



American Academy of Nursing Policy Brief: Military sexual trauma



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Background

The [Ike Skelton National Defense Authorization Act for Fiscal Year \(FY\) \(2011\)](#) (Public Law 111-383-Jan. 7, 2011; Sec. 1631) mandates the Secretary of Defense to submit an “annual report [to Congress] regarding sexual assaults involving members of the armed forces and improvement to sexual assault prevention and response program.” In compliance, the Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) released several reports. The [Annual Report on Sexual Harassment and Violence at the Military Service Academies \(MSAs\) for Academic Program Year \(APY\) 2016–2017 \(DoD SAPRO, 2018a\)](#) was the first to be released in February 2018. It contained information on sexual assaults involving cadets and/or midshipmen, and importantly, updates to policies, procedures, and processes implemented in response to sexual violence for FYs 2013–2016. Two months later, in April 2018, [DoD SAPRO \(2018b\)](#) released *Reports of Sexual Assault Received at Military Installations and Combat Areas of Interest*, containing FYs 2016–2017 data about the number of nondomestic, abuse-related adult sexual assault allegations reported or managed at military installations throughout the world. In May 2019, DoD SAPRO released the *Department of Defense Annual Report on Sexual Assault in the Military Fiscal Year 2018 (DoD SAPRO, 2019)*. The 2019 report indicates that 6.2% of active duty women experienced a sexual assault in the year prior to being surveyed; up from a rate of 4.3% in 2016 (Executive Summary, SA in the Military, 2019, p. 3). The documents reveal a continued upward trend in the number of sexual assault reports from military members during the 2017 and 2018 report periods. Of the 6,769 reports of sexual assault in FY17, 5,864 involved service member

victims (Executive Summary, SA in the Military, 2018, p. 3). Of those 5,864 service member victims,

“about 10 percent made a report for incidents that occurred to them *before* entering military service. In sum, 5,277 service members made a report of sexual assault... [FY 2017] for an incident that occurred sometime *during* military service...[up] from the 4,794 reports from Service members received last year [FY 2016]” (Executive Summary, SA in the Military, 2018, p. 3).

SAPRO’s FY2017 report ([2018b](#)) reflects an almost 10% increase in sexual assault among active duty service members over the previous year. SAPRO attributed the increase to the number of overall sexual assault reports, and not to an increase in the overall number of sexual assaults in the military. SAPRO attributed the increase in sexual assault reports to the implementation of two sexual assault reporting options—*restricted reporting* and *unrestricted reporting*, implemented as a solution to the negative findings in the FY 2016 report. SAPRO contends that the addition of the restricted reporting option provides an avenue for victims to report their sexual assault anonymously *and* receive confidential support with medical-forensic services, including physical examination, testing, treatment, evidence collection, maintenance, and storage. Department of Defense Directive 6541.01, released in 2005 and rereleased with changes in 2008, provided policy on the two types of sexual assault reporting well before the FY 2016 report (DoD, 2008). Evidence obtained under restricted reporting secures the storage of forensic evidence, obtained during the forensic exam, for 1 year regardless of the pursuit of a forensic investigation. If an alleged victim chooses to change to an unrestricted report during the year of anonymity, a full military investigation is initiated.

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Defining Military Sexual Trauma and Its Prevalence

The term military sexual trauma (MST) refers to experiences of sexual assault and/or sexual harassment during a service member's military career. Definitions of MST vary by federal organization. The US Department of Veterans Affairs (VA) uses Federal law 38 U.S.C. §1720D to define MST. The definition is "psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment, which occurred while the veteran was serving on active duty or active duty for training" ([Counseling and Treatment for Sexual Trauma 38 U.S.C. 1720D, 2006](#), p. 261). The Code further defines sexual harassment as "repeated, unsolicited verbal or physical contact of a sexual nature, which is threatening in character" ([Counseling and Treatment for Sexual Trauma 38 U.S.C. 1720D, 2006](#), p. 262). In contrast, the DoD does not use the term "military sexual trauma," but rather uses the term "sexual assault" as defined by DoD Directive 6495.01. The directive defines sexual assault as "intentional sexual contact, characterized by the use of force, physical threat or abuse of authority or when the victim does not or cannot consent. Sexual assault includes rape, nonconsensual sodomy (oral or anal sex), indecent assault (unwanted, inappropriate sexual contact or fondling), or attempts to commit these acts" ([DoD, 2017](#), p. 20). Federal law 10 U.S.C. §1561 defines sexual harassment conduct as: "unwelcome sexual advances, requests for sexual favors, and deliberate or repeated offensive comments or gestures of a sexual nature, ... so severe or pervasive that a reasonable person would perceive, and the victim does perceive, the work environment as hostile or offensive" ([Complaints of Sexual Harassment: Investigation by Commanding Officers 10 U.S.C. 1561, 2006](#), p. 935).

