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Military Sexual Trauma: Violence and Sexual Abuse

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Military sexual trauma includes sexual assault and sexual harassment in military settings by intimate partners and active duty personnel. Such violence triggers a syndrome of episodic, clustered, psychological and physiological symptoms that may be fatal. Despite its pervasiveness, many clinicians fail to recognize as many as 95% of cases among veterans and active duty personnel. Many victims receive inadequate medical treatment or education. They face a decreased quality of life, high morbidity and mortality rates, and economic losses. Their children may also be at risk for abuse. In many settings, clinicians may not realize the high prevalence of this military sexual abuse among veterans and active duty personnel. Clinicians should understand the clinical manifestations, to detect abuse early, to treat it appropriately, and to minimize sequelae.

Introduction

Military sexual trauma falls into the category of domestic violence, which includes sexual abuse and constitutes a social and public health emergency. Military sexual trauma represents a violent crime that causes 2.2 million known injuries and a huge cost in hospital days and other expenses and occurs among 16 to 23% of military personnel.¹ Military sexual trauma may include domestic violence, where one intimate partner or spouse exerts power over another as a means of control. It may involve physical violence, coercion, threats, intimidation, isolation, and emotional, sexual, or economic abuse. Perpetrators also manipulate, threaten, or harm both the victims and their children. Related forms are abuse of children and elderly family members. This article focuses on sexual abuse of military personnel or veterans. Gender, age, and sexual orientation do not prevent such violence.²

Historically, World War II veterans were not asked about and did not report sexual abuse and domestic violence. Interest in this issue grew during the Vietnam era. The statistics since 1990 reflect increasing numbers of people who report sexual abuse and domestic violence inflicted by active duty military personnel. Veterans and military personnel rarely report these problems. Instead, they tend to seek treatment for an array of physical problems related to the violence. According to the Department of Defense, 8% of female Persian Gulf War veterans reported being sexually abused during Operation Desert Shield/ Operation Desert Storm. People rarely spontaneously report sexual abuse but tend to seek treatment for an array of physical problems related to the violence. Health care providers need to increase their suspicion and evaluation of sexual abuse.^{3,4}

The following two vignettes illustrate opportunities to detect and to evaluate the risk of violence in various ambulatory care clinics. See if you recognize the indicators of risk and know how to intervene.

Case Examples

Mr. J was a tall, well-built, 45-year-old, single veteran who complained of headaches, visual disturbances, insomnia, panic attacks, and gastrointestinal problems. He had been seen in a Veterans Administration internal medicine clinic for several years, but the clinician had not suspected that military sexual trauma might relate to his physical complaints. However, Mr. J had been sexually assaulted in the military. He was blindfolded, tied up, held at gunpoint, repeatedly sodomized, and forced to have oral sex. After being beaten, he fainted. Which of his symptoms should suggest military sexual trauma?

Ms. V, a 50 year-old professional and veteran, was being treated in the primary care clinic for narcolepsy, hypertension,

worsening headaches, stomach pain, insomnia, and asthma. The clinician did not suspect that these symptoms might relate to violence.

Ms. V sought treatment for her grief, bereavement, and suicide attempt after her lover died a painful death. The basic issue was grief work and monitoring suicide risk. Because of the suicide risk, the handgun that Ms. V kept for protection had to be safely locked and stored or removed. Neither the clinician nor the grief counselor suspected that Ms. V had suffered sexual trauma before military discharge. Her grief, depression, and suicide risk abated, and she began a new relationship. She stopped therapy but continued in the primary care clinic. Approximately 1 year later, she returned for a brief consultation because she thought she felt sad and might again be depressed. However, she had none of the characteristic signs of depression. She recounted being threatened with a gun.

She reported that, at midnight, her new lover held a gun to her head and threatened, "Are you cheating on me? If you are, I'll kill you." Ms. V recounted the events without fear or emotion and detailed her lover's controlling and jealous behavior. Ms. V had approximately a dozen guns and regularly practiced at the shooting range. The counselor strongly advised that the guns be removed from the home. The consultation focused on the risk of violence, safety precautions, and the veteran's disconnection from her feelings and fear. She did not want to return to counseling. Some months later, Ms. V called the counselor to report that she had left this controlling partner. She said she was spending time with a new friend. The clinic staff members and counselor did not conduct an assessment of military sexual abuse or potential future violence. Approximately 1 year later, Ms. V's ex-partner threatened her and shot her with a handgun.

