harassment is tolerated in the Military

When males and females live in close quarters during training or deployments, sexual harassment becomes tolerated. This happens when both sexes are living together for 12 to 18 months at a time. As much as they are trained to have unit cohesion, to bond, and take care of one another, relationships between soldiers can turn hostile, and this is when sexual assaults may happen. Cohesion is replaced by a very real sense of apprehension and vulnerability, especially when a victim of sexual assault is forced to live and work with their attacker and the fear of reporting is pervasive since everyone in the unit remains in close proximity. There is no way out when the unit is deployed. If the trauma is reported, it can destroy the vital belief that everyone protects each other (Cater & Leach, 2011).

Psychological Impact and the Reporting with Rank Structure

Disclosing a sexual assault in the military can amplify the original trauma, especially when the victim is discouraged from reporting it and/or punished for it. Studies of female veterans who experienced a sexual trauma found that the suffering associated with the trauma can be four times worse than stress related to military life and that suffering leads to PTSD. PTSD from MST is possibly one of the most tenacious mental health concerns facing female veterans today (David, Simpson, & Cotton, 2006).

Veterans who have experienced an MST often report a perception of institutional betrayal. A study of MST survivors revealed a list of twelve negative perceptions imposed by others on those who experienced sexual trauma. The list includes: suggesting the experience might affect the reputation of the unit; being punished for reporting the assault via loss of status and privileges; denying and/or covering up the MST; corruption of the case, if corrective action was requested; inadequate or no response to the MST, making it more difficult to report than it already is; producing a situation to make it look like the experience was bound to happen; recasting the assault as common and normal; as well as saying the victim did not take proactive choices to prevent it from happening (Monteith, Bahraini, Matarazzo, Soberay, and Smith, 2016). The study showed a clear association between the perception of betrayal and the symptoms of PTSD and depression, based on the MST and how it was handled by military authorities. Some victims even reported suicide attempts. This study and other research has established that MST is associated with PTSD, suicidal self-directed violence, and depressive symptoms. Few studies have observed the factors that predict PTSD outcomes from an MST (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016).

Section3: The Relationship between MST and PTSD

PTSD is one the most pressing mental health concerns facing female veterans today. Females who are victims of sexual assault regularly present a specific profile of symptoms: anxious arousal, re-experiencing the trauma, avoidance, and fear. Some may think that these symptoms, which generally show right away, are signs of PTSD. However, they may also represent an acute reaction to the sexual assault. There is a relationship between the different coping strategies and PTSD, which may help explain why some are successful with their recovery, while others develop long lasting problems (David, Simpson, & Cotton, 2006).

Brain Chemistry and Relations to PTSD

Experiencing a traumatic event may affect several systems in the body. Mental processes become detached from other systems that normalize feelings and behavior. Neurobiology proves that systems are shaped and strengthened through maturation and experiences, starting with early attachments through childhood, and reinforced to change within subsequent relationships (Northcut & Kienow, 2014).

The effects of trauma can vary depending on the person's stage of life and brain development. There have been a few studies which looked at the effects of trauma on neurobiology, depending on the victim's stage of development, but research is currently limited. The regions of the brain said to have an important aspect in PTSD are the medial prefrontal cortex, amygdala, and the hippocampus. One study of adult rape survivors found that verbal declarative memory deficits are closely associated with PTSD, and are a nonspecific effect of exposure to trauma (Bremner, 2006).

Protocol on how to report

In the military, there are two official ways to report a sexual assault. One is restricted; the other is unrestricted, which is usually the option preferred by command and the ones taking the report. Restricted reporting is when the victim wants to report the assault but does not want an official investigation, which means no one can be contacted in the victim's chain of command. In this instance, the victim can contact a SARC/SHARP Specialist to make the report, and the Specialist will assist with medical care, treatment and counseling without alerting their command or law enforcement. The restricted report is supposed to be confidential, and not disclosed to anyone such as law enforcement or the chain of command, except in a few extremely infrequent circumstances. The person is still entitled to health care, medical treatment, legal assistance, advocacy services and counseling (U.S Army, 2016).

The limitations of making a restricted report may include: not being eligible for potential expedited transfer; no guarantee of privacy or repercussions if, for some reason, the victim's command finds out about the assault; and not being able to discuss that assault with anyone, including the chain of command or friends within the unit. In addition, if evidence of the sexual assault is lost, there may be significant obstacles to shifting to an unrestricted report. Also, some victims cannot obtain protective care from the military and, most importantly, the victim's attacker goes unpunished (U.S Army, 2016).

By comparison, unrestricted reporting provides the victim with the option for medical treatment, legal assistance, and counseling by reporting their assault to SARC/SHARP Specialist, as well as an official investigation of the crime. The victim

will be advised on legal issues, receive assistance with prosecution resources, and details of the incident will be limited to only those who need to know (U.S Army, 2016).

Education on Symptoms

PTSD symptoms can include: re-experiencing of upsetting traumatic events, avoidance of cues that are reminders of the traumatic events, emotional numbing, and physiological hyperarousal. Inescapable fears of sustaining another attack may distinctly restrict such women's everyday activities and functioning, and thus severely invade on their quality of life (Herman, 1992). PTSD and may, therefore, markedly affect an individual's access to activities outside the home, such as treatment, work, recreation, involvement in community activities, and the pursuit of educational or retraining opportunities (David, Simpson, & Cotton, 2006).

PTSD from a combat-related event has been characterized as a chronic disorder, especially with Vietnam veterans. Multiple studies have found that, even after thorough treatment, the symptoms of PTSD persist with very little change. Subsequently, the multiple programs designed to treat PTSD have switched from a symptom reduction model toward the direction of a rehabilitation model which attempts to maximize patients' coping skills (Murphy & Rosen, 2006).

