Understanding & Treating Co-Occurring Military Sexual Trauma & Substance Use Disorders

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Objectives

• The participant will be able to understand what Military Sexual Trauma is and how co-occurring substance use disorders affect the way men and women cope with having to live in the hyper masculine military culture and subsequent effects on their mental, emotional, and physical health.

• The participant will be able to understand how homelessness and co-occurring Military Sexual Trauma and substance use disorders go together with a focus on female veterans regarding housing, clinical, and psychosocial outcomes.

• The participant will be able to understand what evidence-based treatments and promising treatments are available for treating co-occurring Military Sexual Trauma and substance use disorders.
What is Military Sexual Trauma?

VA IS HERE TO HELP.

Veterans Health Administration, 2016
Defining Military Sexual Trauma

- "Military sexual trauma" or MST is the term used by the U.S. Department of Veterans Affairs to refer to these experiences. The official definition of MST used by VA is given by federal law (U.S. Code 1720D of Title 38). It is:

  - "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."

- Sexual harassment is defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.”

(U.S. Department of Veteran Affairs, 2017)
When Does Military Sexual Trauma Happen?

- Occurs when it is against your will.

- May have been physically forced into sexual activities or coerced or pressured into sexual activities based on threats or promises.

- Includes sexual experiences that happened while one was not able to consent to sexual activities, such as if one was intoxicated.

- Include unwanted sexual touching or grabbing, threatening, offensive remarks about one’s body or sexual activities, and threatening and unwelcome sexual advances.

(Making the Connection, 2017)
Consequences of Military Sexual Trauma

- Consequences of MST may surface months or years after the event(s) affecting mental, physical health, work, relationships, & daily life and severity depends upon:
  - Whether there is a prior history of trauma
  - The types of responses one received from others at the time of the experience
  - Whether the experience happened once or was repeated over time

(Making the Connection, 2017)
Difficulties of Military Sexual Trauma

- Some of the difficulties both female and male survivors of MST may have include:

- Strong emotions: feeling depressed; having intense, sudden emotional responses to things; feeling angry or irritable all the time

- Feelings of numbness: feeling emotionally “flat”; trouble feeling love or happiness

- Trouble sleeping: trouble falling or staying asleep; bad dreams or nightmares

(Making the Connection, 2017)
Difficulties of Military Sexual Trauma

- Trouble with attention, concentration, and memory: trouble staying focused; often finding your mind wandering; having a hard time remembering things

- Problems with alcohol or other drugs: drinking to excess or using drugs daily; getting drunk or “high” to cope with memories or unpleasant feelings; drinking to fall asleep

- Trouble with reminders of the sexual trauma: feeling on edge or “jumpy” all the time; not feeling safe; going out of your way to avoid reminders of the trauma; trouble trusting others

- Problems in relationships: feeling alone or not connected to others; abusive relationships; trouble with employers or authority figures

(Making the Connection, 2017)
Factors Unique to Military Sexual Trauma

- May have had to continue to live and work with the perpetrator, and even rely on him or her for essential things like food, health care, or watching your back on patrol.
- May have been worried about damaging the team spirit of one’s unit if the perpetrator was in the same unit.
- May have been worried about appearing weak or vulnerable, and thoughts that others would not be respected.
- May have thought that if others found out, it would end one’s career or chances for promotion.

(Making the Connection, 2017)
Graphical Representation of MST

Sexual assault in the ranks
About 1.4 percent of active-duty members of the U.S. armed forces — roughly 19,000 people — said they were subjected to unwanted sexual contact in the past year, according to an anonymous, Pentagon-commissioned survey.

Percentage saying they experienced unwanted sexual contact:

<table>
<thead>
<tr>
<th>Service</th>
<th>Total</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>All services</td>
<td>1.4</td>
<td>0.9</td>
<td>0.5</td>
</tr>
<tr>
<td>Army</td>
<td>1.7</td>
<td>1.2</td>
<td>0.5</td>
</tr>
<tr>
<td>Navy</td>
<td>1.8</td>
<td>1.1</td>
<td>0.7</td>
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<tr>
<td>Air Force</td>
<td>0.8</td>
<td>0.4</td>
<td>0.4</td>
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<tr>
<td>Marines</td>
<td>1.2</td>
<td>0.7</td>
<td>0.5</td>
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</tbody>
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SOURCE: RAND Corporation

(Baldor, 2014)
Statistics of Military Sexual Trauma

- “In 1995 the Department of Defense conducted a large study of sexual victimization among active duty populations and found rates of sexual harassment to be 78% among women and 38% among men over a one-year period. Rates of attempted or completed sexual assault were 6% for women and 1% for men.”

- “Research with Persian Gulf War military personnel conducted by Jessica Wolfe and her colleagues found that rates of sexual assault (7%), physical sexual harassment (33%) and verbal sexual harassment (66%) were higher than those typically found in peacetime military samples.”

(Street & Stafford, 2017)
Statistics of Military Sexual Trauma

- The Department of Veterans Affairs has estimated that one in five women veterans who use its health-care program screen positive for MST. The American Psychological Association estimates that in 2012, “the Army had the highest rate of sexual assault reports (2.3 per 1,000 service members), while the marine corps had the lowest (1.7 per 1,000).”

(Lantigua-Williams, 2016)
Statistics of Military Sexual Trauma

• A 2015 APA study titled “Sexual Trauma in the Military” summarized the current state of the issue:

• “Reports of sexual assault in the military have risen by approximately 88 percent between 2007 (2,688 reports) and 2013 (5,061) ... However, the Department of Defense (DOD) has also acknowledged that less than 15 percent of military sexual assault victims report the matter to a military authority ... Therefore, peer-reviewed research may provide more reliable estimates of the incidence of sexual assault. A recent review of research on military sexual trauma (MST) indicated that between 9.5 and 33 percent of women report experiencing an attempted or completed rape during military service. When examining MST, including all forms of assault and harassment, between 22 and 84 percent of women report having these experiences during service...” (Kintzle et al., 2015, p. 394).
Female Veteran Negative Outcomes

“Female Veterans who use VA healthcare and report a history of sexual trauma while in the military also report a range of negative outcomes, including poorer psychological and physical health, more readjustment problems following discharge (i.e., difficulties finding work, alcohol and drug problems), and a greater incidence of not working due to mental health problems.”

(Street & Stafford, 2017)
Co-Occurring Military Sexual Trauma & Substance Use Disorder

“Sexual assault victimization is associated with high lifetime rates of PTSD in both men (65%) and women (45.9%). Interestingly, these rates are higher than the rate reported by men following combat exposure (38.8%). Major depressive disorder (MDD) is another common reaction following sexual assault, with research suggesting that almost a third of sexual assault victims have at least one period of MDD during their lives. Victims of sexual assault may also report increased substance use, perhaps as a means of managing other psychological symptoms.”