If you were the clinician who saw these veterans, would you have current knowledge about the risk and assessment of military sexual trauma? Would you know the resources for management of related health and psychological problems? What steps would you take to reduce the risk of future violence? This article should help increase your knowledge. This article describes the issues related to military sexual trauma and the related assessment, screening, management, and education for veterans and active duty victims.

Military Sexual Trauma

Depending on the population studied and the questions asked, sexual assault in the military is experienced by 4 to 9% of female service members. Rates in the broader category of domestic violence in the military rose from 18.6 cases per 1,000 in 1990 to an estimated 25.6 cases per 1,000 in 1996.⁴ In the same 6 years, 23.2 of 1,000 spouses of military personnel experienced violent victimization (Table I). Early data suggested that 5% of female respondents and 1% of male respondents were victims of actual or attempted rape.⁵ In more-recent surveys, 8% of Persian Gulf War veterans reported sexual abuse during Operation Desert Shield/Operation Desert Storm. Another 34% of female respondents reported a rape or attempted rape during active duty. Many had been raped more than once; 14% reported being gang raped during active duty. However, three-fourths of the women who were raped did not report the incident to a ranking officer. One-third did not know how to report the event, and one-fifth believed that the rape was to be "expected" in the military. Female Persian Gulf War Veterans were the first to report that rape was not expected in military life.⁶

Media coverage of sexual violence has raised awareness of military sexual trauma by highlighting events such as the Tailhook Association Convention in 1991, where high-level Navy officials and junior officers were drunk and sexually harassed female officers. At that convention, Navy aviators surrounded unsuspecting female guests, including 14 female Navy officers, and passed them down a gauntlet, grabbing at their breasts and buttocks, attempting to strip off their clothes, and jeering and taunting.⁷

Although military domestic violence occurs among both genders, the typical victim is a woman who may be either a veteran or a civilian spouse of an active duty service member and is slightly less than 25 years of age. Approximately 10 of 1,000 men are

the victims of military physical or sexual trauma. The victims of spouse abuse have children (78%), and more than one-half have been married ≈ 2 years.⁸ Most (85%) abuse is physical. In approximately one-third of the cases, mutual combat is involved. Of the substantiated abuse documented in 2001, 57% was mild abuse, 36% was moderate, and 7% was severe.⁹ The rate of domestic violence in the military rose from 18.6 cases per 1,000 in 1990 to 25.6 cases per 1,000 in 1996.¹⁰ Few cases are prosecuted. Most of the intervention programs have targeted sexual abuse by intimate partners, however, and we know less regarding interventions for nonintimate partners.

Rates of marital aggression in the military are 2 to 5 times higher than civilian rates. Surveys show that rates of physical and sexual abuse of military personnel have risen from 18.6 cases per 1,000 in 1990 to 26.5 cases per 1,000 in 1996 and 2001. In addition to physical abuse, approximately 9 to 14% of female military personnel experience sexual abuse, depending on the service branch.

This problem is not confined to women. The Veterans Administration treated >22,486 male and > 19,463 female victims of sexual trauma." Trauma and embarrassment keep individuals from reporting the abuse. Reasons why both men and women avoid reporting sexual abuse include fears no one will believe them, that their careers will be disrupted, that they will be harassed or face retribution from their attackers, or that they will be told to "suck it up." They finally seek help often when they are so desperate that their only other option seems to be suicide.

Related Health and Psychological Problems

Victims whose partners sexually abused them often deny the violence, but they seek health care from urgent care clinics for a host of physical ailments, including gastric distress, headaches, pelvic pain, and other problems (Table II).¹² Anxiety disorders, substance abuse, depression, and posttraumatic stress disorder (PTSD) often develop. Veterans may use alcohol and drugs to numb the pain. Unfortunately, health care providers typically detect few sexually or physically abused individuals.¹³

Assessment

To detect this hidden abuse, clinicians need to routinely ask about sexual trauma and to intensify evaluation when a pattern or profile of symptoms suggests trauma. Routine screening might have detected the military sexual trauma of both individuals in the case examples. Women with sexual trauma use primary care for their frequent medical symptoms.¹³ In general, the clinician explains routine screening and says, "Because sexual trauma is so common, I usually ask about the following items when I see patients." If the person reports sexual trauma, then the clinician wants to demonstrate empathy and say, "I'm sorry this happened to you. Please know you are not alone and it is not your fault. Your experience must have been very frightening, and it would not be uncommon to feel angry, embarrassed, and fearful afterward." The clinician should not doubt the client's report that something terrible happened. Clinicians need to avoid suggesting that the victim might be responsible.