Overseas vs Stateside

Veterans report that the stresses of being deployed to Iraq and Afghanistan can be endless. Since OIF and OEF, more than 150,000 female military members have been deployed. From those deployments, more than 160 women were killed during deployment; thousands of women were seriously injured, and the number of female

veterans who suffer from substantial mental health problems is unknown. Mental health problems may arise from exposure to violence in combat, MST, and multiple other stressors that happen during deployments. There has not been a substantial amount of research on females returning from Iraq and/or Afghanistan. Most of the military is made up of men, therefore the research has been on males (Mattocks, Haskell, Krebs, Justice, Yano & Brandt, 2012).

Prevention of MST and PTSD

It is clear, based on multiple articles, studies, and reports, why sexual assaults in the military go unreported. Which is not to say that there are not programs and prevention provided to the military to stop assaults or respond to assaults when they occur. Recent reforms and programs strive to create the belief that the justice system is focused on changing the environment that perpetuates rape culture. Most recently, in 2014, the National Defense Authorization Act was introduced to all United States military branches, and includes requirements that reports handle both victims and perpetrators of sexual assault. It also decriminalized consensual sodomy (Lucero, 2015).

The Department of Defense joined The Rape, Abuse and Incest National Network and in 2011 created the Safe Helpline. This helpline offers support by phone, online chat and texting and provides information in regards to reporting, recovery and support. This asset helps the victim find resources and is confidential (Lucero, 2015). In 2013, the Air Force created a program to provide support to victims called Special Victims Counsel (SVC). SVC was later mandated to all branches of the military. This program provides military lawyers as advocates to help with legal issues or anything else the victim may need with the primary goal of representing their client (Lucero, 2015).

These programs have made a positive impact for more recent sexual assault victims, but there are still problems with military culture. While the relatively new programs seek to help the victims, and the effort has been positive to make changes, there remains the intractable problem of people in the military who sexually assault others, as well as a lack of leadership and attention and care toward this issue (Lucero, 2015).

The focus of the military's latest efforts is to stop MST among active members through increased awareness and prevention. Meanwhile, victims of MST continue to struggle with their perceptions of institutional betrayal, as well as attendant symptoms of PTSD, depression, suicidal ideation and attempts. (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016).

Section 4: Negative Outcomes and Ramifications

Substance Use Problems

It is critically important for service providers to understand the relationship of PTSD to an MST because a misdiagnosis of the traumatic experience can lead to the use of ineffective interventions with female veterans. Alcohol use and abuse after an MST are a common coping style for the emotional distress the person has endured. Although military sexual trauma does not always result in PTSD, it is predominant among female veterans and relates to substance use and mental health problems. The level of alcohol use is based on the person's own principles in regard to the perceived effects of drinking. Alcohol can be positive or negative, depending on the person, how much they drink, why they drink and how they may feel after drinking. Drinking is a form of coping, while avoiding something they do not want to address (Creech & Borsari, 2014).

One study of 93 female veterans examined correlates between drinking, depression, MST and PTSD. Over a 30-day period, the nine participants who reported heavy irregular drinking behavior also reported that they had experienced an MST. Among the drinkers, there was a correlation between a high level of alcohol use and MST. (Abstainers/non-drinkers reported a diagnosis of depression.) This study was the first of its kind to investigate the associations between coping style, expectations for alcohol use (i.e, I'll feel peaceful, I've had good times under the influence of alcohol), experience of MST. Symptoms of PTSD and alcohol consumption in female veterans receiving their primary care through the VA. In this study, 70% of the female veterans had experienced an MST, a number quite higher than what has been reported in past research. Based on this research, it appears that alcohol use was more closely related to

MST than PTSD symptoms. The relationship between alcohol use and MST is complex, but results indicate that more drinkers (especially binge drinkers) reported an MST and/or sexual harassment while in the military. The information gained matched with other studies relating positive expectations of alcohol, which may act as impelling factors for binge or risky drinking, and MST among females who reported heavy drinking within the last 30 days (Creech & Borsari, 2014).

Further results suggest that although increased alcohol use may have some correlation with MST and PTSD among female veterans; a narrow focus strictly on drinking can miss other compelling factors including: depression, avoidant coping, combat exposure, and positive views about alcohol. Alcohol use may not necessarily lead to a positive or negative outcome with MST, but clinicians still need to assess for its use. At the very least, exploration of the relationship between coping and the use of alcohol can benefit the client. If not assessed properly, however, treatment outcomes may not be met (Creech & Borsari, 2014).

In 2004, the DoD implemented a 10 to 15-minute assessment among veterans for high risk alcohol use, PTSD and depression for the Afghanistan and Iraq Post-Deployment Screen. In 2010, the VA required all OEF/OIF veterans who were being actively treated for PTSD to be evaluated for symptoms every 90 days, and for providers to monitor changes (Gates, Holowka, Vasterling, Keane, Marx, & Rosen, 2012).

Disordered eating problems and self-destructive behavior

It has been shown that when a military trauma occurs, it may often co-occur with PTSD. The person who experienced the trauma of physical or sexual abuse frequently engages in behavior that is intentionally destructive and physically harmful such as

burning, cutting, or starving oneself, though not consciously suicidal. These behaviors reflect an attempt to regain control of their disordered world by inflicting pain, having a distraction from the emotional pain, and avoiding overwhelming feelings and thoughts. Often the person feels out-of-touch or has problems connecting with others, due to a paralyzing amount of depression, grief, anxiety, sadness, rage and/or shame. At its core, self-harm is perceived to help one gain or maintain control over something, and bolster a defensive system (Northcut & Kienow, 2014).

