A Comprehensive Guide to Helping Victims of Military Sexual Trauma

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Abstract

Military Sexual Trauma (MST) represents an experience that many of this country’s Veterans have endured, and consequently struggle with today. Many civilian practitioners will encounter survivors of MST, as many Active Duty and National Guard Soldiers have spent a great deal of time deployed overseas in support of military operations. The major aim of this document is to identify the specific prevention, education, and training efforts taken by the Department of Defense (DoD), and the identification and treatment efforts made by the Veterans Health Administration (VHA) in lieu of this problem. This identification process is undertaken in an attempt to establish whether or not current processes to treat MST survivors are effective. DoD and VHA directives, instructions, policy and mandates were examined and referenced, as well as the most current scholarly research in the field regarding MST. Upon conclusion of this document, civilian practitioners will be able to make informed decisions regarding appropriate interventions, beneficial referrals, and relevant information to provide the survivors of MST.

*Keywords*: military sexual trauma, veterans, civilian, practitioners
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A Comprehensive Guide to Helping Victims of Military Sexual Trauma

The definition of MST used by the Veterans Administration (VA) is given by Title 38 of U.S. Code 1720D, which governs Veterans’ benefits, and reads, “psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training” (p. 261). The term “active duty for training” applies to the country’s National Guard soldiers, where in each member of the National Guard completes an annual training requirement that is composed of active duty for training days. It is important for practitioners to understand that this definition highlights the fact that MST can be experienced by both Active and Reserve Component Soldiers, which hints at the term being applicable to Armed Forces personnel in their entirety.

According to the MST Fact Sheet produced by the U.S. Department of Veterans Affairs (2013), MST is an experience, not a diagnosis or mental health condition, and as with other forms of trauma, there are a variety of reactions that Veterans can have in response to MST. The type, severity, and duration of a Veteran’s difficulties will all vary based on factors like whether he or she has a prior history of trauma, the types of responses from others he or she received at the time of the MST, and whether the MST happened once or was repeated over time. Cultural variables such as race/ethnicity, religion, and sexual orientation can also affect the impact of MST (U.S. Department of Veterans Affairs, 2013), and it is important to note that even though men and women share some similarities in their reactions to MST, they may struggle with completely different issues over time.

For some Veterans, the experience of MST may continue to affect their mental and physical health in significant ways many years after it occurs. Some of the experiences both
male and female survivors of MST have include strong emotions, feeling depressed, having intense and sudden emotional reactions to things, and feeling angry or irritable most of the time. In addition to strong emotional reactions, survivors of MST may also experience the opposite, to include feelings of numbness, feeling emotionally flat, and difficulty experiencing emotions like love or happiness. MST survivors may also struggle with difficulties maintaining attention, concentration, and memory, to include trouble staying focused, frequently finding their mind wandering, and having a hard time remembering things. Trouble falling or staying asleep is also common among survivors of MST, as well as disturbing nightmares (U.S. Department of Veterans Affairs, 2013).

Many survivors of MST exhibit problems with alcohol or other drugs, such as drinking to excess or using drugs daily, getting intoxicated or “high” to cope with memories or emotional reactions, and drinking to fall asleep. In addition to substance abuse, survivors also may experience difficulties with things that remind them of their sexual trauma, feeling on edge or “jumpy” all the time, difficulty feeling safe, and going out of their way to avoid reminders of their traumatic experiences. Relationship difficulties may be exhibited by MST survivors as well, such as feeling isolated or disconnected from others, engaging in abusive relationships, trouble with employers or authority figures, and difficulty trusting others. Finally, there may be physical health problems that present themselves within MST survivors, and these may include sexual difficulties, chronic pain, weight or eating problems, and gastrointestinal problems (U.S. Department of Veterans Affairs, 2013).

Many of the symptoms listed above mirror criteria within the Diagnostic and Statistical Manual of Mental Disorder, 5th Edition (DSM-5) regarding the diagnosis of Posttraumatic Stress Disorder (PTSD). Although PTSD is commonly associated with MST, it is not the only
diagnosis that can result from MST. VA medical record data indicate that in addition to PTSD, the diagnoses most frequently associated with MST among users of VA health care are depression, other mood disorders, and substance use disorders (U.S. Department of Veterans Affairs, 2013).

Now that MST had been defined according to VA standards, there is an understanding in regards to whom the term “MST survivor” applies. Also, the potential residual mental and physical health effects have been outlined, so the Department of Defense (DoD) will now be discussed.

**Regulation and Policy Review**

The DoD is examined to construct an accurate understanding of the culture and environment service members operate in with regards to sexual assault. It is important for practitioners to understand how sexual assault situations are viewed in reference to Armed Forces doctrine, and what efforts the armed forces have made to mitigate the problem. The DoD Annual Report on Sexual Assault in the Military Fiscal Year 2012, Volume I will be referenced to investigate current rates of sexual assault reporting and DoD priorities in regards to sexual assault and it’s survivors. The systems in place to address incidents of sexual assault in the Armed Forces and the supports the DoD has installed to help those who have experienced sexual assault while performing service to their country will also be explained.

**The Department of Defense Annual Report**

In the 2012 Workplace and Gender Relations Survey of Active Duty Members (WGRA), 6.1% percent of Active Duty women and 1.2% of Active Duty men indicated they experienced some kind of unwanted sexual contact (USC) in the 12 months prior to being surveyed. USC is the survey term for the range of contact sexual crimes between adults prohibited by military law,
ranging from rape to abusive sexual contact. For women, this represents a statistically significant increase over the 4.4% USC rate that was measured in 2010, but the change in the USC rate for men during the same period was not statistically significant. Furthermore, estimates derived from the WGRA suggest that there may have been approximately 26,000 Service members who experienced some form of USC in the year prior to being surveyed, and this estimate suggests an increase of 7,000 more Service members who experienced some form of USC in 2012 when compared to 2010 reports. The presence of an increased USC rate for women indicates that the Department has a persistent problem and much more work geared toward preventing sexual assault in the Armed Forces (DoD SAPRO, 2013). As the DoD stated, sexual assault is a persistent problem, and with that in mind, the Department has multiple priorities as it moves forward.

**Department of Defense priorities.** The first priority the DoD mentions is a goal to increase the number of victims who make a report of sexual assault. The Department will strive to increase sexual assault reporting by improving Service members’ confidence in the military justice process, creating a positive command climate, enhancing education and training about reporting options, and reducing stigma and other barriers that deter reporting (DoD SAPRO, 2013). The DoD SAPRO (2013) reports, “In FY12, there were 3,374 reports of sexual assault involving Service members”, and “The 3,374 reports involved a range of crimes prohibited by the Uniform Code of Military Justice (UCMJ), from abusive sexual contact to rape” (p. 3). The 3,374 reports represent a 6% increase over the 3,192 received in FY11, and provide the Department greater opportunities to provide victim care and to ensure appropriate offender accountability (DoD SAPRO, 2013).
The second priority mentioned within the report is the goal to improve the quality of the Department’s response to victims of sexual assault through programs, policies, and activities that advance victim care and enhance victims’ experience with the criminal investigative and military justice processes (DoD SAPRO, 2013). An in-depth analysis of the current programs, policies and activities geared toward helping victims navigate through the military justice process will be conducted in the sections ahead, with special attention given to the intricacies of the Sexual Assault Prevention and Response (SAPR) program.

The third priority outlined is the goal to establish a military culture free of sexual assault (DoD SAPRO, 2013). The DoD SAPRO (2013) states, “Sexual assault is a crime that takes a toll on the victim and diminishes the Department’s capability by undermining core values, degrading mission readiness, potentially jeopardizing strategic alliances, and raising financial costs” (p. 6). The Department seeks to reduce, with the goal to eliminate, sexual assault through institutionalized prevention efforts and policies that empower Service members to stop sexual assault before it happens (DoD SAPRO, 2013).

**Sexual assault reporting.** As mentioned above, the DoD has set a goal of increasing the number of victims making a report of sexual assault, and this is important because research shows that reporting the crime is the victims’ primary link to getting medical treatment and other forms of assistance. To encourage greater reporting by sexual assault survivors, the Department offers two reporting options: Restricted Reporting and Unrestricted Reporting. Restricted Reporting allows victims to confidentially access medical care and advocacy services without initiating an official investigation or notification of command. When a survivor makes an Unrestricted Report, they can receive the same healthcare, counseling, and advocacy services, but the report is also referred to a Military Criminal Investigation Organization (MCIO) for
investigation and command elements are notified. Sexual Assault Response Coordinators (SARC) and Sexual Assault Prevention and Response Victim Advocates (SAPR VA), which will be discussed in detail in later sections, support every installation throughout the world and help victims understand these reporting options and how to access care (DoD SAPRO, 2013).