(Street & Stafford, 2017)
“History of military sexual trauma (MST) is another risk factor associated with adverse mental health outcomes that merits consideration. Studies on female veterans predating OEF/OIF have found that female veterans with a history of MST were five to eight times more likely to have current PTSD, three times more likely to be diagnosed with depressive disorders, and two times more likely to be diagnosed with alcohol use disorders compared to female veterans without a history of MST” (Maguen et al., 2012, p. 312).
Co-Occurring Military Sexual Trauma & Substance Use

- “One large-scale study found that compared to non-victims, rape survivors were 3.4 times more likely to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other major drugs. In addition to these psychological conditions, victims of sexual trauma may continue to struggle with a range of other symptoms that interfere with their quality of life.”

- “Common emotional reactions include anger and shame, guilt or self-blame. Victims of sexual trauma may report problems in their interpersonal relationships, including difficulties with trust, difficulties engaging in social activities or sexual dysfunction. Male victims of sexual trauma may also express concern about their sexuality or their masculinity.”

(Street & Stafford, 2017)
Hyper-Masculinity Dimensions

- According to Burk, Burkhart, and Sikorski (as cited in Schmidt, 2015), “Hypermasculinity is posed to be represented by four dimensions; dominance & aggression, sexual identity, conservative masculinity, and devaluation of emotion” (p. 17).

- Corprew, Matthews and Mitchell (as cited in Schmidt, 2015) “Found that the presence of these four dimensions lead to four different types of masculine ideological environments; extreme hypermasculinity, traditional masculine, traditional hypermasculine, and non-hypermasculine. Each of these four types of masculine ideological environments can have various outcomes, based on the level of each dimension (dominance and aggression, sexual identity, anti-femininity, and devaluation of emotion)” (p. 17).
The Hyper-Masculine Military Culture

- Hyper-masculinity is an “exaggeration of stereotypical masculine behavior of strength and stoicism, breeding a sense of power and relentless aggression” (O’Malley, 2015, p. 3).
- Military stated values are at odds with sexual assault and harassment in a solidified military society and a military justice system as its own society – a world of its own (O’Malley, 2015).
- Military as “last bastion of unadulterated masculinity” (O’Malley, 2015, p. 4).
Military Masculinity Myth

- Gender is socially constructed and socially practiced supporting the military masculinity myth of subordinating men and women through sexual assault (O’Malley, 2015).
- Rapes are against both men and women.
- Rapes against male soldiers account for over half of all inter-military rapes (O’Malley, 2015).
- Assaults are acts of dominance and violence and are meant to show the victim who is superior and in control (O’Malley, 2015).
Military culture promotes a binary system of men and women on opposite ends where hyper-masculinity is not simply a belief, but a social system where in hegemonic masculinity proving oneself through performance constantly is needed for acceptance in the male-dominated group and this gives men power as they are part of masculine hierarchy; nonetheless, masculinity is “as much about men's relation to other men as it is about men's relation to women” (O’Malley, 2015, p. 10).

“Gender is the performance of power, and the military has been a historically male-dominated institution hostile to women and promotes hyper-masculinity essentially making the military no place to be a woman” (O’Malley, 2015, p. 10).
Cultural Role Conflicts – Military Sexual Aggression towards Women

• Culture led by a group-identity structure of masculinity as part of military socialization, that attitudes of sexuality are embodied in the military, and that “women are cast largely as the sexual adversary or target, while men are cast largely as promiscuous sexual hunters”, normalizing male sexually aggressive behavior (as cited in Schmidt, 2015, p. 15).
Cultural Role Conflicts - Military Sexual Aggression towards Women

“Because basic training reinforces the cultural perception that men are supposed to be dominant, achievement oriented, powerful, and masculine, male soldiers are socialized that achieving sexual intercourse is a sign that they have met the standards of the military's masculine warrior culture. Simultaneously, this basic training creates a cultural role conflict for women, who must unlearn almost everything they were taught prior to entering the military. Further role conflict can arise when women in the military are challenged by male soldiers who continue to encourage them to meet the attractive, feminine model cultural norms” (Williams & Bernstein, 2011, p. 140).
Coping with Cultural Role Conflicts

- “Women in the military and veterans in general have a significantly higher rate of eating disorders, in particular bulimia, than do their civilian counterparts (McNulty, 2001; Peterson et al., 1995); these conditions are not necessarily preexisting but are caused by contextual military factors (McNulty, 2001). Research suggests that eating disorders, such as bulimia nervosa, are responses to powerlessness that frequently occur in women who have an external locus of control (Dalgleish et al., 2001; Slade, 1982; Waller, 1998) and who are dissatisfied with their appearance; consequently, those who believe that they are not thin enough are likely to manifest abnormal eating behaviors (Tylka, 2004). Bulimia is believed to be a reaction among women to society’s image of the ideal female; controlling food becomes a means to cope with their perspectives that they are somehow lacking (Knafo, 2000). Thus, bulimia becomes a response not only to the search for control but also as a means to cope with the mixed military cultural messages of being a masculine warrior and a feminine model” (as cited by Williams & Bemstein, 2011, p. 140).
Women as Targets - A Man’s World

- Not one of the guys - testing the limits of what is tolerated. Throwing stones in pants holes to aggressive behaviors in trading off guard duty (Sorcher, 2013).

- When she told men in her unit about the incident, they said she'd joined a man's military and asked what she expected to happen. "It definitely made me feel guys who were sexually harassing me, who were violating the rules, who were doing the wrong thing--that guys felt they were more important as soldiers because they were men." (Sorcher, 2013).

- "It's hard to be in a combat zone when I'm expected to rely on these guys for my life, but [I] no longer felt I could trust them to not sexually assault me if I let my guard down." (Sorcher, 2013).
Women as Targets - A Man’s World

• Shrugging off misogyny and pays the price – derogatory
call name for a female pilot, pornography screened in
front of flight crew, and singing ditties from the Vietnam
War era about mutilating and raping women. The
attitude of the older male pilots, Smith recalls, was, "If
you're going to run with the men"--especially when men
are the bosses--"you'd better learn how to deal with it."  
(Sorcher, 2013).