Avoiding People and Reminders of Trauma

During extreme stress, such as PTSD, but specifically for survivors of an MST, the fight or flight defense systems can be randomly activated, triggering disruptions and alterations in day-to-day life. Often, a defensive reaction is based on the influence of disconnected events, such as going to the grocery store, a common thing to do, then suddenly hearing a song in the background that reminds the survivor of the assault. This can prove a major disturbance for some survivors who need help learning how to reorganize their thoughts and disconnect what happens in the present from the past assault. Through therapy, a survivor learns how to leave the store, let go of the protective hyperarousal, and figure out how she will drive home and be okay (Northcut & Kienow, 2014). Recent studies suggest the integration of multiple treatment therapies including talk therapy, cognitive-behavioral techniques and mind-body interventions, with the goal of helping the veteran re-engage with her body and reformulate her identity post-MST. (Northcut & Kienow, 2014).

Anger and Violent Behavior

Initial research has suggested that PTSD among veterans of the Iraq and Afghanistan Wars can be related to violence and aggression toward others in the community, post-deployment. Among the multiple symptoms of PTSD, those that could be relevant to understanding post-service violence, hostility and aggression include: re-experiencing or flashback symptoms, avoidance, emotional numbing, and physical distancing. Empirical research meant to improve understanding of the diverse types of violence in veterans is rather limited (Sullivan & Elbogen, 2014). However, in one year-long, nationwide study of 1,090 veterans post-deployment from Iraq and/or Afghanistan, 9% admitted to engaging in severe violence, 26% reported physical aggression toward others and hyperarousal symptoms, and 35.9% reported anger, outbursts, or irritability, within the previous year. The younger the age and the higher level of combat experienced were significantly related to the highest level of violence. In addition, co-occurring PTSD and alcohol abuse was associated with a marked increase in violence and aggression. However, researchers suggested that a cluster of factors including demographics, violence history, combat exposure, and veterans having money to cover basic needs, was crucial for optimizing violence risk management. (Sullivan & Elbogen, 2014).

Understanding the Effects of Trauma and How They Lead to PTSD

Although female soldiers tend to have less exposure to combat than males, they have higher rates of MST, which is strongly connected with the development of PTSD (Gates, Holowka, Vasterling, Keane, Marx, & Rosen, 2012). It is important to screen for PTSD within the military because of the possible significance of the emotional and

physical health consequences for PTSD if not treated early. The goal of early screening is to identify those who have been exposed to trauma, who have undiagnosed or subsyndromal PTSD, or who show the risk for developing PTSD. Subsequent earlier intervention would permit the cause of PTSD to be treated prior to having the diagnosis (Gates, Holowka, Vasterling, Keane, Marx, & Rosen, 2012).

In 2003, the DoD established the military-wide screening program to assess all personnel within a two-week time frame of returning home from a deployment. Called the Post-Deployment Health Assessment (PDHA), the screening assesses each soldier for mental and physical health, depression, aggression, suicidal ideation, and PTSD. The assessment consists of a self-report questionnaire plus a brief session with a health care professional, who will document any concerns and decide if more care is needed (Gates, Holowka, Vasterling, Keane, Marx, & Rosen, 2012).

In 2005, the DoD made it mandatory for all military to be re-assessed three to six months after their return from deployments. This delayed time frame made it more probable for a positive screening of PTSD and other mental health issues, since the symptoms do not always appear instantly after a deployment (Gates, Holowka, Vasterling, Keane, Marx, & Rosen, 2012).

Section 5: Preexisting Conditions

Assessment Options

A key consideration for clinicians when assessing an MST is to ask the client for her perceptions on how the military responded to her assault. While screening for PTSD, depression and suicide risk are critical parts of care, it is important to learn if and how the assault was reported, as well as the outcome of the report, and how it was perceived by the military (Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016).

Assessment methods may include diagnostic interviewing, self-report questionnaires, behavioral observation, and psychophysiological monitoring. Questions usually asked are about the nature, severity and frequency of the client's symptoms. The interviews can be unstructured, structured or semi structured. The clinician must decide which style of diagnostic interview will best fit the client (U.S Department of Veterans Affairs, 2010).

The VA uses a few options to assess for PTSD. There is a variety of check lists that take from three to ten minutes and range from four to the seventeen questions. Some clients may require a bit more time to assess and diagnose. The following four interviews correspond with DSM-IV criteria: Clinician -Administered PTSD Scale (CAPS) which has 30 items and takes 40-60 minutes; PTSD Symptom Scale-Interview Version (PSS-I) which has 17 items and takes 20-30 minutes; Structured Clinical Interview for DSM- IV PTSD Module (SCID) which has 21 items and takes 20-30 minutes; and Structured Interview for PTSD which has 27 items and takes 20-30 minutes. The Clinician-Administered PTSD Scale for DSM-IV (CAPS), the standard assessment for PTSD, is a structured interview used to make a current/past month diagnosis, a lifetime diagnosis, or

assess for PTSD symptoms over the past week. This assessment was designed to be run by clinicians who have PTSD knowledge, however it can also be done by properly trained paraprofessionals (U.S Department of Veterans Affairs, 2017).

Trauma Prior to the Military

Many women enter the military with a history of adult sexual abuse (33%) or child physical/emotional abuse (35%). They don't usually have PTSD when entering the military, but they do have significantly higher rates of developing PTSD while in the military, and most will require more health care once they are out of the service (Burkhart & Hogan, 2015).

Diversity

There was a limited amount of research previously conducted on diversity related issues when it came to female veterans who have experienced a MST and now have PTSD. However, there is documented research on what rape victims want the interviewer to know. Researchers have created trainings for programs such as rape crisis centers and domestic violence shelters to place new volunteers on how to speak to the survivor. The trainings are 40 hours or more and tend to include awareness raising about violence against women, myths and facts, causes of violence, cultural sensitivity, safety planning, crisis intervention, community resources and understanding diversity (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009).