Due to the underreporting of this crime in both military and civilian society, reports to authorities do not necessarily equate to the actual prevalence of sexual assault. In fact, the Department estimates that about 11 percent of the sexual assaults that occur each year are reported to a DoD authority, which is roughly the same pattern of underreporting seen in segments of civilian society. Underreporting of sexual assault interferes with the Department’s efforts to provide survivors with needed care and its ability to hold offenders appropriately accountable, and concerns about loss of privacy and negative scrutiny by others often act as barriers that keep both military and civilian survivors from doing so (DoD SAPRO, 2013).

In FY12, the President signed an executive order establishing Military Rule of Evidence (MRE) 514, “Victim-Victim Advocate Privilege”, which protects communications between survivors and their SARC or SAPR VA. While there are certain exceptions, the privilege allows the survivor to refuse to disclose and prevent any other person from disclosing confidential communications between the survivor and a SAPR VA when the communication was made for the purpose of obtaining advice or assistance. Even with executive orders and clearly established policies, the DoD continues to face several reporting process challenges, however. In deployed environments, sexual assault response procedures must be continually revised as forces redeploy within or depart an area, and communication difficulties within combat zones or amongst geographically dispersed units have the potential to slow response to a survivor in need of support (DoD SAPRO, 2013).
Despite the challenges reported, with the SAPR program implementation in 2005, there has been a 98% increase in the number of sexual assaults reported to the Department, and the Department receives reports of sexual assault from both military and civilian victims (DoD SAPRO, 2013). This statistic appears to be a double-edged sword in some ways however, because even though an increase in reported sexual assaults results in greater access to care for more survivors, the increase also suggests that there were more sexual assaults committed. Now that a basic understanding of reporting options and challenges has been discussed, information regarding the SAPR program’s creation and origins will be detailed.

**Sexual assault prevention and response.** In 2004, the Department aggressively changed its approach to SAPR after learning of reports of sexual assault from Service members deployed to Iraq and Kuwait. On February 5th, 2004, then-Secretary of Defense Donald Rumsfeld directed the Department to undertake a 90-day review of all sexual assault policies and programs and recommend changes to increase prevention, promote reporting, and enhance the quality of support provided to victims. The DoD Care for Victims of Sexual Assault Task Force was then created, and it identified 35 key findings relevant to sexual assault policies and programs within Military Services. The Department then established the Joint Task Force for Sexual Assault Prevention and Response (JTF-SAPR) in October of 2004 to develop a comprehensive SAPR policy for the Department based on the recommendations of the Care for Victims of Sexual Assault Task Force (DoD SAPRO, 2013).

Task Forces and policies are both important, but the training of Service members in the prevention of sexual assault also plays an integral role. Service members receive annual awareness and prevention training per SAPR policy, and sexual assault awareness and prevention training is also a mandatory component of all accession, professional military
education, and pre-command training. Unfortunately however, despite the enhanced SAPR policies and training, sexual assault remains a persistent problem in the military (DoD SAPRO, 2013). In addition to the SAPR overview just provided, a detailed discussion about DoD Instructions and Directives regarding the application of the SAPR program will be provided in subsequent sections.

**DoD resource implementations.** In April of 2011, the Department launched the DoD Safe Helpline as a crisis support service for adult Service members of the DoD community who have experienced sexual assault. The DoD Safe Helpline is available 24 hours a day worldwide, and survivors can call or text for anonymous and confidential support. Safe Helpline is owned and operated through a contractual agreement by the non-profit Rape, Abuse and Incest National Network (RAINN), the nation’s largest anti-sexual violence organization. Safe Helpline boasts a robust database of military, civilian, and veteran services available for referral, and the database also contains SARC contact information for each Military Service, the National Guard, and the Coast Guard. Additionally, Safe Helpline contains referral information for legal resources, chaplain support, healthcare services, Department of Veterans Affairs (DVA) resources (benefit claims, healthcare, and National Suicide Prevention Lifeline), Military OneSource, and over 1,100 civilian rape crisis affiliates (DoD SAPRO, 2013).

In FY12, the DoD SAPRO required RAINN to incorporate a course on the neurobiology of trauma to provide Safe Helpline staff with skills to better understand and address the impact of sexual assault on a survivor’s thoughts, behaviors and relationships. Also, DoD Safe Helpline has a Safe Helpline Mobile Application for smartphones to give members of the military community free access to resources and tools to help manage the short-term and long-term effects of sexual assault. Users can also use the application to connect with live sexual assault
response professionals via phone or anonymous online chat, as well as create a customized self-care plan that, once downloaded, can be accessed without an internet connection (DoD SAPRO, 2013). Also, in April of 2012, the Department observed Sexual Assault Awareness Month (SAAM), and highlighting SAAM each year gives the Department an opportunity to join a national effort to raise awareness and promote the prevention of sexual violence.

Finally, the Intervene, Act and Motivate (I. A. M.) Strong sexual assault prevention campaign is designed to help combat sexual assaults by engaging all Soldiers in preventing sexual assaults before they occur (SHARP Program, 2013b). The “I. A. M. Strong” messaging features leaders establishing a positive command climate and Soldiers as influential role models who personally take action to set a respectful standard of conduct. Specific actions under this strategy also address secondary and tertiary prevention efforts, which include reducing the stigma of reporting sexual assaults, and holding offenders accountable for their actions (DoD SAPRO, 2013). As mentioned on the Army’s sexual assault website (SHARP Program, 2013b), those who commit assaults hurt a member of the team and wound the Army, and the criminal act is cowardly and damaging to the very moral fiber that gives the Army its innermost strength. These are powerful words regarding a powerful topic, and hopefully those words take hold in the minds of each and every Soldier that serves this country at home and abroad.

With all the information presented about the DoD and its annual report on sexual assault, it appears as if the processes are in place and actions are being taken each day to progress toward a military environment of reduced sexual assault. It’s important to remember though, that the reduction and eradication of sexual assault requires sustained focus and resources that produce a cultural change, both in the military and in the population of the United States as a whole (DoD SAPRO, 2013). In the next section, specific and detailed information will be presented
regarding the SAPR program, to include directives published by the DoD, and instructions to bolster the directives. Specific personnel will be identified to help civilian practitioners discern whom to provide contact information if a client who has experienced MST is in need, and specific aspects of the chain of events surrounding a sexual assault scenario will also be highlighted to help educate civilian practitioners of the process.

**SAPR Program Specificity**

Like most thorough and thought-out programs in existence, specific directives and instructions exist for their implementation and administration. The SAPR Program is no different, in that it exhaustively explains exact administration instructions and rules regarding how survivor’s of sexual assault are to be treated, what actions specific personnel are to take when contacted, and legal constraints that all involved must follow. These instructions may be challenging for Soldiers to remember or understand, and even more difficult for civilian practitioners. The examination of DoD directives and instructions will highlight the most pertinent information, and shed light on crucial aspects of SAPR conduct.

**DoD directive, number 6495.01.** According to DOD Directive, Number 6495.01 (2012), the DoD goal is culture free of sexual assault, through an environment of prevention, education and training, response capability, victim support, reporting procedures and accountability. To ensure progress is made toward this goal, DoD policy governs the SAPR Program, and the SAPR Program is responsible for many actions, and its objective is an environment and military community intolerant of sexual assault (Under Secretary of Defense [P&R], 2012).

The SAPR Program shall focus on the victim and on doing what is necessary and appropriate to support victim recovery, and also, if a Service member, to support that Service
member to be fully mission capable and engaged. The SAPR Program shall also provide care that is gender-responsive, culturally competent, and recovery-oriented, while ensuring survivors of sexual assault are protected from coercion, retaliation and reprisal. Furthermore, survivors of sexual assault shall be treated with dignity and respect, and shall receive timely access to comprehensive medical treatment (Under Secretary of Defense [P&R], 2012).

In reference to medical treatment, the SAPR Program dictates that emergency care shall consist of emergency medical care and offer of a sexual assault forensic examination (SAFE). The SAFE Kit is conducted under controlled circumstances and consists of regimented procedures. These controls are necessary to ensure the physical examination process and collection, handling, analysis, testing, and safekeeping of any bodily specimens and evidence meet requirements for use in criminal proceedings. As an important caveat, the victim’s SAFE Kit is treated as confidential communication when conducted as part of a Restricted Report (Under Secretary of Defense [P&R], 2012).