• Found porn in storage unit, reported it to commander,
called “bitch”. Same unit deploys, service members tries
to rape her. She reports it, called “snitch” dropped like a
“hot potato by her co-workers.” (Sorcher, 2013).
Women as Targets - A Man’s World

- Grace recounted her experience:
  “We would drive past {male soldiers} on the base and they made hand signals for different sexual things that they wanted to do to somebody. I mean these guys were married and most of them their wives were pregnant, you know, at home with their kids or just had kids and they were deployed. But, you know, they did it even more when I would say, you know, you need to stop. And then I brought it up to my superiors. I was like this needs to stop. This is just getting ridiculous and then it went on even worse and they did nothing. They did absolutely nothing” (Mattocks et al., 2012, p 540).
Women as Targets - A Man’s World

- Similarly, Glenda tells of her experiences with sexual harassment and rape in the military.

“One of the problems over in Iraq for female soldiers is that there is a lot of sexual harassment and rape is huge. And it does not matter if you’re 18 or 58. It does not matter. Women serving over there don’t have to be worried about enemy fire. They have to be worried about the guy that’s next to them, you know, that’s supposed to be protecting and taking care of them and a lot of times he becomes like public enemy number one for them” (Mattocks et al., 2012, p. 540).
Women as Targets - A Man’s World

• They asked her, "Why would you ruin a man's career just because you can't take it?" She inferred that because she was a woman and not allowed in combat, she was effectively a "second-class citizen": "My career was seen by my peers as being less important." (Sorcher, 2013).

• At Officer Candidates School, one female sergeant instructor stalked through the squad bay and yelled at our sixty-woman platoon, "If you're a woman in the Marine Corps," she hollered, "you're either a bitch, a dyke, or a ho." (Fazio, 2017).
It’s not about Sex, it is about Power

- “I kept my few relationships low-profile. I cut off my vestigial femininity and buried all emotions other than anger. These tactics worked; professionally, I was well respected. But it came at a price.” (Fazio, 2017).

- “I didn’t feel like I could openly be fully human. I was simultaneously ashamed of my plainness yet unwilling to change, lest I be viewed as anything other than highly competent. At the time, I thought less of my fellow female lieutenants who wore sexy Halloween costumes, openly dated other officers, and seemed to effortlessly attract male attention whenever we went out. It was years before I learned the term "slut-shaming;" all I knew was that I was unwilling to risk their level of vulnerability.” (Fazio, 2017).

- “To be perceived as sexually desirable - especially in front of fellow Marines - felt like a sign of weakness. This double bind can especially trap military women, who walk a razor’s edge if they display femininity while working under a microscope of potential male attention.” (Fazio, 2017).
It’s not about Sex, it is about Power

• “I'd also add that much of our military's culture is predicated on gendered shame. Puritanical American attitudes still shame women who exhibit any form of sexual agency - who act on their desires and revel in their bodies, rather than passively and modestly awaiting admiration. For men, it’s the flip side of the same coin. Toxic masculinity encourages sexual aggression to the point of assault. Anything less than total domination, the ethos goes, is shamefully unmanly.” (Fazio, 2017).
Myths about Male Rape & Culture

- Regular use of insult talk (sissies, pussies, etc.) during basic training reinforces the equation with women and sexual minorities with degradation causes victim-blaming and under-reporting in male rape victims (O’’Brien, Keith, & Shoemaker, 2015).

- “In a hyper-masculine culture, what’s the worst thing you can do to another man? Force him into what the culture perceives as a feminine role,” says Asbrand of the Salt Lake City VA. “Completely dominate and rape him.” (Penn, 2014)
Myths about Male Rape

- “Men Don’t Get Raped” or at Least “Real Men/Strong Men Don’t Get Raped”
- “Male on Male Rape is About Homosexuality”
- “Male Rape Is Not Serious”
- “A Man Can’t be Raped by a Woman” or “Female on Male Rape is not Serious”

(O’Brien, Keith, & Shoemaker, 2015)
Males-Reporting Military Sexual Trauma

“Shame is not the only reason men do not report MST - there is fear of physical retaliation, professional ruin, and social stigma. Research shows military leadership illegally discharges MST victims by giving them a personality disorder discharge problem which means this was a preexisting to service and there are no expenses for treating the PTSD as a result of the assault. Between 2001 and 2010, 31,000 service members were discharged for personality disorders” (Penn, 2014).
Males-Reporting Military Sexual Trauma

- “The conviction rate in MST cases that go to trial is 7 percent, and an estimated 81 percent of male MST victims never report being attacked due the perception their attackers will not be punished” (Penn, 2014).

- “Let’s say I’m a company commander and I’ve got this sergeant first class who’s done a great job of getting my company ready for combat. Then this private I don’t know from Adam come in and says, “Sergeant X assaulted me last night.” I don’t believe that private. I don’t want to believe that private. I can’t imagine Sergeant X would do such a thing. Is there a natural bias that would say, “Can I make this go away?” That’s probably a very typical reaction.” (Penn, 2014).
Males-Reporting Military Sexual Trauma

• “I’ve told my psychologist, “Maybe it’s my fault, because I’m gay.” I was looking for friendship, companionship, some kind of emotional connection with somebody. They were predators. They knew what they saw in me that allowed them to be that way.” (Penn, 2014).

• “Afterward they started kicking the shit out of me and said, “If you ever tell anybody, we’ll come back and get you.” But it was like the angels were singing, because I realized I wasn’t going to die. Later I wished I did.” (Penn, 2014).
Males-Reporting Military Sexual Trauma

- “The way we socialize people probably has some effect on the incidents. We cut your hair, we give you the same clothes, and we tell you that you have no more privacy, you have no more individual rights – we’re gonna take you down to your bare essence and then rebuild you in our image.” (Penn, 2014).

- “I still don’t believe I didn’t bring this on. I keep telling myself, If only I hadn’t had a few beer that night. If only I hadn’t invited him back to my room. I tried to resist. He was just so f***ing strong.” (Penn, 2014).
Reporting Procedures in the Military

• “Underreporting incidents of sexual assault in the military minimizes the severity of this problem and its impact on the U.S. veterans, yet institutional rules and regulations may be inadvertent barriers to reporting. The DOD has a two-tiered system of restricted and unrestricted reporting of sexual assault; if the victim wants to get medical assistance and counseling, then she can file a restricted report and remain anonymous, but if she seeks punishment for her attacker, she must file an unrestricted report and cannot be anonymous” (as cited by Williams & Bemstein, 2011, p. 141).
Limitations of the Sexual Assault Prevention & Response Program