The World Health Organization did a study on two groups of interviewers and they found that the trained community interviewers attained higher response rates and disclosure rates for physical and sexual abuse than the professional interviewers. The end result came to that all types of interviewers do require extensive training on victimization,

no matter what their job title or education level is (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009).

The predominant theme of the participants in the study wanted the interviewers to have knowledge about rape and the impact it has on victims. There are four issues that the survivors wanted the interviewers to know, first they wanted it to be known that rape can happen to anyone and that there is no profile for a rape survivor. Second, was being able to engage with the women and for the interviewer to understand how deeply this can affect their life. Third, was understanding the limits of being the person doing the interview and what they can and cannot understand about rape, particularly if they have not experienced it personally. Lastly, to take the knowledge they have about rape and its impact and use it for a fundamental purpose, to help women ease and feel comfortable about talking freely and to establish trust (Campbell, Adams, Wasco, Ahrens, & Sefl, 2009).

Section 6: Treatment Options

The three characteristics especially salient for MST survivors include: the loss of personal and professional identity, the prevalence of self-harming behaviors, and the effects from an institutionalized military culture. These characteristics must be factored into the recovery process to disentangle the traumatization which can interfere with the survivors' ability to seek and receive help (Northcut & Kienow, 2014).

Clients with PTSD can view hypervigilance and isolation as effective and reasonable ways to reduce stress and certify safety, rather than as the “symptoms” of PTSD often identified by a treatment provider. PTSD clients also use anger to minimize, externalize, and rationalize a symptom (Murphy & Rosen, 2006). It is common for the client to see their anger as a normal response to any interaction which they perceive as aggressive. There is a lack of trust and potential for harm in the daily life of clients with PTSD (Murphy & Rosen, 2006). It is important to understand that the therapeutic alliance can be impacted based on the differing assumptions between client and clinician. The client and clinician may agree what the problem is; but they may disagree on the causes of it, and the reasons why the client is coping the way she is. In the experience of VA researchers Murphey and Rossen, some clients with PTSD are skeptical or distrustful of the process, and externalize and resist treatment. In the past, this would be handled by confrontation or “attack therapy,” yet that is just one of the confrontational approaches available. In their view, it is critical to prevent blaming the survivors of trauma for complications resulting from avoidance, distrust and other symptoms of PTSD (Murphy & Rosen, 2006).

Early Intervention

Quick response to the needs of an MST survivor can help to prevent PTSD. The key to early intervention is to focus on safety, reduce distress, get information, and provide support. Some call this psychological debriefing, a method frequently used for people who have been through a traumatic event. There is valid research on why it is important to provide mental health services using interventions that can help. There is more research which suggests that early intervention for trauma do not prevent subsequent psychopathology. VA studies have shown that multiple survivors of trauma show a series of PTSD responses within a few weeks after the traumatic event, and quite a few of them adapt within three months. Those who do not adapt in that time frame are at risk for PTSD (U.S Department of Veterans Affairs, 2016).

Cognitive Processing Therapy (CPT) VA

CPT, which includes talk therapy, is a treatment which has the most evidence of success for treating PTSD. It is usually comprised of 12 sessions of psychotherapy to assist the client in learning how to evaluate and shift their upsetting thoughts since experiencing the trauma. This is done by learning to change one's thought processes as well as one's feelings about the trauma. CPT provides patients with coping skills to deal with disturbing thoughts by assessing the facts and figuring out if they support the negative thought process or not. Eventually, they are able to decide whether and when it makes sense to adopt a new viewpoint (U.S Department of Veterans Affairs, 2016).

The therapist begins by explaining how the treatment is going to work and answering any questions the client may have about the process. The first part includes a review of PTSD symptoms and helping the client deepen their understanding of PTSD.

The client will be asked what type of trauma they experienced, with minimal details at this point. Later the client will do some writing about the trauma and how it has affected him/her. Over several sessions, issues covered include: negative and unhelpful thoughts which have affected the client since the trauma; how to deal with the situation, and ways to redirect his/her thought process. There are work sheets to take home, fill out, and bring back to each session exploring the client's thought process over the past week plus strategies to help with negative feelings. When ready, the client is asked to write about the trauma in as much detail as remembered and then, in the following session, to read it aloud. If not told ahead of time that this will happen, the client may find reading aloud difficult, but it helps him/her cope with common emotions such as anger, sadness and guilt. This is all done through talking with the therapist. The closing sessions of treatment will involve discussions of the client's life and how the trauma has affected the client including his/her sense of safety, self-esteem, control, trust, and intimacy (U.S Department of Veterans Affairs, 2016).

There are only minimal risks with CPT, most notably some uneasiness when talking or writing about trauma related memories. But the feelings tend to be brief and usually clients feel better and continue with CPT. For the most part, those who finish CPT say the benefits balance any initial distress (U.S Department of Veterans Affairs, 2016).

Prolonged Exposure Therapy (PE) VA

Some PTSD clients may opt for prolonged exposure therapy (PE), which teaches them progressively how to approach the memories related to trauma, as well as feelings and situations which they may have been avoiding. Avoidant behaviors can make the

person feel better in the moment but not in the long run, since avoiding situations and feelings keeps them from recovering. This process works by confronting situations which, though safe, the client has been avoiding. Eventually, safe confrontation helps decrease avoidance symptoms.