Returning to the topic of medical treatment, the directive mentions that sexual assault patients be given priority, and shall be treated as emergency cases, regardless of whether physical injuries are evident. A sexual assault survivor needs immediate medical intervention to prevent loss of life or suffering resulting from physical injuries, sexually transmitted infections, pregnancy, and psychological distress. Individuals disclosing a recent sexual assault shall, with their consent, be quickly transported to the exam site, promptly evaluated, and treated for serious injuries. Sexual assault survivors shall also be assessed for immediate mental health intervention regardless of their behavior, because when severely traumatized, sexual assault survivors may appear calm. Sexual assault survivors may also appear indifferent, submissive, jocular, angry,
emotionally distraught, or even uncooperative or hostile towards those who are trying to help (Under Secretary of Defense [P&R], 2012).

Now that the DoD Directive regarding the SAPR Program has been discussed and the key elements highlighted, the DoD Instruction will fill in the gaps about reporting procedures, survivor communication expectations and other areas applicable to potential MST clients.

**DoD instruction, number 6495.02.** Reporting options for survivors of sexual assault were briefly discussed in a previous section, but the purpose here is to convey the specifics about each option (Restricted, Unrestricted), and present DoD instructions within each option. To reiterate, Service members and military dependents 18 years and older who have been sexually assaulted have two reporting options, Unrestricted or Restricted Reporting. The DoD favors Unrestricted Reporting, but this form of reporting may present a barrier for victims to access services when the victim desires no command or DoD law enforcement involvement. The DoD does recognize a fundamental need to provide a confidential disclosure vehicle via the Restricted Reporting option, but still prefers an Unrestricted Report (Under Secretary of Defense [P&R], 2013).

The Unrestricted Reporting option triggers an investigation, command notification, and allows a person who has been sexually assaulted to access medical treatment and counseling services. When a sexual assault is reported through this option, a SARC shall be notified, respond or direct a SAPR VA to respond, assign a SAPR VA, and offer the survivor healthcare treatment and a SAFE. It is important to draw attention to the fact that if a survivor elects this
reporting option, a survivor may not change from an Unrestricted to a Restricted Report (Under Secretary of Defense [P&R], 2013).

As opposed to Unrestricted Reporting, the Restricted Reporting option does not trigger an investigation, the command is only notified that an “alleged sexual assault” occurred, and is not given the survivor’s name or other personally identifiable information. Restricted Reporting allows Service members and military dependents that are adult sexual assault survivors to confidentially disclose the assault to specific individuals, such as the SARC, SAPR VA, or healthcare personnel. It also allows the survivor to receive healthcare treatment and the assignment of a SARC and SAPR VA. When a sexual assault is reported through Restricted Reporting, the same personnel are initially notified and healthcare treatment and a SAFE are also offered, but it is important to note that the Restricted Reporting option is only available to Service members and adult military dependents. The DoD Instruction, Number 6495.02 (2013) explains that Restricted Reporting may not remain an option in a jurisdiction that requires mandatory reporting, or if a survivor first reports to a civilian facility or civilian authority. A key difference between the reporting options however, is that one may change from a Restricted Report to an Unrestricted Report at any time (Under Secretary of Defense [P&R], 2013).

Only the SARC, SAPR VA, and healthcare personnel are designated as authorized to accept a Restricted Report, but healthcare personnel have certain duties to fulfill. Healthcare personnel, to include psychotherapists and other personnel, who receive a Restricted Report must immediately call a SARC or SAPR VA to assure that a survivor is offered SAPR services and so that DD Form 2910 can be completed. An important caveat to mention here is that the survivor’s decision to participate in an investigation or prosecution will not affect access to SARC and
SAPR VA services or medical and psychological care (Under Secretary of Defense [P&R], 2013).

A survivor’s communication with another person, for example, a roommate, friend, or family member, does not prevent the victim from later electing to make a Restricted Report. Restricted Reporting is confidential, not anonymous, but if the person to whom the survivor confided the information is in the survivor’s chain of command or DoD law enforcement, there can be no Restricted Report (Under Secretary of Defense [P&R], 2013).

As mentioned previously, the DoD seeks increased reporting by survivors of sexual assault. A system that is perceived as fair and treats survivors with dignity and respect, and promotes privacy and confidentiality may have a positive impact in bringing survivors forward to provide information about being assaulted. The Restricted Reporting option is intended to provide survivors additional time and increased control over the release and management of their personal information, and empowers them to seek relevant information and support to make informed decisions about participating in a criminal investigation. A survivor who receives support, appropriate care and treatment, and is provided the opportunity to make an informed decision about a criminal investigation is more likely to trust that their needs are of concern to the command. As a result, this trust may eventually lead the survivor to decide to pursue an investigation and convert their Restricted Report to an Unrestricted Report (Under Secretary of Defense [P&R], 2013).

The DoD Instruction, Number 6495.02 (2013) states, “Collateral misconduct by the victim of a sexual assault is one of the most significant barriers to reporting assault because of the victim’s fear of punishment” (p. 41). Some reported sexual assaults involve circumstances where the survivor may have engaged in possible misconduct (e.g., underage drinking, adultery,
or fraternization), but commanders shall have discretion to defer action on alleged collateral misconduct. The commanders shall not be penalized for such a deferral decision, and they may defer action against the survivor until final disposition of the sexual assault case, taking into account the trauma to the survivor and encouraging continued survivor cooperation. Ultimately, survivor cooperation should significantly enhance timely and effective investigations, as well as the appropriate disposition of sexual assault cases (Under Secretary of Defense [P&R], 2013).

Finally, the DoD Instruction, Number 6495.02 (2013) discusses protocol regarding the SAFE Kit, which has been mentioned previously, and mentions how it can be performed at local civilian medical facilities. These facilities however, are bound by State and local laws, which may require reporting the sexual assault to civilian law enforcement. As far as the evidence garnered from the SAFE Kit in Restricted Reporting cases, it’s interesting to note that the evidence shall be stored for 5 years from the date of the survivor’s report of the sexual assault. This fact allows the survivors additional time to accommodate multiple deployments or deployments exceeding 12 months. Additionally, the SARC will contact the survivor at the 1-year mark of the report to inquire whether the survivor wishes to change their reporting option to an Unrestricted Report (Under Secretary of Defense [P&R], 2013).

It would appear that the DoD has adopted and enforced numerous policies and procedures that operate with the goal of reducing sexual assault in the Armed Forces. It would also appear as if the DoD strives to ensure survivors of sexual assault are provided comprehensive and effective services to address their needs in a timely fashion. The following section will discuss in detail the personnel identified earlier as having key roles in the helping process of sexual assault survivors, as well as identify one key position that the Veterans Health Administration (VHA) has created for that same purpose, entitled the MST Coordinator. This
discussion will also serve as a transition into the specific actions the VHA has taken to ensure all Veterans experiencing sexual assault are cared for properly.

**Specific Personnel Responsible for Helping MST Survivors**

The SARC and SAPR VA have been mentioned briefly throughout the literature presented regarding DoD Directives and DoD Instructions, but their specific roles require elaboration. Also, the role of the MST Coordinator requires explaining, as many practitioners may utilize this position as an avenue to gain insight into many topics related to MST.

**SARC.** The SARC serves as the single point of contact at an installation or within a geographic area that oversees sexual assault awareness, prevention, and response training. The SARC also coordinates medical treatment, including emergency care, for survivors of sexual assault, and tracks the services provided to a survivor from the initial report through final disposition and resolution (Under Secretary of Defense [P&R], 2012). In short, the SARC serves as the single point of contact to coordinate sexual assault response when a sexual assault is reported (Under Secretary of Defense [P&R], 2013).

Many other duties exist for the SARC, and one of those duties is to assist the installation commander in ensuring that survivors of sexual assault receive appropriate, responsive care and understand their available reporting options. SARCs are also responsible for providing around-the-clock response capability to survivors of sexual assault, to include deployed areas. SARC shall also provide a response that recognizes the high prevalence of pre-existing trauma, shall offer appropriate referrals to survivors, facilitate access to referrals, and provide referrals at the request of the survivor. In addition, SARC will encourage sexual assault survivors to follow-up with the referrals and facilitate the referrals, as appropriate (Under Secretary of Defense [P&R], 2013).
Collaboration is also a major role of the SARC, as they are responsible for collaborating with Military Treatment Facilities (MTFs) within their respective areas of responsibility to establish protocols and procedures to direct notifications. These notifications include the SARC and SAPR VA for all incidents of reported sexual assault. The SARC will also facilitate ongoing training of healthcare personnel on the roles and responsibilities of the SARC and SAPR VA, as well as facilitate annual SAPR training. The collaboration continues to local private or public sector entities that provide medical care to Service members or TRICARE eligible beneficiaries who are sexual assault survivors, as well as provide a SAFE outside of a military instillation (Under Secretary of Defense [P&R], 2013).