- “In addition, there are several limitations in the current DOD Sexual Assault Prevention and Response Program (SAPR; DOD, 2004). Only active duty soldiers are eligible to go to SAPR for help, which means that neither inactive reservists nor veterans are eligible: (a) Soldiers are encouraged to report rapes to chaplains, who are not trained as rape counselors; (b) If a soldier tells a friend about an assault, then that friend is legally obliged to report it to officials; (c) Soldiers must disclose their rank, gender, age, race, service, and the date, time, and/or location of the assault, which in the closed world of a military unit hardly amounts to anonymity; and (d) In practice, because most people in the Army are men, the female soldier will likely find herself reporting her sexual assault to a male superior (Benedict, 2007). Many victims of harassment believed that reporting the incident would result in problems for them: 38% were afraid work would get unpleasant, and 33% thought they would be labeled a troublemaker (Sagawa & Campbell, 1992)” (as cited by Williams & Bernstein, 2011, p. 141).
Suffering in Silence

- “Suris (2008) reports that military unit cohesion promotes the belief that things that happen in the military services remain in the military and consequently create an environment in which victims are strongly encouraged to keep silent about their experiences, have their reports ignored, or are blamed by others for the assault. All of these have been linked to poor outcomes among general population assault survivors. Perpetrators in the military are typically other military personnel, and victims often must continue to live and work with their assailant daily. The continuous association with the perpetrator increases the risk for distress and for subsequent victimization. Consequently, the victims of MST are often left to suffer silently and endure the symptoms of PTSD rather than to seek help (Gruber, 1998)” (as cited by Williams & Bemstein, 2011, p. 141).
Retaliation against Military Sexual Assault Survivors

“In a 2012 study, nearly half (47 percent) of female service members who did not report a sexual assault indicated one reason they did not do so is because they were afraid the perpetrator or his supporters would retaliate against them. The same percentage indicated they did not report because they feared they would be labeled a “troublemaker.” More than a quarter (28 percent) feared they would receive poor performance evaluations, and 23 percent feared they would be punished for other infractions (such as underage drinking) if they reported. The 2014 RAND Military Workplace Study also indicates that concern about retaliation is a significant reason for not reporting an assault, though the figure is lower (15 percent). Unfortunately, these fears are well-grounded as retaliation is pervasive” (as cited in Human Rights Watch, 2015).
Retaliation against Military Sexual Assault Survivors

- “The military conducts workplace and gender relations surveys every two years. The 2014 RAND survey shows that reported rates of retaliation have not changed since the last workplace survey in 2012, despite aggressive efforts by the military to reform its handling of sexual assault cases, including efforts to address retaliation” (as cited in Human Rights Watch, 2015).

- “In the 2014 survey, more than half the victims who made a report (53 percent) indicated experiencing social retaliation; 32 percent reported professional retaliation; 35 percent indicated experiencing administrative action (such as a reprimand); and 11 percent reported being punished for an infraction (such as underage drinking). In a separate 2014 Defense Department Survivor Experience Survey, 40 percent of victims who made an unrestricted report of sexual assault reported experiencing professional retaliation, 59 percent experienced social retaliation, and one-third experienced both” (as cited in Human Rights Watch, 2015).
Retaliation against Military Sexual Assault Survivors

• “Many survivors we interviewed, some of whom did not initially report their assault, said they did not want to report because they had seen what happened to others. As one said, “I know how it works in the military. If you report, you are out [of the military].” One Marine who was ostracized after reporting walked in on her roommate being violently gang-raped. When she asked her roommate if she would report the assault, her roommate said that she would not report because “I don’t want to end up like you.” When a trainee turned her drill sergeant in for sexual misconduct in 2012, she experienced such intense abuse in retaliation that she later discovered his other victims made a pact never to reveal what he had done to them” (as cited in Human Rights Watch, 2015).
Retaliation against Military Sexual Assault Survivors

- An Army survivor who provided a written account to Human Rights Watch, reported a sexual assault by a male soldier from another platoon in 2012 only to find his safety further threatened:

- “Within 6 months I had been physically attacked twice and verbally belittled by no less than six senior NCOs [Non-Commissioned Officers] as well as my entire platoon of peers. It wasn't until I started drinking so heavily and failing at physical fitness that my Chief then finally found me a real counselor almost a year after being there. By then a certain Sergeant in my platoon had told me he would kill me if we ever went to Afghanistan because "friendly fire is a tragic accident that happens." I started carrying a knife for protection from people in my own unit. After I had been there for a year, someone tried to knife me in a bar and kept screaming "DIE FAGGOT, DIE" and that was when I told my Captain that I wanted a discharge before I ended up dead on the evening news which would be bad for him too” (as cited in Human Rights Watch, 2015).
Retaliation against Military Sexual Assault Survivors

- “An Army Specialist said she felt targeted, isolated, and harassed after reporting her assault. Her close friends, people she considered her “brothers and sisters,” were ordered not to talk to her. One friend told her that the platoon sergeant told them not to talk to her, and if they did “they would face charges under the [Uniform Code of Military Justice].” SPC P. said, “Sexual assault is not what messes you up. It is the reprisals, the hazing. I could recover from the assault but nothing is done for the retaliation.” (as cited in Human Rights Watch, 2015).

- “A lance corporal said her friends were told they would get “NJP’d” (non-judicial punishment) if they hung out with her. “I was alone all the way until the end.” She was discharged in June 2012 after being charged with “destruction of government property” for hurting herself after attempting suicide” (as cited in Human Rights Watch, 2015).
Retaliation against Military Sexual Assault Survivors

“One lance corporal who had been trained to fix computers was transferred to the armory unit after reporting a sexual assault in 2014. There she was enclosed in a locked cage with five men for over four months, cleaning and passing out weapons. She had little to do to occupy her time and was stressed being alone in that position. By the time she was reassigned she felt she had “no idea what [she] was doing anymore because [she] had been out of it for too long.” She was also assigned to fix equipment she had not been trained on, negatively impacting her performance. Out of her two-and-a-half years in the Marines, she spent less than six months working in the job she was supposed to do. She was not recommended for promotion” (as cited in Human Rights Watch, 2015).
Retaliation against Military Sexual Assault Survivors

“After reporting a sexual assault in late 2013, Senior Airman R. had her weapon taken from her because she was considered "emotional" because she cried during a meeting discussing her concerns about living directly across from her perpetrator. As a military police officer, she was unable to do her job without a weapon. During the investigation, R. received her "dream deployment" and was scheduled to leave before the case was concluded. However, she was unable to deploy without her arms. Since her commander told her she would get her arms back when the case was over, R. decided to withdraw her participation in the case. However, her squadron commander told her she was "unable to get off the train" so she could not get her arms back and deploy” (as cited in Human Rights Watch, 2015).
Results of Sexual Assault Reporting