PE treatment starts with the therapist getting to know the client, briefly discussing the trauma, and explaining some breathing techniques which can help manage anxiety. In the next part of treatment, usually the second session, the client will create a list of places, people, activities that the client has avoided since the trauma. Over time in therapy, they will work through the list practicing in vivo exposure. This involves the client's gradual confrontation of situations they have been avoiding. Under the therapist's supervision, the client learns to assess his/her anxieties, feel more comfortable, and become conditioned not to avoid anymore. The imaginal exposure is done after a few sessions, when details of the trauma are starting to surface. The client will listen to recordings of the imaginal exposure between sessions and, by confronting the details of the trauma, discover he/she now has fewer unwanted memories. Prolonged exposure is usually eight to fifteen weekly individual sessions, and each session is an hour and a half. (U.S Department of Veterans Affairs, 2016).

Present-Centered Therapy (PCT)

PCT is a non-trauma focused treatment for PTSD. Its main mechanism is change to a present-centered perspective. The objective of PCT is to alter present maladaptive behaviors and patterns without revisiting the specific details of the original trauma. PCT provides psycho-education concerning the impact of a past trauma on the current life of the client. It teaches the use of problem solving to focus on current issues, while omitting

the use of exposure and cognitive restructuring techniques. (Society of Clinical Psychology, 2016).

Eye Movement Desensitization and Reprocessing

Though relatively new, EDMR can help with chronic PTSD symptom relief. This form of psychotherapy begins with the client focusing on a back-and-forth movement or sound while they recall a disturbing or traumatic memory long enough for it to become less painful. EMDR is divided into eight phases. In the first phase, the client will learn emotional and physical reactions to trauma and discuss how ready they are to recall and focus on the traumatic memories in therapy. These may include bodily sensations related to the memory, as well as negative thoughts and feelings. Next, the client will be instructed to simultaneously hold the memory of the event in mind and also focus attention on the sounds or movements provided by the therapist. This could be a moving finger, a tone that makes noise in one ear at a time, a flashing light, or a back-and-forth movement, for roughly 30 seconds at a time. In theory, the process is designed to engage the brain's natural adaptive information processing mechanisms by overwriting past negative coping reactions with present, less stressful ones. After each treatment, the therapist and client discuss the experience and outcome. Ultimately, the goal is to reduce the intensity of disturbing, unprocessed memories and strengthen adaptive beliefs. At the end of treatment, the provider will reassess the client's symptoms and, if needed, recommend any further steps. (U.S Department of Veterans Affairs, 2016).

One thing that EMDR clients appreciate is there is no required homework or practice projects. Treatment generally lasts from one to three months with weekly sessions of 50 to 90 minutes. Clients have reported benefits after a few sessions and the

treatment benefits can last for a long period after the final session (U.S Department of Veterans Affairs, 2016).

Motivational Interviewing (MI)

Motivational interviewing is a psychotherapeutic intervention where clinicians encourage clients to discuss and explore discrepancies between their principal morals and personal behaviors. In theory, this therapy seeks to engage the client's intrinsic motivation in order to change behavior.

In a small study by Dr. Karen Seal, 73 Iraq and Afghanistan veterans were screened for more than one mental health issue and no current treatment. Then they were randomly separated into the MI group or the control group for treatment. Those in the MI group participated in four sessions of telephone Motivational Interviews, plus four neutral check-in phone calls, and received the invitation to seek further mental health treatment. Conversely, the control group only received the invitation for further mental health treatment. The study found that 62% of the MI group pursued further treatment, while only 26% of the control group pursued further treatment. Dr. Seal concluded that preliminary trial demonstrated the efficacy of MI over the phone to engage subjects in the need to seek treatment. Of course, further research with larger groups needs to be done. But this is one example of how MI can work to replace veterans' usual check-in phone calls with a more meaningful exchange that yields positive results. There are approximately a half-million Iraq and Afghanistan veterans being seen by the VA who have one or more mental health diagnoses, from anxiety to depression to PTSD. MI can facilitate a more meaningful client-clinician exchange, help identify the client's desire to

change a behavior, and motivate the client to seek, with the clinician's help, further help and treatment. (U.S Department of Veterans Affairs, 2017).

Group Therapy

Over the past 20 years, a program called Warrior Renew has been specifically designed to address unique aspects of MST for both male and female veterans as well as active duty members. Based on Epstein's Cognitive-Experimental Theory, the program provides participants with skills to manage their trauma symptoms, and guides them toward insight and changes within the experiential system. Provided in a 12-week group format, Warrior Renew encourage group interactions, address issues related to MST using insight, imagery, metaphors, experiential activities and interactive exercises (Katz, 2016). Generally, members receive weekly at-home reading assignments then attend a two-hour group session for discussion and experiential exercises. Topics include defining MST, coping with feelings and nightmares, getting a good night's sleep, recognizing triggers and anxiety, and releasing anger and resentments as well as guilt, self-blame, and shame. Further, Warrior Renew delves into MST-related interpersonal issues such as assessing relationship patterns, forming healthy intimate relationships and effective communication habits.

Like CBT, though in a group format, Warrior Renew offers a practical approach to problem solving with the goal of changing the patterns of thinking or behavior that are behind participants' difficulties, and so change the way they feel. It is also available in an accelerated seven-week program. Findings reveal significant decreases in symptoms of anxiety, depression, and posttraumatic negative thinking. (Katz, 2016).

Medications

Multiple studies report that a therapeutic approach is more effective in dismissing symptoms of PTSD than a pharmaceutical one. There have been a few comparisons. Some patients prefer to take medications, or could benefit from a combined approach of therapy and medication. When considering pharmaceuticals, it is crucial for the clinician to know the amount of evidence for each specific medication. When considering this way of treatment. There are multiple factors in prescribing, such as clinical custom, patient preferences, and marketing; these can be inconsistent with the existing evidence (Jeffery's, 2016).