**SAPR VA.** The SAPR VA is a person who, as a victim advocate, shall provide non-clinical crisis intervention, referral, and ongoing non-clinical support to adult sexual assault survivors. The support will include providing information on available options and resources to survivors. The SAPR VA will also, on behalf of the sexual assault survivor, provide liaison assistance with other organizations and agencies on victim care matters and reports directly to the SARC when performing victim advocacy duties (Under Secretary of Defense [P&R], 2012). SAPR VAs, as well as SARCs, are also responsible for ensuring survivors have access to medical treatment, counseling, chaplain assistance, legal advice, and other support services (SHARP Program, 2013a). It is important to note that a referral for service can happen at any time while the survivor is receiving assistance from a SAPR VA, and may happen several times throughout the military justice process (DoD SAPRO, 2013).

There are two different classifications of SAPR VAs, the Instillation Victim Advocate (IVA), and the Unit Victim Advocate (UVA) (Department of the Army, 2008). The IVAs are Department of the Army (DA) civilian or contract employees trained to provide advocacy
services to survivors of sexual assault. The UVA is one of two Soldiers/civilians who is appointed by each battalion-level commander and trained to perform collateral duties in support of survivors of sexual assault. The IVAs duties have a larger scope than the UVAs, as they operate on a larger scale and establish contact with each survivor who alleges that an act of sexual assault occurred, with ties to a specific instillation (Department of the Army, 2008).

**MST coordinator.** To serve as a catalyst to the investigation of the VHA’s response to the issue of sexual assault in the military, which will be covered next, the specific responsibilities assigned to the MST Coordinator will be discussed. VHA Directive 2010-033 (2010) states, the MST Coordinator at VHA facilities is responsible for monitoring and helping to ensure national policies related to MST screening and treatment are implemented at each facility. An example of this point would be, that MST Coordinators must help ensure unique eligibility guidelines and monitoring requirements are implemented. The MST Coordinator establishes and monitors mechanisms to ensure that all Veterans and potentially eligible individuals receiving VHA health care are screened for experiences of MST. Those that screen positive will be ensured expedient access to a continuum of appropriate MST-related care, and the care provided will be free of charge. The MST Coordinator also monitors local MST-related programming and, as needed, makes efforts to expand the program’s scope. It is important to note that MST survivors often have complex clinical needs and may be high utilizers of care, so taking into account local needs and resources, programming may involve development of specialized MST treatment teams (Under Secretary of Health, 2010).

Education is also a priority of MST Coordinators, as they help to ensure national policies regarding staff education related to MST are implemented at VHA facilities and associated Community-Based Outpatient Clinics (CBOCs). The MST Coordinator directly provides or
establishes and monitors mechanisms to ensure the staff at the facilities and CBOCs receive legally mandated education and training related to MST (Under Secretary of Health, 2010). VHA Directive 2010-033 (2010) states, “Given VA policy of universal MST screening and the tendency for MST survivors to present with multiple mental and physical health comorbidities, education must occur in clinics throughout the facilities and associated CBOCs” (p. 5). Depending on a staff member’s role and level of contact with MST survivors, training needs to cover such topics as sensitivity and confidentiality, treatment options, screening, and background information on MST (Under Secretary of Health, 2010).

Outreach is also an important responsibility of a MST Coordinator, as they monitor and ensure that national policies about informational outreach related to MST are implemented at facilities and associated CBOCs. The MST Coordinator directly engages in and establishes and monitors mechanisms to provide informational outreach to Veterans and potentially eligible individuals. Furthermore, the MST Coordinator ensures that Veterans and potentially eligible individuals are aware of the MST Coordinator role, contact information, and are familiar with available local services (Under Secretary of Health, 2010).

The MST Coordinator is also the subject matter expert on MST, as they serve as the point of contact (POC), source of information, and problem solver for MST-related issues at their facility and associated CBOCs. The MST Coordinator establishes formal mechanisms for communication and problem solving related to MST issues at the facility, with particular emphasis on establishing relationships with the facility business office. The business office is highlighted because it deals with enrollment, eligibility and billing issues. The MST Coordinator also communicates with the Information Resource Management Service, Women Veterans...
Another important duty MST Coordinators carry out is serving as the POC for Veterans and other individuals with questions about MST-related services at the facility and associated CBOCs. Accordingly, the MST Coordinator ensures that staff at various points of entry into the facility system (telephone operators, information desk staff, Mental Health clerks, Business Office staff) knows the MST Coordinator’s role and contact information (Under Secretary of Health, 2010).

MST Coordinators also address systems issues that may create barriers to Veterans and eligible individuals entering care and act as an advocate for them in their interactions with relevant VHA clinics and offices. Furthermore, MST Coordinators help ensure that systems are in place to prevent Veterans and eligible individuals from encountering difficulties in obtaining reimbursement, filling prescription medications, or receiving appropriate care (Under Secretary of Health, 2010).

It appears as if the role of a MST Coordinator is an important one, and one that all civilian practitioners treating MST survivors would benefit from being associated with by virtue of the position’s responsibilities and influence. Now that the DoD’s efforts in response to MST have been discussed, and the specific individuals tasked with assisting survivors of MST have been examined, the VHA will now be the topic of discussion. The analysis of the VHA’s efforts in regards to MST will encompass what all Veterans, regardless of current or active service, can expect in terms of treatment and assistance. Overarching policies that dictate medical and mental health treatment in general will be referenced to set the tone, and policies specific to MST-related circumstances will provide additional detail in the next section.
The Veterans Administration’s Response to MST

Since 1992, the VA has been developing programs related to MST screening and treatment, training staff on MST-related issues, and outreach to Veterans about available services. All Veterans seen within the VA are asked whether they have experienced MST, and all treatment for physical and mental health problems related to MST is free for both men and women. Veterans can receive treatment even if they have never reported an incident of sexual assault, and Veterans do not have to worry about providing proof that an incident happened. Every VA facility has a MST Coordinator, as detailed above, and they can help Veterans access services and may also be aware of state and federal benefits and community resources. Every VA facility has providers that know about treatment for the effects of MST, and many facilities have special outpatient mental health services for sexual trauma. Across the country, Vet Centers have specially trained sexual trauma counselors, and special residential or inpatient sexual trauma treatment programs exist for those needing more intense treatment support (National Center for PTSD, 2013).

In 2003, the President’s New Freedom Commission on Mental Health filed its report, “Achieving the Promise: Transforming Mental Health Care in America” (VHA Handbook, 2013). The report mentions envisioning a future where everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured and detected early, and a future when everyone with a mental illness has access to effective treatment and supports. This report was the catalyst for the “VA Action Agenda, Achieving the Promise: Transforming Mental Health Care in VA”, written in 2004, and the Mental Health Strategic Plan (MHSP) derived from it and approved by the Secretary of Veterans Affairs in fall of 2004. The overall intent of the MHSP was to ensure that all Veterans have prompt access to state-of-the-art general and
specialized mental health services that would be consistent with the vision of the President’s New Freedom Commission report (VHA Handbook, 2013).

**VHA policy for uniform mental health services.** In FY08, VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Facilities and Clinics, was published and incorporated many of the requirements of the MHSP. The Handbook specifies the range of mental health services, including inpatient care that must be made available to all eligible Veterans (Under Secretary for Health, 2013). Specific entries within the Handbook that deal primarily with MST-related care will be discussed below, as well as important aspects of the Handbook that apply to all Veterans.

VHA Handbook 1160.01 (2008) states that within VA Medical Centers and Clinics, a designated MST Coordinator will be appointed, and that a MST Counselor or team will be available “so that all enrolled Veterans, including OEF and OIF Veterans, are screened for MST and that necessary staff education and training is provided” (p. 39). Veterans receiving MST-related counseling and treatment are not billed for inpatient, outpatient, or pharmaceutical co-payments. Also, scheduling priority for outpatient sexual trauma counseling, care, and services must be consistent with VHA performance standards for scheduling clinics (Under Secretary for Health, 2008).

In terms of data, accurate documentation of screening, referral, and treatment services provided to Veterans, aggregated by gender, is maintained. This process includes use of the MST software and the MST clinical reminder to track and monitor the level of compliance with the standard, which is 100% of enrolled Veterans are screened. The nationwide tracking system to ensure consistent data on screening and treatment of survivors of MST must also be used according to the Handbook (Under Secretary for Health, 2008).
MST counseling is provided by contract with a qualified mental health professional if it is clinically inadvisable to provide MST counseling in VA facilities or when VA facilities are not capable of furnishing such counseling to the Veteran economically. This situation could happen because of geographic inaccessibility or the inability of the medical center to provide counseling in a timely manner. If this happens, a referral to the local Vet Center may be an appropriate alternative (Under Secretary for Health, 2008).