FIGURE 1: SEXUAL ASSAULT AND INVESTIGATION IN THE US MILITARY

18,900 Estimated sexual assaults in the US military in FY 2014

5,121 Reported assaults with service member victim

3,520 DOD investigations

2,419 Service member cases reviewed for possible action by commanders

910 Service member perpetrators who had court-martial charges initiated

496 Service member perpetrators court-martialed

359 Service member perpetrators convicted on any charge

175 Service member perpetrators convicted of an offense requiring sex offender registration

Results of Sexual Assault Reporting

FIGURE 2: LIMITED JUSTICE FOR SERVICE MEMBER VICTIMS

- 62% Service member victims who reported sexual assault and faced retaliation in FY 2014
- 15% Service member perpetrators court-martialed
- 11% Service member perpetrators convicted on any charge
- 5% Service member perpetrators convicted of an offense requiring sex offender registration


(Human Rights Watch, 2015)
Results of Sexual Assault Reporting

**Figure 3: Whistleblower Protection for Sexual Assault Victims (2004 - 2013)**

- **5,728**: Estimated number of victims who reported sexual assault and experienced professional retaliation
- **38**: Sexual assault retaliation complaints received by DOD Inspector General
- **5**: Sexual assault retaliation cases investigated by DOD Inspector General


Note: Estimated number of victims who experienced professional retaliation who where eligible for military whistleblower protection is the (total number of reported service member victims (24,467) - restricted reports (6,567)) * the rate of people who experience professional retaliation (.32).

(Human Rights Watch, 2015)
Results of Sexual Assault Reporting

**Figure 4**: Alleged perpetrators outnumber victims in board cases related to sexual assault/harassment

- **829** Alleged perpetrators (78.5%)
- **227** Victims (21.5%)

Source: Database search of Board of Correction of Military Records reading rooms (all branches). (Human Rights Watch, 2015)
Risk Factors for Female Military Sexual Trauma

- Identified risk factors fall into three major categories: age, alcohol abuse, and previous assault history.

- “Corbett (2007, March 18) reported in the New York Times Magazine that young men who join the military are generally less than 25 years of age, are often developmentally still adolescents, and therefore may fit a perpetrator profile of sexual assault, whereas young women who join the military have the profile of being sexually victimized and sometimes do not have personal boundaries in social and interpersonal relationships” (as cited by Williams & Bernstein, 2011, p. 140).
Several studies have found high rates of childhood and adolescent sexual abuse occurring prior to military service. Rates of abuse are generally high but vary across samples and studies with 15.1% of female Air Force recruits (Smikle et al., 1996), 49% of Army women (Rosen & Martin, 1996), 45.5% to 48.5% of female Navy recruits (Merrill et al., 1998; Trent, Stander, Thomsen & Merrill, 2007), and 27% of female veterans reporting a history of childhood sexual abuse (Coyle et al., 1996). Among men, 11% to 22.5% of Navy recruits (Merrill, Thomsen, Gold & Milner, 2001; Trent, Stander, Thomsen & Merrill, 2007), 15% of Army men (Rosen & Martin, 1996), and 1.5% of Air Force recruits reported a history of childhood sexual abuse (Smikle et al., 1996)” (as cited in Turchik et al., 2010, p. 270).
Risk Factors for Female Military Sexual Trauma

- “In three large samples of male Navy recruits, 9.9% to 11.6% across samples reported perpetrating a completed rape of a woman prior to entering the Navy (Merrill et al., 2001), which is much higher than the 4.4% prevalence reported by a large sample of college men (Koss, Gidycz & Wisniewski, 1987). Another study of male Navy recruits found similar rates, with 14.8% admitting to committing attempted or completed rape prior to joining the Navy (Merrill et al., 1998). Childhood abuse has been found to be related not only to sexual victimization, but also to sexual perpetration (Merrill et al., 2001; Weeks & Widom, 1998; White & Smith, 2004). In a military sample, Merrill et al. (2001) found that childhood sexual and physical abuse was related to greater rates of perpetration in three samples of Navy men. Those men who reported either childhood physical or sexual abuse were two times more likely to commit rape than those with no childhood abuse history and those with a history of both physical and sexual abuse were four to six times more likely to commit rape. No known research studies have reported on the prevalence of female perpetration of sexual assault in the military, although a DoD report noted that in sexual assault cases reported between 2002 and 2003, 99% of the alleged perpetrators were men (DoD, 2004a)” (as cited in Turchik et al., 2010, p. 270).
Risk Factors for Military Sexual Trauma

“The use of alcohol as a risk factor associated with sexual aggression and assault is reported both in the military (DOD, 2004) and in the general population (Abbey, Clinton-Sherrod, McAuslan, Zawacki & Buck, 2003). Data provided by the military services indicated that the use of alcohol was associated, on average, with 50% of alleged sexual assault cases involving service member victims during 2002 and 2003 (DOD, 2004)” (as cited by Williams & Bemstein, 2011, p. 140).
Coping Skills in Female Veterans

- VA tests for alcohol using Alcohol Use Disorders Identification Test (AUDIT) and often accompanied by co-occurring mental disorders and/or other health factors.
- Female veterans are less likely to than men to seek substance abuse services.
- In a social-cognitive perspective, alcohol use expectancies interact with coping styles and the amount of emotional distress and facilitates early treatment interventions.

(Creech & Borsari, 2014)
Coping Skills in Female Veterans

- “Alcohol expectancies are defined as an individual's beliefs regarding the effects of drinking and they give insight into the functionality of alcohol use. Expectancies can be either positive (e.g., “drinking allows me to relax around others”) or negative (e.g., “when I drink, I often say things that I regret later”)” (p. 2).

- “According to VA research, MST was associated with binge drinking, in that all women who reported a heavy drinking episode in the last month also reported experiencing MST. With the number reporting MST using alcohol as a result of positive expectancies and avoidant coping strategies” (p. 2).

(Creech & Borsari, 2014)
“Endorphin withdrawal plays a part in the use of alcohol or drugs to control PTSD. When an individual experiences a traumatic event, his or her brain produces endorphins — neurotransmitters that reduce pain and create a sense of well-being — as a way of coping with the stress of the moment. When the event is over, the body experiences an endorphin withdrawal, which has some of the same symptoms as withdrawal from drugs or alcohol:

- Anxiety
- Depression
- Emotional distress
- Physical pain
- Increased cravings for alcohol or drugs

According to Alcohol Research & Health, many of those with PTSD will turn to alcohol as a means of replacing the feelings brought on by the brain’s naturally produced endorphins. But the positive effects of alcohol are only temporary”.

(DualDiagnosis.org, 2017)
Learned Helplessness, PTSD, & Alcohol Consumption

- Both PTSD and learned helplessness develop following exposure to negative stressors or uncontrollable events where the fear of being re-exposed of the traumatic event and/or the reexperiencing of the traumatic event causes the individual to give up and prompts a biochemical response where stress hormones are elevated between episodes of trauma causing an increase of alcohol consumption a day later due to endorphin withdrawal.