Most recently, the VA/DoD Clinical Practice Guideline for PTSD psychopharmacology strongly recommends the selective serotonin reuptake inhibitors (SSRI's). For which fluoxetine, sertraline (Zoloft), and paroxetine (Paxil) have the strongest support; or serotonin norepinephrine reuptake inhibitors (SNRIs), for which venlafaxine has the most support (Jeffery's, 2016).

When discussing options of treatment with the client, it is important to be aware that each person is different and brings his or her own beliefs to treatment. There are times when the medication for PTSD can have an influence on other co-occurring disorders, such as substance use and depression. The main symptoms of PTSD that the medications target are: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity (Jeffery's, 2016). Intrusions can consist of flashbacks, nightmares, and traumatic memories with emotional distress. Avoidances can include avoiding triggers such as conversations, places, or other reminders. Negative alterations in cognitions and mood can be: inaccurate blame of self and others; harmful

beliefs about self and the world; and constant negative emotions such as shame, guilt and fear, and powerlessness to experience encouraging emotions. Alterations in arousal and reactivity can be anger, uncontrolled or self-destructive behavior, and problems sleeping or concentrating and hypervigilance. The above symptoms can improve at different rates with different medications (Jeffery's, 2016).

Marijuana

Since the Vietnam era, the use of marijuana among veterans has been an issue and a concern. Some veterans do use marijuana to help with symptoms of PTSD and quite a few states do approve the use of medical marijuana use for PTSD. There have not yet been any controlled studies done that evaluate the safety and/or effectiveness for PTSD treatment. Currently there is no evidence that suggests this line of treatment. In fact, existing research suggests that this line of treatment can be more harmful to people with PTSD (Bonn-Miller & Rousseau, 2016).

Within the VA health care system, cannabis use disorder has been the most diagnosed substance use disorder (SUD) since 2009. The percentage of veterans who have PTSD and a substance use disorder, and were also diagnosed with cannabis use disorder, rose from 13% in 2002 to 22.7% in 2014. Since 2014, more than 40,000 veterans have come to the VA with PTSD and substance use disorder as well as cannabis use disorder (Bonn-Miller & Rousseau, 2016).

There is data that suggests prolonged use of marijuana by individuals with PTSD can lead to such negative consequences as marijuana tolerance and addiction. Meanwhile, there is persistent belief that marijuana can be used as a treatment for PTSD, though information is limited to anecdotal reports from individuals with PTSD who say it helps

with their symptoms. There are studies that show oral CBD can decrease anxiety. There was one open trial of 10 participants with PTSD which showed that THC was safe and well tolerated and resulted in a decrease in hyperarousal symptoms (Bonn-Miller & Rousseau, 2016).

It is important to note that the VA/DoD PTSD Clinical Practice Guidelines recommend providing evidence-based treatments and PTSD clinicians need to offer education about issues that can be associated with long-term marijuana use. There is limited information, and no controlled trials defining its efficacy on how the use of marijuana can treat PTSD, while people who use it do say that it helps with their symptoms (Bonn-Miller & Rousseau, 2016).

Alternative Treatments Options

A 2006 research study by Murphy and Rosen, concluded that when offered to coping-focused treatments such as emotion management, resolution training, and cognitive restructuring, most of the time the veterans were hesitant to try a new skill or stop their old coping ways. Externalization and minimization have been the justification of trauma-based coping strategies which tend to result with clients not wanting to change or feeling the responsibility for significantly changing their behavior (Murphy & Rosen, 2006).

In response, researchers have been developing a PTSD motivation enhancement group using the Stages of Change model. The group is for anyone with PTSD or with behaviors--depression, anger, substance use, hypervigilance, smoking and others--associated with PTSD. The goal is to support clients shift from stage to stage while having a regard for specific problems which they have, in the past, minimized or

dismissed. Called PTSD ME Group, this is typically a seven-session group treatment. This group encourages active participation and works with coping skills and direct therapeutic exposure. The anticipated outcome for clients is to promote changes in symptoms and adaptive functioning (Murphy and Rosen, 2006).

Conclusion

This manual has explained how big of an impact that a sexual assault can have on a female serving in the military. From the stories that were disclosed to the statistics on MST in relation to PTSD and deciding whether reporting the assault is in the victim's best interest. The stigma of sexual assaults within military culture and how it can have a major psychological impact on the person that can lead to issues once they leave the military has been reviewed along with issues such as, substance problems, avoidance, anger and PTSD. When a sexual assault is not addressed it can lead to PTSD and the goal is to prevent that from happening. For future research the goal would be to end sexual assaults all together, which the military is trying to accomplish. That may not happen, however learning how to address the assault without the negative ramifications when it comes to reporting is the goal. Military culture is not going to change but the way one reports an assault and the way they are treated can be changed as well as preventing the development of PTSD. The biggest limitation I had was finding larger studies on MST and the relation to PTSD. The goal with this project is to educate therapists and therapists in training on MST, how military life is different from civilian life and to offer a variety of treatment options.

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Appendix A

Assessment Options

Are you troubled by the following?

Yes No You have experienced or witnessed a life-threatening event that caused intense fear, helplessness, or horror.

Do you re-experience the event in at least one of the following ways?

Yes No Repeated, distressing memories, or dreams

Yes No Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)

Yes No Intense physical and/or emotional distress when you are exposed to things that remind you of the event

Do reminders of the event affect you in at least three of the following ways?

Yes No Avoiding thoughts, feelings, or conversations about it

Yes No Avoiding activities and places or people who remind you of it

Yes No Blanking on important parts of it

Yes No Losing interest in significant activities of your life

Yes No Feeling detached from other people

Yes No Feeling your range of emotions is restricted

Yes No Sensing that your future has shrunk (for example, you don't expect to have a career, marriage, children, or normal life span)

Are you troubled by at least two of the following?