Factors that increase risk for violence include witnessing violence during childhood, being female, and being young. Physical problems such as shortness of breath, headaches, abdominal pain, and injuries that do not match the history suggest a risk of violence.¹⁴ Because clinicians may lack both time and skills to detect violence, screening tools can help identify those at risk.¹⁵ The Woman Abuse Screening Tool has eight items, with a 3-point Likert scale, for a general population in family practice settings.¹⁶ The Abuse Risk Inventory is a 25-item self-report measure to detect frequency of abuse. A score of ≥ 50 suggests an abusive situation and a risk for abuse. The Abuse Risk Inventory has demonstrated reliability ($\bar{r} = 0.91$).¹⁷ Another screening tool is the Harassment in Abusive Relationship, a self-report scale and a danger assessment (e.g., description of the pattern of abuse or violence and the risk of homicide). This tool would have been very useful with Ms. V; it might have identified the risk of future abuse from the ex-partner and suggested some preventive steps.

Assessment begins with observations and an interview about the triggers, the antecedents, the abuse, and the consequences of

the abuse. When the veteran has difficulty describing violent episodes, the clinician should suggest a safe way to document each violent event (e.g., diary/calendar) and describe what happened. Assessment should include the precipitating factors, impact, function (secondary benefits of violence), fear, safety, psychological coercion or abuse, partner's resistance or openness to discussing violence, and evaluation of historical factors such as past violence, victimization, conflict management, drug or alcohol use, and any mood or substance disorder. Understanding the onset and pattern of violence may suggest some preventive approaches.

Assessment of the violence risk includes evaluating safety, escape plans, and resources (finances, social support, job skills, child care, and housing). Some individuals have a bag with keys, medicines, cash, Identification and insurance papers, and shelter locations. In the case examples, Ms. V had skills, a good salary, housing, and social support, but she did not recognize the risk of the threatened abuse and plan to prevent any recurrence. Others need to plan for such escape and may have limited resources. Clinicians should ask whether the person has ever talked about this before and should inquire about support systems, current danger, and any injuries that need treatment. The goal is to establish rapport and triage the physical and emotional trauma. Some programs, such as Womankind, provide an integrated model of 24-hour health care response to domestic violence.¹⁸

Risk Reduction Interventions

Several strategies can help reduce the risk of violence, including a plan for safe escape. To escape safely, the victim and children need a plan, a predetermined meeting place, and a bag with essential items (e.g., identification, medication, clothes, money, and telephone numbers for shelters and contacts). Asking neighbors and family members to call the police if they hear sounds of a violent confrontation is another strategy. One community program provides used cellular telephones programmed to call 911 for help. The individual can also obtain a legal or military protective order to prevent contact with the abuser. This document should be kept handy and attached to shoes or clothing. As evident in the case study, the clinician should recommend removing guns or lethal weapons from the house and safe storage. In both case studies, the guns in the house represented serious risks that needed to be removed from the house. Having a gun in the home environment increases the risk that a child or other family member will be shot sevenfold. An evaluation of the environment can also help the veteran take steps to prevent unauthorized entry into the home. In the case of Ms. V, an evaluation of the home environment would have potentially identified the sources for unauthorized entry that left her home vulnerable. When the ex-lover entered the house through an unsecured open area, she shot Ms. V. Ms. V had surgery to remove the bullet, was placed on artificial ventilation for several days, and subsequently died.

Treatment Strategies

The clinician needs to respect the individual's barriers to leaving a partner. Several factors, such as economics, dependent children, wage-earning capacity, social support, and fear of retaliation, influence whether a dependent person feels able to leave. In many cases, if the female veteran earns the same or more than the partner, leaving the relationship is easier. Approximately 50% of women report that they leave an abusive partner in the first 2 years. However, many others feel too vulnerable to escape until the partner threatens a child or some change in circumstances occurs. In addition, the veteran's risk of serious and often fatal retaliation increases after separation.