(Volpicelli et al., 1999)
Figure 1 Biochemical responses to stress. Exposure to an uncontrollable negative event elicits the familiar “fight-or-flight” response. Fear prompts the release of corticotropin-releasing hormone (CRH). In turn, CRH stimulates the release of proopiomelanocortin (POMC), a hormone that is divided into several components. These components include adrenocorticotropic hormone (ACTH), which increases arousal and produces the fight-or-flight response, and beta-endorphin, which has a numbing effect and thereby reduces both emotional and physical pain. (Volpicelli et al., 1999, p. 259).
Homelessness and the Female Veteran

- “According to the U.S. Government Accounting Office (as cited in Decker et al., 2013, p. 363), the number of homeless female veterans has increased 140 percent in recent years.”
- “Homeless female veterans have a history of sexual assault before and after service to include military sexual trauma in 41 to 53 percent of homeless female veterans” (as cited in Decker et al., 2013).
Homelessness and the Female Veteran

Increasing Numbers of Homeless Women Veterans

Women veterans identified as homeless by Veterans Affairs increased from 1,380 to 3,328.

Homelessness and the Female Veteran

- According to Buchholz et al., (as cited in Decker et al., 2013, p. 374), “Military Sexual Trauma, homelessness, and childhood victimization are associated with difficulties in treatment. Homeless veterans receiving substance use treatment were less likely to show improvement in substance use or psychiatric outcomes than housed veterans, whereas homeless women with childhood abuse histories were less likely to benefit from substance use treatment than those without childhood abuse.”
Homelessness and the Female Veteran

- “Five predominant “roots” (precipitating experiences) initiated pathways toward homelessness: 1) childhood adversity, 2) trauma and/or substance abuse during military service, 3) post-military abuse, adversity, and/or relationship termination, 4) post-military mental health, substance abuse, and/or medical problems, and 5) unemployment. Contextual factors, which promoted development of homelessness in the setting of primary roots, included women veterans’ “survivor instinct,” lack of social support and resources, sense of isolation, pronounced sense of independence, and barriers to care. These contextual factors also reinforced persistence of the roots of post-military adversity and mental health and substance abuse problems, serving to maintain cycles of chronic homelessness” (as cited by Hamilton et al., 2011).
Homelessness and the Female Veteran

“Figure 1. Web of vulnerability illustrating inter-related pathways into homelessness for women veterans. (1) – (5) Roots of homelessness, namely, initiators or precipitating factors for path toward homelessness; (6) Subsidiary factor; Links (arrows), that is, pathways from roots toward homelessness, where weight of arrow conveys strength of link; [Contextual factors] – individual characteristics or structural factors, that when present, promote the pathway. Pronounced sense of independence inhibits care-seeking; access barriers (mental health, social service) lead to unmet need. Note: Not all roots, links/pathways, or contextual factors are present in all individuals, for example, military trauma without an adverse premilitary history could initiate the pathway” (as cited in Hamilton et al., 2015).
In the Orange County Community Court – Veteran’s Treatment Court, in 2015, 85 percent men and 15 percent women veterans were seen for criminal acts.

“My observations are mainly about the women. That is, there is only so much money. And almost all of the people who end up sideways of the law as defendants in the veterans court are men, so that the court is necessarily geared towards the men rather than the women,” Moore said. She believes the women’s needs are not completely different from the men’s, but estimates that in her years supporting vets in the program “between 90 and 95 percent of the women that I’ve mentored have been victims of military sexual trauma.”

(Lantigua-Williams, 2016)
Nicolaas-John Van Nieuwenhuysen, a staff psychiatrist at the Long Beach Department of Veterans Affairs, has been with the Orange County Community Court’s veterans treatment court for two years. “I see a lot of people with alcohol-use disorder, fair amounts using cannabis, stimulants, meth, sometimes cocaine,” he said. Substance-use issues are certainly part of the problem, with some people self medicating their PTSD, not sleeping well, having nightmares, unable to relax or being overly anxious, he explained. “You might resort to drinking to get a better night’s sleep or to take the edge off during the day. They often end up with an alcohol problem, in addition to already having PTSD,” Van Nieuwenhuysen said.

(Lantigua-Williams, 2016)
Criminal Justice Issues

“Some veterans in the United States face severe obstacles while adjusting to civilian life after completing their service. These difficulties land thousands in jail for crimes ranging from public intoxication and simple assault, to domestic violence or drug use. About 8 percent of people in prison and jail are veterans (excluding those in military facilities). Veterans are actually slightly underrepresented in jails and prisons, compared to their percentage of the adult population. Women veterans make up 1.1 percent of all inmates in state and federal prisons, and 3.2 percent of those in local and county jails, according to the Bureau of Justice Statistics. Overall, 48 percent of all those in prison and 55 percent of those in jail “had been told by a mental health professional they had a mental disorder,” according to the BJS.

(Lantigua-Williams, 2016)
Use of Alcohol & Drugs in Coping

Making the Connection, 2012
Barriers & Stigmas to Treatment

- I can handle it on my own. To ask for help implies weakness. I do not have a substance use or mental health problem. Soldiers are supposed to be strong, courageous, and fearless. If anyone knows about this they will not respect me and it will show I have a character problem. I do not want anyone in my chain-of-command to know about this. My career and reputation will be destroyed.

(Menna & The Gift Within, 2017)
Attitudes toward Counseling

- The counselor is an outsider who can effect clearance levels and placement in the military.
- Issues of confidentiality, trust
- Counseling is only for those with mental illness and to imply that means I failed as a soldier.
- The feeling that no one can help them, especially an outsider that does not know them.

(Menna & The Gift Within, 2017)
What Caregivers Can Do

- Offer to be with the person in making appointments, providing transportation, and going with the person to the appointment to relieve sense of aloneness and fear.
- Move past caregiver fear of getting the soldier in trouble by seeking treatment; failure to get treatment puts individual’s life in danger.
- Teach treatment is an asset and not liability, encourage questions, see benefits of help.

(Menna & The Gift Within, 2017)
Overcoming Military Sexual Trauma

Making the Connection, 2011
Assessment for Military Sexual Trauma

- “The Sexual Experience Questionnaire by Louise Fitzgerald is the most widely used measure of sexual harassment. One of the most widely used measures of sexual assault, the Sexual Experiences Survey by Mary Koss and her colleagues, is a self-report measure that assesses a variety of unwanted sexual experiences including those associated with substance use. An example of an interview developed for the purpose of assessing sexual assault is The National Women's Study interview developed by Heidi Resnick and her colleagues. It includes a series of behaviorally specific questions that ask about a variety of unwanted sexual experiences.”