Veterans who report experiences of MST, but who are otherwise deemed ineligible for VA health care benefits based on length of military service requirements, may only be provided MST counseling and related treatment. For instance, if a Soldier attends Basic Training upon enlistment into the Armed Forces, but during the first month of Basic Training an incident of sexual assault occurs, the Soldier may end up requesting separation and not have fulfilled the length of military service requirement to meet classification as a Veteran. The VHA Handbook mentions how the determination as to whether care is MST-related is made by the clinician providing care, and that all MST-related care must be designated by checking the MST box on the encounter form for the visit. As previously mentioned, a MST software application then activates the MST Clinical Reminder within the Computerized Patient Record System (CPRS) (Under Secretary for Health, 2008).

Finally, the VHA has specific verbiage regarding time frames for evaluations of Veterans for possible mental disorders resulting from MST, and they must follow specific requirements. All new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs, and to trigger hospitalization or the immediate initiation of
outpatient care when needed. The initial 24-hour evaluation can be conducted by primary care, other referring licensed independent providers, or by licensed independent mental health providers. It is also important to note that waiting times for all services for established patients must be less than 30 days from the desired date of appointment (Under Secretary for Health, 2008).

Now that VHA Handbook 1160.01 has been evaluated for MST-related policy, the specific VHA Directive created in 2010 that deals explicitly with MST will be investigated. **VHA directive regarding MST programming.** VHA Directive 2010-033 (2010) provides policy for clinical care, monitoring, staff education, and informational outreach related to MST counseling, care, and services. MST-related care must be provided in a setting that is therapeutically appropriate, taking into account the circumstances that resulted in the need for such counseling. Public Law 103-452 removed limits on the duration of this care and specified that it must be available to both male and female survivors of MST, and Public Law 108-422 made VA’s authorization to provide this care permanent (Under Secretary for Health, 2010).

The VHA Directive mentions that there are no requirements for the condition (MST) to be adjudicated as service connected, and Veterans experiencing MST do not need to have filed a disability claim or provide evidence of the sexual trauma to receive MST-related care. This benefit extends to Reservists and members of the National Guard who were activated to full-time duty status in the Armed Forces, and given the current climate of multiple deployments for Guardsmen and Reservists, this benefit likely applies to the majority of the force. Veterans and eligible individuals who received an “other than honorable” discharge may be able to receive free MST-related care with the Veterans Benefits Administration (VBA) Regional Office approval. Also, to expand upon a previously mentioned point, because eligibility accrues as a
result of events incurred in service and is not dependent on length of service, some individuals may be eligible for MST-related care even if they do not have Veterans status (Under Secretary for Health, 2010).

Staff training and informational outreach are important components of MST-related programming as well (VHA Directive, 2010). Mental health and other health care personnel must receive appropriate training on MST-related issues, and the VA engages in efforts to ensure that Veterans are informed about MST-related services available through the VHA (Under Secretary for Health, 2010). This Directive also has verbiage regarding the MST Coordinator, and the following paragraph will highlight new insights not previously discussed in other sections.

VHA Directive 2010-033 (2010) also mentions how every facility must have a designated MST Coordinator, but includes how the facility MST Coordinator needs to be a professional who is knowledgeable about trauma and mental health and who possesses expertise in issues specific to MST. Given that part of the role of the MST Coordinator is to provide information and assistance to Veterans in accessing MST-related care at the facility, they must be sensitive to issues arising in the clinical care of MST survivors. Although some facilities have established the MST Coordinator as a full-time position, it is permissible for the role to be assigned as a collateral duty. If it is a collateral duty, care must be taken to ensure that the MST Coordinator is given adequate protected time to fulfill the responsibilities of the role. Facility size and complexity, number of associated CBOCs, the size of the facility’s catchment area, and the size of the local MST population are to be considered in making this assessment. It is important to mention that although the MST Coordinator may engage in the provision of clinical care to MST survivors as part of the MST Coordinator’s primary position, the role is defined by other duties.
These duties include screening and treatment program development, monitoring, staff education and training, informational outreach to Veterans and potentially eligible individuals, as well as other administrative responsibilities (Under Secretary for Health, 2010).

The screening process for MST has been mentioned before, but VHA Directive 2010-033 (2010) also mentions how screening is to be conducted in appropriate clinical settings by providers with an appropriate level of clinical training, and that screenings are not to be conducted by clerks or health technicians. In terms of available staff and preparedness, facilities and associated CBOCs must have appropriate physical and mental health care available for all conditions related to MST. The directive also notes how care must be delivered by staff with appropriate qualification and training. Facilities must ensure that there are a sufficient number of clinicians trained in the provision of specialized mental health care related to MST to adequately meet the demand for care. Furthermore, when clinically indicated, facilities are strongly encouraged to accommodate the requests of Veterans for a provider of a particular sex for their care for conditions related to MST (Under Secretary for Health, 2010).

Finally, the instructions provided by the Directive ensure that staff receives education and training about MST-related issues appropriate to their role with Veterans. Also, providers of clinical services are aware of the requirement to screen for MST and know how to screen sensitively. Staff will also be aware of the referral process for treatment and recognize how a history of MST may affect their provision of care (Under Secretary for Health, 2010).

Now that the VHA’s policies regarding uniform mental health services and MST-specific services have been discussed, the next section will describe the VHA’s specific efforts toward providing the best possible mental health care for Veterans. Evidence-based mental health care
will be discussed, as it is VHA policy that all Veterans diagnosed with mental health conditions resulting from MST receive evidence-based care (Under Secretary for Health, 2008).

**VHA directive regarding evidence-based psychotherapies.** VHA Handbook 1160.05 (2012) specifies the expectations and procedures for locally implementing evidence-based psychotherapies (EBP), which must be made available to Veterans with specific mental and behavioral health conditions. VHA Handbook 1160.05 (2012) states, “EBPs are specific psychological treatments that have been consistently shown in controlled clinical research to be effective for one or more mental or behavioral health conditions” (p. 1). The VA is strongly committed to making EBPs widely available to Veterans with mental and behavioral health conditions (Under Secretary for Health, 2012).

The VHA has developed and implemented competency-based EBP staff training programs, and as of August 31, 2012, the VHA has provided EBP training to over 6,000 VA mental health staff. The VHA has also developed other mechanisms to promote the dissemination and implementation of these therapies, including designation of a local EBP Coordinator at each facility. Initial program evaluation results associated with the dissemination of EBPs in the VHA reveal that, as a system, the VHA has significantly increased its capacity to provide these treatments. Also, that training in, and implementation of, EBPs has yielded significant, positive therapist and patient outcomes (Under Secretary for Health, 2012).

Beginning in FY12, the VHA developed and implemented a performance measure requiring the delivery of at least eight psychotherapy sessions within a 14-week therapy period for Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans with PTSD (Under Secretary for Health, 2012). These sessions consisted of the utilization of EBPs, and the VHA communicates that it is committed to making EBPs
widely available to Veterans for whom they are clinically indicated. EBPs are highly recommended in the VA/DoD Clinical Practice Guidelines, and are considered as first-line treatments for many conditions in the VHA. EBPs promote significant improvement in symptoms and recovery for many Veterans with mental or behavioral health conditions. All Veterans with PTSD, depression, and other mental and behavioral health conditions must have access to specific EBPs being nationally disseminated and implemented in the VHA when these treatments are clinically appropriate. EBPs must be fully available to Veterans when clinically indicated, and there must be sufficient staff capacity to provide these therapies, because they were designed and shown to be effective in a timely fashion (Under Secretary for Health, 2012).

Pursuant to VHA Handbook 1160.01, EBPs for PTSD are Cognitive Processing Therapy (CPT) or Prolonged Exposure Therapy (PE), and EBPs for depression are Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy, or Interpersonal Therapy. The VHA also prescribes Social Skills Training for Veterans with serious mental illness. All of the EBPs mentioned must be available, and need to be offered when clinically appropriate to all Veterans with a primary diagnosis of one of the conditions mentioned above. EBPs for PTSD, depression, and serious mental illness need to be provided in a timely fashion to existing and new mental health patients who choose to receive these treatments (Under Secretary for Health, 2012). Initiation of a course of EBP should generally be within 14 days of when the provider and patient agree EBP should begin (Under Secretary for Health, 2012).