In addition to evaluating the previous abuse and current risk, PTSD and physical disorders resulting from violence require treatment, and referrals to resources and programs are often needed (Table III). Other psychiatric problems typically associated with trauma include anxiety, depression, phobias, alcoholism or chemical dependency, eating disorders, increased risk of suicide, self-harm and risk-taking, dissociative disorders, and changes in sexual desire and intimacy.¹⁹

Although many treatment and prevention programs exist, few have adequate evaluations of effectiveness. Programs teach

about the precursors and consequences of family violence, self-defense strategies, assertive reactions, and nonviolent conflict resolution.²⁰ Some programs aim to reduce offenders' anger and couples' violence. One program, Stop Anger and Violence, focuses on military couples with high risk for marital violence. It teaches the consequences and management of physical aggression in relationships. Holtzworth-Munroe et al.²¹ have adapted and expanded the Stop Anger and Violence program to create a hybrid approach. Another program, called Physical Aggression Couples Treatment, targets violent couples²² and aims to prevent anger and future violence and to improve communication. It encourages both individuals to explore their roles in the relationship and violence. Evaluation of Physical Aggression Couples Treatment showed that participants had less aggression, better marital adjustment, and more-positive feelings toward their spouse. Empirical follow-up studies of such programs and outcomes for diverse populations are needed.

Several medications are available for treating the anxiety, depression, or PTSD that may follow military sexual abuse. Selective serotonin reuptake inhibitors are first-line therapy for PTSD and include sertraline, paroxetine, fluoxetine, fluvoxamine, nefazodone, and venlafaxine. Selective serotonin reuptake inhibitors have fewer bothersome side effects than tricyclic antidepressants. Mood stabilizers may help some survivors to deal with emotional instability, whereas anxiolytic drugs (such as diazepam, alprazolam, clonazepam, and lorazepam) can help reduce anxiety.

Diverse therapeutic methods include cognitive behavioral therapy to help the veteran change irrational and negative beliefs and improve coping and mastery and therapies focused on anxiety reduction, anger management, and conflict resolution. For those with PTSD, eye movement desensitization and reprocessing combines several treatment techniques. The strategy teaches the survivor to focus on past and present experiences while simultaneously focusing on an external stimulus.

Education

Education offers information about resources and referrals, such as counseling, self-defense strategies, assertiveness and relaxation training, group support, shelter locations, and anger management classes. For instance, the Miles Foundation has a toll-free advocacy helpline (1-877-570-0688) for victims of interpersonal violence associated with the military. The helpline is staffed by counselors and may also be accessed on the World Wide Web at milesfdn@aol.com or milesfd@yahoo.com. The Domestic Violence Survivor Assessment is useful for counseling abused women.²³ In discussing the option of leaving a violent relationship, the clinician needs to consider the patient's readiness for change.²⁴ The individual who has not contemplated any type of escape plan often needs time to go through the stages of precontemplation and contemplation before considering escape and leaving.

The clinician aims to empower the veteran by explaining the usual responses to trauma and clarifying depressive symptoms and PTSD symptoms, such as excess vigilance and intrusive nightmares and memories. This can help dispel fears of going crazy and reduce self-blame. Although the veteran may feel powerless, he or she can also be resourceful and strengthen coping responses. The veteran can also identify resources in support systems and external supports such as shelters, legal aid, and health care. Patient teaching may also include some relaxation strategies to reduce discomfort, guidelines to build social support and a safety support network (such as having neighbors call the police if they hear loud yelling), and adult education classes for developing self-advocacy skills.

The veteran may also need to learn some facts about obtaining a civilian or military restraining order, navigating the legal or court system, and social welfare. Veterans may need guidance to create an escape plan and a cache of necessary items (e.g., keys, glasses, medications, cash, and shelter or housing options) in case the risk of injury escalates. A restraining order should be attached to clothing or shoes, so that it is available at all times. Copies can be kept at work and in the car, in case the batterer appears at the market or at work. A restraining order does not deter the batterer from pursuit, but it does facilitate law enforcement Intervention.

Reporting

The first legislation about domestic violence related to child abuse. All 50 states have passed some form of a mandatory child abuse and neglect reporting law; however, the specifics may vary by state. Although state regulations regarding adults differ, any health practitioner employed in any health facility is mandated to report providing medical services if he or she knows or reasonably suspects that the patient is suffering from a wound or physical injury that is the result of assaultive or abusive conduct and/or caused by a firearm. The clinician also has obligations to honor the veteran's confidentiality. In the best scenario, the veteran is willing to report the event and gives permission for disclosure. The challenge occurs when the veteran does not want to report the abuse. Health care providers should know about and adhere to local and state laws and regulations governing the reporting of sexual assault and domestic violence. The specific features of these regulations vary among states and regions. For example, the Penal Code of California, section 11160-11163.6, states the following, in part:

11160. (A) Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department, or a clinic or other type of facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a person described as follows, shall immediately make a report in accordance with subdivision (b):

(1) Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.