(Street & Stafford, 2017)
“Basically, a trauma-informed system uses the understanding of the vulnerabilities of trauma survivors and avoids inadvertent retraumatization. First, applying the concept of the trauma-informed system to treating women soldiers with PTSD, Jennings (2004) states that a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services needs to be evaluated. This basic understanding starts with a thorough assessment by the service providers entailing a detailed trauma history, including precipitating factors of trauma, psychological coercion or abuse at the time of the events and their impact on the individual's function, fear, and perceived personal safety” (Williams & Bernstein, 2011, p. 143).
**Conceptual Framework to Treatment**

- “Further evaluations, including family/significant other's resistance or openness to discussing violence, other past history of violence, victimization, conflict management, drug or alcohol use, and any mood or substance disorder, would be helpful in developing a comprehensive care plan (Valente & Wight, 2007). Another important component is how to accommodate these trauma survivors by providing the environment where they feel safe during the treatment process” (as cited in Williams & Bernstein, 2011, p. 143).
Conceptual Framework for Treatment

“According to Resick and Schnicke (1992), being able to process trauma in a safe environment is the key to recovery. Those people who cannot make sense of what happened to them are more likely to continue reliving it through flashbacks and intrusive memories. Although treatment usually takes place in an outpatient environment, short-term hospitalization during periods of crisis and longer term inpatient programs for intensive treatment and rehabilitation may be necessary (Friedman et al., 1994)” (as cited in Williams & Bernstein, 2011, p. 143).
Conceptual Framework for Treatment

- “Trauma-specific services are designed to treat the actual sequel of sexual or physical abuse trauma by using grounding techniques to help survivors manage dissociative symptoms, desensitization therapies to render painful images more tolerable, and behavioral therapies for the modulation of powerful emotions. The trauma-specific treatment approach is based on assumptions that effective responses to trauma occur in natural community surroundings where people are comfortable with familiar organizations, feel less stigmatized in asking for help, and are able to exchange their experiences freely” (as cited in Williams & Bernstein, 2011, p. 143).
Conceptual Framework for Treatment

- “This framework is characterized by (a) safety from physical harm and retraumatization; (b) understanding clients and their symptoms in the context of their life experiences and history, cultures, and their society; (c) open and genuine collaboration between provider and consumer at all phases of the service delivery; (d) emphasis on skill building and acquisition rather than on symptom management; (e) understanding symptoms as attempts to cope; (f) view of trauma as a defining and organizing experience that forms the core of an individual's identity rather than as a single discrete event; and (g) focus on what has happened to the person rather than what is wrong with the person” (as cited in Williams & Bernstein, 2011, p. 143).
“In addition, building bridges between behavioral health and spiritual communities can be beneficial to effective trauma treatment (Jennings, 2004). A study of spiritual counseling in treating the veterans with PTSD supported the same and reported that spiritual counseling reduced PTSD symptom severity (Bormann, Thorp, Wetherell, & Golshan, 2008). Ultimately, these individuals who have experienced trauma and who have learned the skills necessary to manage their lives and their emotions can also be tremendous resources to others who are experiencing the consequences of trauma and instill hope in their lives” (as cited in Williams & Bernstein, 2011, p. 143).
Conceptual Framework for Treatment

“Jennings (2004) has suggested that a model of transformation or transcendence may be appropriate than a model of recovery because of the nature of the emotional distress. Jennings explains that people who experience severe trauma do not ever “recover” from it fully, at least in the sense of going back to the pre-trauma state. People and their lives are changed permanently by their experiences, particularly if the trauma is prolonged or repeated. However, people are sometimes able to transcend their experience and become deeper and stronger than they were before the trauma” (as cited in Williams & Bernstein, 2011, p. 144).
Conceptual Framework for Treatment

“Safety and support, developing empowering relationships, and developing the skills necessary to manage physical, psychological, and spiritual needs and to maintain wellness are critical factors to this process. Ultimately, the recovery requires re-conceptualizing the trauma experience and using it as a source of energy for personal and interpersonal social growth and activism” (as cited in Williams & Bernstein, 2011, p. 144).
Conceptual Framework to Treatment

“Well-established, theory-based PTSD treatment strategies are essential elements for a therapeutic alliance and recovery from trauma. Health care providers need to have a knowledge-based treatment approach for helping female veterans who have MST. Furthermore, health care providers need to provide services for anxiety management and reduction; facilitate the reexperiencing of the trauma in a tolerable, safe manner and environment; and help with the integration of the traumatic events (Friedman et al., 1994)” (as cited in Williams & Bernstein, 2011, p. 143).
Strength to Overcome MST through Counseling

Make the Connection, 2012)
Evidenced-Based Treatments

“A variety of PTSD treatment strategies commonly utilized with proven efficacy are the following: psychoeducation, pharmacotherapy, stress inoculation therapy (SIT), prolonged exposure (PE) therapy, and cognitive-behavior therapy (CBT); Valente & Wight, 2007; Bradley, Greene, Russ, Dutra, & Westen, 2005)” (as cited in Williams & Bernstein, 2011, p. 144).
“Psychoeducation can be used to empower victims of MST by explaining the usual responses to trauma and by clarifying depressive and PTSD symptoms, such as hyper-vigilance and intrusive nightmares and memories. This can help dispel fears of going “crazy” and reduce self-blame. The veterans can also identify resources in the community, such as shelters, legal aid, and health care. Patient teaching may also include breathing exercises, progressive relaxation, imagery, and music to reprogram inner calm in the patient. Some relaxation strategies aim to reduce discomfort, provide guidelines to build social support and a safety support network, and adult education classes for developing self-advocacy skills” (as cited in Williams & Bemstein, 2011, p. 144).
Evidence-Based Treatments

“An example of one such program is Taking Charge, which is a 12-week, 3-hour session (36-hour) structured group intervention designed to provide training to women with sexual assault histories, including training on assertiveness, boundary setting, prevention skills, and physical techniques designed to resist assault. Each session is divided into three parts: (a) 1 hour of psychoeducation on facts about sexual assault and role-play practice exercises on assertive communication and boundary setting, (b) 1 hour of physical self-defense training with two self-defense specialists, and (c) 1 hour of group debriefing. A 3-month follow-up of the intervention indicated a significant improvement of women's perception of their ability to discern risky versus safe situations, and improved scores on scales of avoidance, hyperarousal, and depression (David et al., 2006)” (as cited in Williams & Bernstein, 2011, p. 144).
Evidence-Based Treatments