Sufficient levels of dedicated and appropriately-trained staff need to be maintained to deliver EBPs in a timely fashion, and do so with high fidelity to the research established model, which should include regular monitoring of patient outcomes. Clinic structures and processes need to be in place that align with and support widespread, regular use of specific EBPs, as well
as support the use of other psychotherapy, psychosocial and psychopharmacological treatment services as clinically indicated. EBP protocols typically require 9 to 16 sessions, and are generally delivered on a weekly or more frequent basis, dependent on client needs and circumstances (Under Secretary for Health, 2012).

Guidelines based on research and clinical experience substantiates the treatment lengths of different EBPs and can be found in the treatment manuals for the different EBPs. These treatment manuals can be found on an internal VHA website that is not available to the public (Under Secretary for Health, 2012). EBPs delivered in individual format usually require weekly sessions from approximately 60 to 90 minutes in length, depending on the specific treatment. Also, treatment planning needs to explicitly match client diagnosis and problem behaviors with the most effective treatments known for those conditions (Under Secretary for Health, 2012).

The consideration of EBPs needs to be documented in the treatment plan, with indication made in the medical record whether an EBP was offered to the patient and whether the patient chose to engage in the treatment. Decisions made to not offer or implement an EBP that is considered to be a standard of care for a particular condition also needs to be documented in the medical record. Departures from the use of EBPs that have been identified as the standard of care need to be based on the Veteran’s preference. Departures also need to serve a defined clinical purpose, based on evidence-based principles of care, such as coping skills training to prepare a patient with PTSD to participate more effectively in an EBP for the disorder (Under Secretary for Health, 2012).

A number of facilities have established mental health orientation groups, EBP information sessions, or other similar mechanisms for offering and discussing one or more EBPs and other potential therapy options for Veterans. These processes typically include information
about the length of process of the therapy, effectiveness and potential utility of the therapy, and consideration of the patients. These groups have often included a family member that can help to facilitate the adherence of the Veteran to the protocol (Under Secretary for Health, 2012).

A course of EBP needs to be delivered by the same therapist for the duration of the therapy protocol, except in rare instances where a transfer to a new therapist may be necessary due to unforeseen circumstances. This applies to multiple therapists as well, as in the case when co-therapists are delivering a group-based EBP. EBPs need to be delivered by clinicians who are qualified, trained, and competent to deliver them, or by clinicians in the process of receiving EBP training who are supervised by clinicians competent to deliver EBPs. The Military Health System (MHS) in the VA Central Office has established a national workgroup that is finalizing the development of criteria for recognizing staff who have received competency-based training in EBPs outside of VHA. These criteria will indicate competency-based training in EBPs outside of VHA as equivalent to the training provided in the VHA EBP training programs (Under Secretary for Health, 2012).

Clinicians learning and implementing EBPs require access to supplies and equipment that allow them to deliver EBPs as designed and shown to be effective. Supplies and equipment that may be needed include, but are not limited to audio recording equipment, copies of printed therapy materials, and clinical assessment materials. When possible, staff members specifically trained in a particular EBP need to devote a significant amount of their clinical time to implementing that therapy and using their learned skills. This is done to avoid staff members becoming formally trained in one EBP, but implementing a number of EBPs, which can be a less efficient use of EBP training and staff resources (Under Secretary for Health, 2012).
The availability of specific doctrine relating to the mental and physical healthcare available to Veterans with MST-related conditions suggests the VHA has responded comprehensively in an effort to help mitigate the effects of sexual assault. The VHA has strict protocol when access to and timeliness of care for MST-related conditions is involved, and each individual protocol is spelled out succinctly within policy. It is possible that many Veterans suffering from the aftereffects of MST may be unaware of the fact that they qualify for essentially free of charge mental or physical healthcare, but if civilian practitioners are aware of current policy, no Veteran should be left to pay out of pocket.

**Helping Victims of Military Sexual Trauma**

Military Sexual Trauma is the term that the Department of Veterans Affairs utilizes to refer to sexual assault or repeated threatening sexual harassment that occurred while the individual (veteran) was serving in the military. Treatment for MST may necessitate differences when compared to other rape or sexual assault because MST is a form of high betrayal trauma, and many cases occur while the victim is separated from friends and family and possibly conducting combat operations. This literature review will attempt to discover how the current VHA treatment process for victims of MST is improving the mental health of veterans. The current VHA treatment process for MST will be investigated and analyzed, and any and all treatment results to ascertain whether veteran’s mental health is improving, or changes to the process need to be made in order to better serve this country’s veterans.

This literature review is not without its fair share of limitations. The current research on the topic of MST is not robust, and the study of male veterans experiencing MST is even more limited. To this writer’s knowledge, there may actually be only one study that has been conducted which attempted to show the improving mental health of males who have experienced
MST and been treated with a specific therapeutic approach. This literature review is also a culmination of only 15 scholarly articles, which limits the depth and breadth of the topic of MST. Regardless of the limitations though, this paper will investigate the current VHA treatment process for victims of MST, whether the mental health of MST victims is improving, and provide an in depth analysis of what constitutes MST, prevalence of MST, and the resulting mental health conditions.

The Current VHA Treatment Process

Treatment efforts. Kimerling et al. (2011) describe how the VHA is a national leader in MST management and abides by numerous public laws and directives aimed at providing expansive services for MST-related care. The VHA is legislatively mandated to provide treatment for veterans suffering from the effects of MST, and as a result of these mandates, several initiatives have been implemented (Ferdinand, Kelly, Skelton, Stephens, & Bradley, 2011). Ferdinand et al. (2011) report that every VA medical center will have an MST coordinator responsible for education, outreach, compliance with mandatory screenings, and assurance of treatment. The VHA has also shown educational efforts, such as offering providers and MST coordinators at each facility ongoing opportunities for clinical training and continuing education (Kimerling et al., 2011). These efforts have been accompanied by regular monitoring of both MST-related screening and treatment, as well as patient perceptions of quality (Kimerling et al., 2011). Kimerling, Street, Gima, and Smith (2008) describe in further detail the role of the MST coordinator by reporting how the coordinators facilitate treatment for sexual trauma when providers determine clinical need among patients that screen positive. It seems the VHA has taken steps to ensure that MST is identified and treated, but a more extensive
investigation into the screening process mentioned above will take place later in the literature review.

**Who administers treatment?** Current scholarly research is relatively thin when looking for a specific practitioner who administers treatment to victims of MST. Scaturo and Huszonek (2009) report that a nationwide Veterans Administration MST program now provides counseling and treatment for the aftereffects of sexual trauma for both men and women veterans, but does not identify specific practitioners. Ferdinand et al. (2011) discuss how there has been a rapid development of specialized programs designed for female veterans focused on the health and mental health issues related to MST, including the establishment of inpatient and day-treatment programs. These inpatient and day-treatment programs do not reference specific providers however. The available literature has mentioned psychiatrists, psychologists, therapists and counselors, but has not assigned specific tasks to specific personnel.

**Treatment techniques.** The increasing numbers of veterans seeking MST-related mental health services at VHA facilities have created an urgent need to identify and implement efficient, effective methods for treating veterans with Posttraumatic Stress Disorder related to MST (Suris, Link-Malcolm, Chard, Ahn, & North, 2013). Though the current literature does not identify specific therapeutic approaches the VHA endorses for the treatment of MST, there has been plenty of focus on the approaches that work. To begin, Baltrushes and Karnik (2013) write that cognitive behavioral therapy and trauma-focused therapy have both been shown to have positive outcomes in patients with sexual trauma and PTSD. Hyun, Pavao, and Kimerling (2009) report that the interventions with the strongest level of empirical support (i.e., exposure-based cognitive behavioral therapies like prolonged exposure and cognitive processing therapy), were initially developed for and rigorously tested among civilian sexual assault survivors. Hyun,
Pavao, and Kimerling (2009) go on to describe how studies found that prolonged exposure was superior to present-centered therapy in reducing PTSD symptoms, and how this suggests how successful treatments for civilians are likely to be effective among female veterans with MST. Furthermore, “Seeking Safety”, a cognitive behavioral treatment for comorbid PTSD and substance use disorders is another example of a potentially effective intervention for Veterans who have experienced MST, as effectiveness has been demonstrated with civilian sexual assault victims (Hyun, Pavao, & Kimerling, 2009). Interestingly, Ferdinand et al. (2011) describes an emerging model of treatment, a phase model for complex symptom presentations in trauma survivors. This model includes an initial phase focused on stabilization, a second phase focused on trauma memories, and a third phase focused on re-establishing adaptive functioning (Ferdinand et al., 2011).