Yes No Problems sleeping

Yes No Irritability or outbursts of anger

Yes No Problems concentrating

Yes No Feeling "on guard"

Yes No An exaggerated startle response

Having more than one illness at the same time can make it difficult to diagnose and treat the different conditions. Depression and substance abuse are among the conditions that occasionally complicate PTSD and other anxiety disorders.

Yes No Have you experienced changes in sleeping or eating habits?
More days than not, do you feel...

Yes No sad or depressed?

Yes No disinterested in life?

Yes No worthless or guilty?

During the last year, has the use of alcohol or drugs...

Yes No resulted in your failure to fulfill responsibilities with work, school, or family?

Yes No placed you in a dangerous situation, such as driving a car under the influence?

Yes No gotten you arrested?

Yes No continued despite causing problems for you or your loved ones?

Reference:

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
YES / NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
YES / NO
3. Were constantly on guard, watchful, or easily startled?
YES / NO
4. Felt numb or detached from others, activities, or your surroundings?
YES / NO

Current research suggests that answering yes to three or more further evaluation needs to be done for PTSD diagnosis. (U.S Department of Veterans Affairs, 2017).

Appendix B

Medication Options

Medication	Dosage	When to Take
Sertraline (Zoloft)	50 mg to 200 mg	daily
Paroxetine (Paxil)	20 to 60 mg	daily
Fluoxetine (Prozac)	20 mg to 60 mg	daily
Note: Only sertraline and paroxetine have been approved for PTSD treatment by the FDA		

Table 1 Medications for PTSD (Jeffery's, 2016)

Appendix C

Military and Army Terms and Phrases

S1, S2, S3, S4, S6 shops

S1- personnel

S2- intel and security

S3- training and operations

S4- supply

S6- IT support

Armed Forces — Used to denote collectively only the regular components of the Army, Navy, Air Force, Marine Corps, and Coast Guard. See also Armed Forces of the United States

Post Exchange (PX) - the military store, there is one on every post, from groceries, military clothing, and has anything anyone need without having to leave post

Enlisted and Officers- enlisted means the backbone of the army, they have specific specialties and duties and officers act as managers, they plan missions give orders and assign tasks (U.S Army, 2016).

Expiration Term of Service (ETS) – The date the military member is set to leave the military

Basic- also known as “boot camp” where the military members are trained from civilian to soldier

Advance Individual Training (AIT) – where soldiers go after basic to learn their job

Warrior Leaders Course (WLC)- lower enlisted NCO’s learn to be leaders

Basic Noncommissioned Officers Course/Advanced Noncommissioned Officer Course (BNCOC/ANCOC) that provides leadership and training, based on the NCO’s rank

Active Duty- works for the military full time, they may live on base, can be deployed at any time (National Center for PTSD, 2012).

Reserve units of any branch- purpose is to provide and maintain trained units and qualified people to be available for active duty if needed (National Center for PTSD, 2012).

Active Guard Reserve (AGR)- the Army and Air Force federal military program placing National Guard and Army Reserve soldier and Air Guards and Air Force Reserve on federal active duty status to provide full-time support to National Guard and Reserve organizations. The purpose of AGR is organizing, administering, recruiting, instructing or training the Reserve Components (US Legal Inc, 2016).

Criminal Investigation Command (CID) - investigates felony crime and serious violations of the military law within the Army

Division - usually has 10,000 to 16,000 soldiers, with three brigades' that are commanded by a major general who is assisted by two brigadier generals. It can conduct major tactical operations and sustained battlefield operations and engagements (Powers, 2016).

Brigade - includes 1,500 to 3,200 soldiers, a brigade headquarters commands the tactical operation of two to five combat battalions, brigades are usually employed on independent or semi-independent operations and are normally commanded by a colonel with a command sergeant major as a senior NCO (Powers, 2016).

Battalion - consists of four to six companies between 300 and 1,000 soldiers, is normally ran by a lieutenant colonel and a command sergeant major. It can conduct independent operations if needed (Powers, 2016).

Platoon- can be from 16 to 44 soldiers, and is led by the lieutenant with an NCO in second command has had three to four squads or sections (Powers, 2016).

Squad- sections that a platoon is divided into

Company - contains three to five platoons, with a total of 60 to 200 soldiers, commanded by a captain with a first sergeant as the commanders principal NCO assistant (Powers, 2016).

In country - a term used for when they are operating outside of the US, usually when deployed this term is used

Idiot proof – incapable of doing something wrong, directions that anyone could figure out without guidance

Acquire- to obtain something that may not be in the most ethical way

Military Intelligence (MI) - a company that is mostly meant for MI personal

Motor Pool - most military vehicles are kept and used for dispatch and maintenance

Military Police (MP) - the military version of a police officer

Meal, Ready to Eat- (MRE) - known as MRE- is usually used during field training, food that is in small and light packaging

Close of business (COB) - a commonly used, especially at the end of a work week

Outside Continental United States (OCONUS) (to include Hawaii and Alaska)

Field training exercise (FTX) — An exercise in which actual forces are used to train commanders, staffs, and individual units in basic, intermediate, and advanced-level warfare skills (Dictionary of Military and Associated Terms, 2016).

Unaccounted for — when military equipment is either missing or can't be found and can be commonly used when referring to personnel who are killed in action and whose bodies are not recovered (Dictionary of Military and Associated Terms, 2016).