(2) Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct.²⁵

It is beyond the scope of this article to catalogue all of these various regulations; however, providers can review pertinent penal codes and state legislation to ascertain the provisions that govern their practice. Professional associations are another good resource.

The Joint Commission on Accreditation of Healthcare Organizations,²⁶ in its 2006 Comprehensive Accreditation Manual for Hospitals, under the Additional Standard for Victims of Abuse, Standard PC.3.10, states, "All cases of possible abuse or neglect are reported to appropriate agencies according to hospital policy and law and regulation."

The challenge, however, is to respect patients' autonomy and empower them to decide whether they wish to report this and, at the same time, to inform patients about a professional's obligation to report. When the trauma is recent and the veteran agrees to report it, it is easy to be therapeutic and comply with the law about reporting. The clinician has a more-complex situation and competing obligations to consider when the veteran does not wish to report the trauma.

Assertiveness Training and Conflict Management

Because some victims have difficulty speaking up, have a strong startle reflex, and use compliant, submissive, or passivesubmissive responses, assertiveness training can be useful. If the battering is chronic, however, submission may also be a survival mechanism. Assertiveness training can help veterans control responses to attack, calm situations, reduce aggressive acts, and express personal rights and needs. Assertiveness may also increase the danger of retaliation, and assertiveness must be used cautiously. Adult education classes and books and recordings from a local library can be useful training aids.

Improving coping strategies and conflict resolution can also reduce the risk of violence.¹⁹ When conflict begins, it often leads to angry voices, name calling, and offensive jibes that increase the conflict. Anger management classes can teach ways to

control anger and to deescalate tension. Conflict resolution techniques are a valuable approach to talk through problems and to reduce violence. The clinician recognizes that there is no excuse for domestic violence. Even if the victim engages in provocative behavior, the perpetrators remain responsible for the violence they inflict.

Individuals can also learn and practice approaches to deescalate violence. These may include lowering one's speaking tone and volume, taking a time-out, and listening and respectful communication. In addition, the individual learns to observe and to monitor the partner's arousal, to predict and to reduce violent outbursts, and to leave the environment before violence erupts. Individuals can also learn their personal style and what comments or behaviors (e.g., name calling, sarcastic responses, and gestures) may increase violence. These strategies need to reflect the patient's culture.²⁷

An evaluation of the environment can also lead to improved safety to prevent unauthorized entry into the home. Having a gun in the home has also been linked to increased mortality rates for family members. Regardless of whether the adults have weapons training, having a gun in a violent and hostile home environment increases the chances sevenfold that a child or other family member will be shot.²⁸

Many veterans and clinicians do not know that victims are entitled to submit a claim for a service-connected disability secondary to military-related sexual assault and sexual harassment. Public law 102-585 covers the treatment of sexual assault and sexual harassment in the Veterans Administration system; it contains no gender-specific language and applies to men and women. The veterans benefits counselor and the women veteran coordinator or women veteran program manager at a veteran facility can provide information and assistance in reporting.

Summary

Clinicians can improve the identification of military sexual trauma by using screening tools. Once this problem is identified, it requires reporting and intervention to increase safety, to treat physical and psychological conditions, and to refer veterans for programs to prevent violence. Psychological strategies include evaluating and treating the common emotional disorders that can accompany violence (e.g., mood disorders, substance abuse, PTSD, and dissociative reactions). Counseling can help the veteran build self-esteem and assertive and constructive coping strategies for dealing with conflict. The clinician can recommend that the safety and escape plans be well designed and that a bag contain survival essentials (cash, medicines, prescriptions, identity papers, telephone numbers, and shelters and support services). Nurses in diverse care settings have a critical role to play in treatment and prevention of intimate partner violence.²⁹ Risk of future violence requires evaluation, so that the clinician can help veterans create a plan for safety and prevention. In particular, weapons must safely locked and stored or removed. The clinician has a pivotal role to play in the detection and evaluation of violence and in recommending improved safety and coping strategies.

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