There has been some research mentioning the VHA and specific treatments of interest, although nothing that directly links the VHA to a specifically endorsed approach. Ferdinand et al. (2011) report that the VHA has implemented nationwide training and supervision in two cognitive behavioral treatments for PTSD, Prolonged Exposure and Cognitive Processing Therapy. PE and CPT have both demonstrated efficacy in randomized controlled trials for the treatment of sexual assault. Also, the VHA has been providing training to clinicians in Acceptance and Commitment Therapy (ACT), which has been implemented in numerous treatment programs for women with MST (Ferdinand et al., 2011).

**Summary.** Legislative mandates and the initiatives that sprung about because of them have ensured that the VHA is striving to provide help for veterans with a history of MST. MST coordinators, trained providers, and free services have been offered up as evidence that the VHA does care about the issue of MST. This writer was surprised at the general lack of direction
when it comes to who exactly provides mental health treatment for victims of MST however. Government entities, specifically entities of a military nature, usually have specific protocols for all to follow, no matter how nominal the task. Put simply, Hoyt, Rielage, and Williams (2011) report that VA policy emphasizes the importance of MST treatment for both women and men and includes provisions for both to receive free services, but specific guidelines for treatment are vague. The scholarly research presents that same viewpoint, because evidence of a specific and delineated treatment protocol for MST just isn’t there, or at least hasn’t been studied.

Treatment techniques were not hard to find when pursuing information regarding the improvement of individuals with PTSD, which is common among MST victims. What was hard to find though, were the exact techniques that the VHA prescribes for MST victims. There seems to be numerous techniques and approaches for which the VHA urges its practitioners to pursue education in, but evidence of exact protocols were scarce. Ferdinand et al. (2011) came close to identifying some by reporting how it is logical that the VHA is working to systematically implement two treatments, PE and CPT, because both have research supporting their effectiveness. It appears that treatment models that address the complexity of MST victim’s mental health issues are still being developed, but it also seems as if the VHA is committed to providing treatment to veterans who have experienced MST (Ferdinand et al., 2011).

Is the Mental Health of Veterans Improving?

**Treatment effectiveness.** Evidence of the effectiveness of particular treatment programs for male and female veterans whom have experienced MST is scarce. Information regarding the improved mental health of veterans has not come close to what is available for civilians exposed to sexual violence. Hyun et al. (2009) identify that there have yet to be controlled trials for the
treatment of PTSD among male veterans who have experienced MST, and the contemporary information, or lack thereof, seems to lend credence to their claim. A study referenced earlier conducted by Suris et al. (2013) described how their work was the first randomized controlled trial of psychotherapy for PTSD specifically related to MST of which they were aware. That statement alone provides justification for the claim of there being very little research on the topic of mental health improvement in veterans exposed to MST. Until more research is conducted and more empirical evidence is offered to highlight the current state of veteran mental health related to MST, determining if said mental health is improving may be difficult.

**Access to care through screening.** With so little evidence available in scholarly journals regarding the effectiveness of treatment designed to improve the mental health of MST victims, or empirical evidence stating whether veteran mental health is improving or declining, another approach had to be taken. Operating under the assumption that any treatment for MST is better than no treatment at all, the current screening process the VHA employs was investigated.

The VHA was first authorized to provide outreach and counseling for sexual assault to women veterans after a series of hearings in 1992, and increased attention to these issues led Congress to extend services to male veterans shortly thereafter (Kimerling, Gima, Smith, Street, & Frayne, 2007). As Kimerling et al. (2007) report, in 1999, the VA’s responsibility was extended from counseling to all appropriate MST-related care and services, and it was at this time that universal screening was initiated. They also mention that Public Law 108-422, signed in 2004, made the VA’s provision of sexual trauma services a permanent benefit for veterans (Kimerling et al., 2007).

Because MST is a stressor, rather than a diagnosis, treatment efforts in the VHA focus on detecting MST and access to care (Hyun, Pavao, & Kimerling, 2009). Kimerling et al. (2008)
report that VHA facilities screen for MST in mental health, as well as primary care treatment settings. Kimerling et al. (2008) also states, “this universal screening program represents one of the most comprehensive responses to sexual violence of any major U.S. health care system” (p. 636). This screening, or universal screening, is accomplished through the use of a clinical reminder in the patient’s electronic medical record (Kimerling et al., 2007). Kimerling et al. (2007) also go on to mention how documentation of a positive screen enables the provider to classify the visit as MST related, thus allowing the care to be delivered free of charge.

A study conducted by Kimerling et al. (2008) reported that in fiscal year 2006, 86.7% of all VHA patients had been screened for MST, and suggested that the screening program was indeed feasible and acceptable to patients and providers. They went on to mention how the screening process was found to be an efficient method to promote access to specialty mental health care, and how their study provided prima facie evidence that detection of MST via screening increases rates of mental health treatment for these specific patients (Kimerling et al., 2008). Once again, no evidence was found or suggested that would hint at the improving mental health of veterans being a direct result of treatment, but as mentioned above, being identified and provided mental health treatment would be the first logical step in the process.

**Summary.** Discovering the relative lack of information regarding proven effectiveness in the treatment of MST-related mental illness, and the lack of information stating whether the mental health of veterans is improving or not, led to an extensive search for another facet of improvement for veterans. The current screening process for MST in veterans receiving health-related services through the VHA appears to be a source of positivity for many. Treatment for mental health issues cannot begin until the need for those services is identified, so because the screening process identifies this need, then there is a greater probability that veterans mental
health could improve. No research could be located, however that identifies any correlation between MST victims being appropriately screened, and ultimately having their mental health improve. The only correlation found would be that of the screening process making it possible for more veterans to receive specialized care for their mental health. Kimerling et al. (2008) sum it up eloquently by stating how an effective screening program coupled with a mental health care system that provides evidenced-based care will go far in reducing the burden of illness for those who have experienced MST. Apparently, if these conditions exist today, scholarly publications have yet to identify them and their positive outcomes.

Victims of Military Sexual Trauma

Definition of MST. Military Sexual Trauma garners its definition from the Department of Veterans Affairs, and the term is specific to the VA healthcare system and will only be used when referring to VHA populations (Hyun et al., 2009). As described by Hyun et al. (2009):

The VA uses the term Military Sexual Trauma (MST), specifically defined by public law, to refer to sexual assault and to repeated, threatening sexual harassment occurring during military service. MST is conceptualized within an occupational exposure framework as a duty-related hazard and therefore, sexual assault and sexual harassment are grouped together. (p. 1)

Military service is mentioned in the definition, but is not exclusive to combat, overseas service, or active duty. Also, the term MST applies regardless of geographic location of the trauma, gender of the victim, or relationship to the perpetrator (Department of Veterans Affairs Employee Education System, 2004).

There are several factors specifically associated with MST that may be particularly traumatizing. Ferdinand et al. (2011) describe how being victimized by fellow military service
members may intensify the sense of betrayal, how victims may perceive that escape is not possible, and how victims may fear negative repercussions for disclosing the sexual trauma. Baltrushes and Karnik (2013) also state, “Soldiers on deployment are typically isolated from their normal support systems, under significant pressure, and unable to leave their post, which often means they have ongoing exposure to the abuser” (p. 121).

Lutwak and Dill (2013) describe MST as “a form of high betrayal trauma, meaning trauma in which depended-upon-for-survival individuals harm or violate a dependent person, thus breaking the social agreement of trust” (p. 359). Furthermore, the victim of the particular harm, who is in a dependent position, is unable to confront or break ties with the perpetrator (Lutwak & Dill, 2013). This can result in the damaging of a victim’s well being, self-concept, relationships, and ultimately their view of the world, because the dependent victim experiences a trauma where expectations and reality are incongruous (Lutwak & Dill, 2013). Being in a dependent position seems to be even more detrimental, because escape may be impossible, and more violations may occur (Lutwak & Dill, 2013).

**Prevalence of MST.** Prevalence data concerning Military Sexual Trauma appears to be generally agreed upon throughout scholarly articles. Kimerling et al. (2007) reported that the prevalence of MST among the population of VHA outpatients, as reported by data from the VHA universal screening program collected shortly after its implementation in 2003, was 21.5% among women and 1.1% among men. The measure of 1.1% for men appears to have held steady for the last ten years, because both Turchik et al. (2013) and Baltrushes and Karnik (2013) have documented that same rate of prevalence in the same VHA population. Baltrushes and Karnik (2013) go on to mention, however that a range of 0.03% to 12.4% accompanies the 1.1%
prevalence rate. Hoyt et al. (2011) found similar statistics, in that reported rates range from 0.02% to 12%, and they go on to mention that the lifetime prevalence rate they found was 1.1%.