Appendix D
Rank Structure for Enlisted and Officers

	Rank	Army	Navy	Marines	Air Force	Coast Guard
Enlisted	E1	Private (PVT)	Seaman Recruit (SR)	Private (PVT)	Airman Basic (AB)	Seaman Recruit (SR)
	E2	Private 2nd Class (PV2)	Seaman Apprentice (SA)	Private First Class (PFC)	Airman (Amn)	Seaman Apprentice (SA)
	E3	Private 1st Class (PFC)	Seaman (SN)	Lance Corporal (LCpl)	Airman First Class (A 1C)	Fireman Apprentice (FA)
	E4	Specialist (SPC)	Petty Officer Third Class (PO3)	Corporal (Cpl)	Senior Airman (SrA)	Airman Apprentice (AA)
	E4	Corporal (CPL)	Petty Officer Second Class (PO2)	Sergeant (Sgt)	Staff Sergeant (SSgt)	Seaman (SN)
	E5	Sergeant (SGT)	Petty Officer First Class (PO1)	Staff Sergeant (SSgt)	Technical Sergeant (TSgt)	Fireman (FN)
	E6	Staff Sergeant (SSG)	Chief Petty Officer (CPO)	Gunnery Sergeant (GySgt)	Master Sergeant (MSgt)	Airman (AN)
	E7	Sergeant First Class (SFC)	Senior Chief Petty Officer (SCPO)	Master Sergeant (MSgt)	Master Sergeant w/Diamond (MSgt)	Petty Officer 3rd Class (PO3)
	E7	1st Sergeant (1SG)	Master Chief Petty Officer (MCPO)	First Sergeant (1st Sgt)	Senior Master Sergeant (SMSgt)	Petty Officer 2nd Class (PO2)
	E8	Master Sergeant (MSG)	Master Chief Petty Officer of the Navy (MCPON)	Master Gunnery Sergeant (MGySgt)	Senior Master Sergeant w/Diamond (SMSgt)	Petty Officer 1st Class (PO1)
	E9	Sergeant Major		Sergeant Major of the Marine Corps (SMMC)	Chief Master Sergeant (CMSgt)	Chief Petty Officer (CPO)
	E9	Command Sergeant Major (CSM)			Chief Master Sergeant w/Diamond (CMSgt)	Senior Chief Petty Officer (SCPO)
					Command Chief Master Sergeant (CCM)	Master Chief Petty Officer (MCPO)
					Command Master Chief Petty Officer of the Coast Guard (MCPOCG)	Command Master Chief Petty Officer of the Coast Guard (MCPOCG)

	Rank	Army	Navy	Marines	Air Force	Coast Guard
Officers	O1	2nd Lieutenant (2LT)	Ensign (ENS)	Second Lieutenant (2ndLt)	Second Lieutenant (2d Lt)	Ensign (ENS)
	O2	1st Lieutenant (1LT)	Lieutenant Junior Grade (LTJG)	First Lieutenant (1tLt)	First Lieutenant 1 Lt)	Lieutenant Junior Grade (LTJG)
	O3	Captain (CPT)	Lieutenant (LT)	Captain (Capt)	Captain in (Capt)	Lieutenant (LT)
	O4	Major (MAJ)	Lieutenant Commander (LCDR)	Major (Maj)	Major (Maj)	Lieutenant Commander (LCDR)
	O5	Lieutenant Colonel (LTC)	Commander (CDR)	Lieutenant Colonel (LtCol)	Lieutenant Colonel (Lt Col)	Commander (CDR)
	O6	Colonel (COL)	Captain (CAPT)	Colonel (Col)	Colonel (Col)	Captain (CAPT)
						Real Admiral (Lower Half) (RDML)
						Real Admiral (Upper Half) (RADM)
						Vice Admiral (VADM)
						Admiral Chief of Naval Ops/Commandant of CG (ADM)
Warrant Officers	W1	Warrant Officer 1 (WO1)		Warrant Officer (WO)		
	W2	Chief Warrant Officer 2 (WO2)	Chief Warrant Officer 2 (CWO2)	Chief Warrant Officer 2 (CWO2)		Chief Warrant Officer 2 (CWO2)
	W3	Chief Warrant Officer 3 (WO3)	Chief Warrant Officer 3 (CWO3)	Chief Warrant Officer 3 (CWO3)		Chief Warrant Officer 3 (CWO3)
	W4	Chief Warrant Officer 4 (CO4)	Chief Warrant Officer 4 (CWO4)	Chief Warrant Officer 4 (CWO4)		Chief Warrant Officer 4 (CWO4)
	W5		Chief Warrant Officer 5 (CWO5)	Chief Warrant Officer 5 (CWO5)		Chief Warrant Officer 5 (CWO5)

Table 2(Military.com, 2017), (Official U.S Marine Corps Website, 2017), (Military Factory, 2017), (Rate insignia of navy enlisted personnel, 2009), (Rank insignia of navy commissioned and warrant officers, 2009).

Appendix E

Power and Control Wheel

Figure 1 Power and Control Wheel

Appendix F

A Collection of Soothing Activities

Copyrighted Material. Not Available

Appendix G

Detaching from Emotional Pain (Grounding)

Copyrighted Material. Not Available

Appendix H

Outside Resources

U.S Department of Veterans Affairs: PTSD: National Center for PTSD

This link can provide information on awareness and treatment.

<https://www.ptsd.va.gov/>

Substance Abuse and Mental Health Services Administration (SAMHSA)

This link can provide risk factors, recovery and support services and activities.

<https://www.samhsa.gov/treatment/mental-disorders/post-traumatic-stress-disorder#risk-factors>

Operation We Are Here: Resources for the Military Community and Military Supporters

This link gives support for PTSD and resources for female military veterans

<http://www.operationwearehere.com/FemaleVeterans.html>

Support Organizations for Female Veterans: Academy Women

www.academywomen.org

Fatigues to Fabulous

A national campaign designed to support women serving the military and the unique issues faced by women veterans.

www.fatigustofabulous.com