“Psychoactive medications can be used to reduce anxiety and to improve mood and sleep. Medications are most effective when combined with other therapeutic modalities, such as CBT (Valente & Wight, 2007). Selective serotonin reuptake inhibitors are a first-line medication treatment for veterans with MST suffering from PTSD because they have fewer side effects than do tricyclic antidepressants” (as cited in Williams & Bernstein, 2011, p. 144).
Evidence-Based Treatments

• “Reimagining the trauma again and again, or exposure therapy, has long been believed to be the most effective way of overcoming PTSD. The process of PE calls for a client to visit and revisit traumatic memories in a safe environment, such as a therapist's office, to lessen their power so that they become organized rather than fragmented stories. During PE, clients are encouraged to describe their traumatic experience in detail. The oral narrative is repeated several times during each session to reduce fears associated with the memory. Clients are also asked to confront situations outside the session that are not dangerous but became associated with danger at the time of the trauma (Corbett, 2007)” (as cited in Williams & Bernstein, 2011, p. 145).
Evidence-Based Treatments

- “A study of PE therapy in treating female veterans with PTSD reported a significant improvement of symptom severity as the primary outcome (Schnurr et. al., 2007). Another study indicated that PE was superior to no treatment, traditional counseling, and stress inoculation training in reducing PTSD symptoms in a group of rape victims (Foa, Rothbaum, Riggs, & Murdoch, 1991)” (as cited in Williams & Bernstein, 2011, p. 144).
Evidence-Based Treatments

• “SIT is a behavioral treatment consisting of three phases: education, skill building, and application. During the education phase, clients learn how fear develops as a learned response to trauma, learn how to identify cues in the environment that trigger fear, and learn relaxation exercises, such as progressive muscle relaxation. In the skill-building phase, clients learn to control their fear reactions via exercises designed to reduce physiological sensations and fearful thoughts. In the application phase, clients apply the skills they have learned to engage in fearful behavior, control self-criticism, and manage avoidance behavior (Jennings, 2004)” (as cited in Williams & Bernstein, 2011, p. 145).
Evidence-Based Treatments

“A comparison study among three treatments (PE, SIT, and PE-SIT combined) for reducing PTSD in female assault victims compared to a wait-list control group reported that all three active treatments reduced the severity of PTSD and depression. PE was reported to be superior to SIT and PE-SIT (Foa et al., 1999)” (as cited in Williams & Bernstein, 2011, p. 145).
Evidence-Based Treatments

“CBT focuses on the interplay of maladaptive behavioral, emotional, and cognitive responses that characterize and perpetuate mental disorders (Matthews, Raybum, & Otto, 2004). Clients in CBT initially start with a basic education about how self-statements affect emotions and are encouraged to identify “stuck points” (i.e., inadequately processed emotions about the trauma) in their own narrative statements. Specific cognitive strategies are used to challenge maladaptive beliefs about the rape (e.g., self-blame), helping the victim to accommodate her experiences in a healthy manner and to maintain a balanced and realistic perception of the world (Foa, Rothbaum, Riggs, & Murdock, 1991)” (as cited in Williams & Bemstein, 2011, p. 145).
Evidence-Based Treatments

"When treating military veterans, CBT is used to help individuals reframe their thinking by shifting the way a soldier interprets a traumatic event. The goal is to help integrate the traumatic experience into the realistic perception of their present lives by processing emotions and confronting cognitive distortions and maladaptive beliefs concerning it (Resick & Schnicke, 1992; Valente & Wight, 2007)” (as cited in Williams & Bernstein, 2011, p. 145).
Other Evidence-Based Treatments endorsed by the VA

- Acceptance and Commitment Therapy (ACT) – a type of CBT with emphasis on mindfulness and psychological flexibility
- Dialectical Behavior Therapy (DBT) – a type of CBT focusing on skills building, behavioral change, problem solving, and emotional regulation
- Seeking Safety (SS) – a therapy often used in the treatment of PTSD and substance abuse, promotes safety as the overall goal with emphasis on the four content areas of cognitive, behavioral, interpersonal, and case management
- CBT for Depression – focuses on identifying and changing negative and extreme thoughts that contribute to depression, and promotes engagement in personally meaningful activities.
- EMDR – focuses on changing negative cognitions, shifts memories to become less distressful.

(U.S. Department of Veteran Affairs, 2017)
“Cognitive-processing therapy (CPT), a therapeutic programs developed by Resick and Schnicke et al. (1992), combines the exposure therapy and the cognitive restructuring/skill development. Historically, it had been tested in the populations of sexually assaulted females” (Basharpoor et al., 2011, p. 139).

“CPT effectively treats PTSD by having the patient recognize cognitive “stuck points,” which are negative/distorted cognitions related to the patient’s trauma(s). Over the course of CPT treatment, the therapist teaches the patient how to challenge negative cognitions (NCs). The patient learns how irrational interpretations of the traumatic experience maintain PTSD symptoms and negatively affects beliefs about self and the world. Through cognitive restructuring, reductions in PTSD symptoms will occur” (Holliday et al., 2014, p. 1077).
Promising Treatments

“Holographic reprocessing (HR) is a cognitive-experiential psychotherapy based on Epstein's cognitive experiential self-theory of personality (CEST). HR uses the principles of this personality theory to access information about cognitive, emotional and behavioral tendencies that lead to the replication of situations, and replays of different aspects of the previous trauma and it also alters those patterns. HR is an integrative approach to psychotherapy, combining a variety of techniques such as cognitive-behavioral therapy, psychodynamic therapy and experiential therapy. In addition, HR uses the hologram as a model to reconstruct traumatic memories. To date, only one controlled experimental research has studied the effectiveness of the holographic reprocessing therapy” (Basharpoor et al., 2011, p. 139).
Promising Treatments

• “iRest is a guided mindfulness meditation intended to induce deep relaxation; from this place of ease, participants can become aware of self and conduct meaningful self-inquiry to resolve or begin to reduce physical, mental, and emotional symptoms or lack of ease (Integrative Restoration Institute, 2011)” (Pence et al., 2014, p. 53).

• “iRest is an integrative treatment (CAM) utilizing many components of somatic therapy. Several published studies evaluating iRest have yielded promising results, with consistent findings of decreased negative affect and improved well-being and its ability to reduce symptoms associated with sexual trauma, including military sexual trauma (MST), in a sample of women seeking psychotherapy services at a Department of Veterans Affairs (VA) medical center. (Pritchard, Elison-Bowers, & Birdsall, 2010; Birdsall, Pritchard, Elison - Bowers, & Spann, 2011; Eastman-Mueller, Wilson, Jung, Kimura, & Tarrant, 2013; Borchardt, Patterson, & Seng, 2012)” (Pence et al., 2014, p. 53).
Wishing I Had Gone Sooner to Therapy

Making the Connection, 2014)
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