Prevalence rates in women do not compare as equitably as those in men throughout scholarly research, but still seem to fall within published norms. Baltrushes and Karnik (2013) discuss how female service members have shown a 20% to 43% prevalence rate according to internal reports, and how studies outside the military have reported rates that range from 3% to as high as 71%. The above mentioned prevalence rate of 21.5% seems to fall within these findings, albeit not as close as rates for males. Absolute prevalence of MST has been described by Platt and Allard (2011) as difficult to assess, but regardless of that conclusion, it is clear that it is experienced by a substantial number of women and men, and as will be discussed below, can result in devastating outcomes.

**Resulting health conditions in survivors.** The overwhelming opinion throughout scholarly articles is that MST victims are more likely to suffer from debilitating mental and physical health issues. Baltrushes and Karnik (2013) write that veterans with a history of MST are more likely to report physical symptoms and to have a lower health-related quality of life, poorer overall health status, and more outpatient visits than veterans who were not exposed to MST. Furthermore, as Kimerling et al. (2010) describe, women and men who reported a history of MST were significantly more likely to receive mental health diagnosis, including Posttraumatic Stress Disorder, other anxiety disorders, depression, and substance use disorders. Also, there appears to be a link between MST and suicide and intentional self-harm, as these negative reactions are over twice as common among men and women who have reported experiencing MST (Lutwak & Dill, 2013).
The majority of data available describes the resulting conditions female veterans experience. Baltrushes and Karnik (2013) explain that women with a history of MST are more likely to be obese and sedentary, to smoke and drink, and to have a hysterectomy before the age of 40 years. Forman-Hoffman, Mengerling, Booth, Torner, and Sadler (2012) mention that many women veterans are likely at high risk for having or developing eating disorders. Further physical symptoms such as increased gynecological, urological, gastrointestinal, pulmonary, and cardiovascular problems have also been shown in women veterans (Lutwak & Dill, 2013). As far as additional mental health issues female victims of MST face, higher rates of PTSD have been found when compared to females experiencing other types of trauma. Furthermore, PTSD is made even worse when it occurs in the military because of continued exposure and involvement with the perpetrator (Lutwak & Dill, 2013). Valente and Wight (2007) also mention other psychiatric problems typically associated with trauma such as phobias, dissociative disorders, and changes in sexual desire and intimacy.

Summary. Due to the nature of military-related applications, MST has an accepted and understood definition. The VHA has provided Soldiers and providers with a wealth of information governing MST and its many forms. The aspect that seems to separate MST from sexual assault in general appears to be the double-edged sword that women specifically face. As Scaturo and Huszonek (2009) describe, “women in the military often suffer not only from the fear of assault by the enemy but also their male comrades in arms” (p. 6).

Prevalence data for males seems to have held steady over the last 10 years, but it appears that for both men and women, rates of MST exposure in veterans encompasses a very large range. The literature suggests that this may result because of the underreported nature of MST. What was interesting about the facts and figures was that despite the lower prevalence of MST
among male veterans, because the VHA treats so many more men than women, the populations are actually of a similar size (Hyun et al., 2009). This writer was surprised at the fact that both sexes of veterans appear to have relatively similar numbers experiencing MST. The problem of sexual assault in the military seems to usually be focused toward the impact on female Soldiers, but in all actuality, the same number of males may actually be affected.

As with most data sought throughout this literature review, it seems as though the resulting health conditions of male victims is just as limited. Baltrushes and Karnik (2013) share this same viewpoint, but go on to mention how one study found an association with pulmonary and liver disease and human immunodeficiency virus and acquired immune deficiency syndrome. It is surprising to this writer how MST can demonstrate any kind of association with such grave conditions. To further this point with regard to female victims of MST, Lutwak and Dill (2013) report that these women are more likely to report being treated for a heart attack in the past year than those who have no history of sexual assault. This information doesn’t prove causality, but it definitely sheds light on potentially damaging health conditions that may be more likely to affect MST victims.

**Conclusions and Future Study**

With civilian practitioners in mind, the document has examined the available policy and procedures both the DoD and VHA follow to ensure the issue of MST is comprehensively planned and accounted for. The DoD has incorporated extensive training for personnel, awareness campaigns, MST-related duty positions, and a wealth of doctrine to help service members, DA civilians and civilian contractors quickly respond to and understand the intricate needs of MST survivors. The VHA has also put forth great effort to ensure survivors of MST, regardless of their Veteran status, are provided the most timely and relevant care possible. The
VHA has done this by way of specific protocols, marketing material and the creation of the MST Coordinator position. It would appear as if the DoD has done the requisite work to help quell the issue of MST, or at least establish controls to help mitigate it. It would also appear that the VHA has done its requisite work to ensure all survivors of MST are afforded opportunities for care, regardless of circumstances. The information provided will help to ensure civilian practitioners are armed and ready for when they encounter a MST survivor, and provide them the tools to best serve this population of clients. The information provided does not speak to effectiveness however, only policy.

Throughout the course of this literature review, it has become clear that the current treatment process for victims of MST, prescribed by the VHA, is more closely akin to a process of identification. The VHA has amassed serious efforts toward screening for MST, due to the importance of identifying and treating it, and made it possible for victims of MST to receive free of charge physical and mental health care. There was a lack of specific identification of providers for which the VHA requires to treat victims of MST, but specific techniques the VHA provides education and training in were available for study. Without the presence of literature detailing specific treatment for victims of MST, it was difficult to establish if a particular treatment approach was improving veteran mental health or not. It was also difficult to establish if a specific practitioner was responsible for greater mental health improvement in veterans as opposed to another. It was clear, however that the VHA has made it a priority to provide access to care for anyone screening positive for MST, which is a positive in and of itself.

The overwhelming findings throughout the literature review actually did not address the specific question of whether the mental health of veterans exposed to MST was improving or not. The findings suggest that veterans exposed to MST are provided better access to care, and
specifically specialty care, designed to treat their specific issues, but a determination regarding mental health improvement could not be made. This writer expected research to have been conducted that investigated mental health improvements being made as evidenced by specific outcome measures, as in patient health questionnaires or another similar measurement device. What was found fell short of that goal, in as much as the establishment of improved, or worsened mental health, could not be defined. Taking into account the current literature presented throughout this review, the only claim to be made is that the VHA indeed has processes in place to identify and treat victims of MST, but concrete evidence regarding the mental health improvement of those victims proved difficult to establish.

Since research on MST treatment is relatively new, it is this writers hope that specific EBPs will be examined to determine the best interventions available for this population. Much research has been done in order to establish the fact that specific interventions can be deemed EBPs, as well as how those EBPs treat conditions that MST survivors have been shown to present with. The research falls short however, because there are very few studies that have been conducted specifically targeting those conditions in MST survivors. It would not be accurate to assume that the established EBPs have the ability to show the same outcomes in MST survivors as they do in other survivors of sexual assault that were not military-related.

An interesting topic to be examined would be that of telemedicine, and its effectiveness in serving MST populations. Lutwak and Dill (2013b) mention in an editorial within the Military Medicine journal, that as more and more women who experience MST return from Iraq and Afghanistan, there will be greater need to provide them with EBPs. Furthermore, using telemedicine to deliver therapy to groups of women would provide a valuable innovative technique to disseminate this care while reducing cost and travel time, since there aren’t VA
medical facilities in every town (Lutwak & Dill, 2013b). As Lutwak and Dill (2013b) have found, women Veterans who have experienced MST are often anxious and feel uneasy at large VA centers, as they often have environments dominated by a male presence. Thus, having a therapy option in a secure, safe environment for women is important. Also, using telemedicine should decrease the sense of isolation many women Veterans feel because they can share similar experiences with others, while remaining in a quiet and private location (Lutwak & Dill, 2013b). The research on this form of group treatment would be interesting, and may lead to its permanent establishment amongst VHA protocols.

Much research and study lies ahead for effective MST-related interventions, but the topic appears to gaining attention. Even though the research is scarce, available benefits for MST survivors are not. Each practitioner that serves to help MST survivors would benefit from familiarizing themselves with DoD and VHA policy, as its possible many do not know what is out there and available to them. If a survivor of MST is encountered, listed below is an excellent first step.

How can Veterans get help?

For more information you can:

Speak with your VA health care provider.

Contact the MST Coordinator at your nearest VA Facility.

Call Safe Helpline at 1-877-995-5247 to get confidential one-on-one help.

Contact a Vet Center near you.

Call VA’s general information hotline at 1-800-827-1000
References