MST has been present throughout military history, with the first recorded cases occurring during the Vietnam war ([Rossiter, D'Aoust, Shafer, Martin, & Kip, 2017](#)). The 1991 Tailhook scandal at the US Navy Fliers' Convention, the 2003 sexual assault charges at the US Air Force Academy, and the 2017 widespread dissemination of nude photos of servicewomen among US Marines significantly increased national attention to the magnitude of MST and its personal and societal consequences ([Associated Press, 2017](#); [Mullen & O'Connor, 2011](#); [Valente & Wright, 2007](#)).

The awareness of the regularity of MST prevalence continues with annual reports revealing sequential increases. The VA's national screening program in 2018 reported that approximately 1 in 4 women and 1 in 100 men, when screened by their VA provider, revealed that they have experienced MST. Additionally, prevalence studies indicate that MST is widespread ([Filo et al., 2017](#); [Wilson, 2016](#)). A meta-analysis of 69 MST prevalence studies indicated that active duty military personnel (15.7%) and veterans

(3.9% men; 38.4% women) reported MST when the generic MST definition included both harassment *and* sexual assault ([Wilson, 2016](#)). Prevalence data are variable with methodological confounders that include variability in definitions, demographic inconsistencies (including location and Service status), and underreporting by affected individuals, possibly due to fear or stigma ([National Center for PTSD, 2004](#); [Rossiter, D'Aoust, Shafer, Martin, & Kip, 2017](#); [U.S. Department of Veterans Affairs, 2018](#)).

A recent RAND Corporation report sheds insight on unique aspects surrounding MST in the context of risk conditions at military installations. Further work is needed to evaluate how these risks relate to reporting of MST ([Morral et al., 2018](#)). Furthermore, perpetrators of the crime are often other military personnel, living and working in close proximity to the victim, thereby increasing the victim's distress and risk for revictimization ([National Center for PTSD, 2004](#)). Victims are urged not to speak up about their MST to prevent a reduction in the highly valued "unit cohesiveness." Victims who do disclose sexual assault and/or sexual harassment often report fear of retaliation and/or stigma ([SAPRO, 2018b](#)). Frequently, victims do not receive support from their peer service members or superior officers ([SAPRO, 2018b](#)). Another barrier to disclosure and seeking mental health treatment for trauma is the implicit threat that reporting will interfere with the advancement of their military careers ([Kimerling, Gima, Smith, Street, & Frayne, 2007](#); [Rossiter, D'Aoust, Shafer, Martin, & Kip, 2017](#); [U. S. Department of Veterans Affairs, 2018](#)).

Consequences of MST

MST is not a diagnosis. It is an experience of sexual assault and/or sexual harassment during one's military service. However, the experience of MST may cause female and male survivors to have a broad range of symptoms that predictably and negatively influence their quality of life and longevity. MST has an association with reduced heart rate variability and a subsequent potential for cardiovascular disease and post-traumatic stress disorder (PTSD) ([Lee et al., 2013](#)). MST is also associated with an increased risk for other mental health problems, particularly anxiety disorders, that are precipitated from frightening or horrific events ([Kimerling, Gima, Smith, Street, & Frayne, 2007](#); [Kimerling et al., 2010](#); [Sadler, Booth, Mengeling, & Doebbeling, 2003](#); [Skinner et al., 2000](#); [Suris & Lind, 2008](#); [Suris, Lind, Kashner, Borman, 2007](#); [Suris, Holder, Holliday, Morris, 2016](#)).

MST symptoms include, but are not limited to:

- Strong emotions (feeling depressed, angry, or irritable and having intense, sudden emotional responses);
- Emotional numbness (feeling emotionally "flat");
- Sleep problems;

- Difficulties with attention, concentration, and memory;
- Substance use or abuse;
- Difficulty with situations that trigger the experiences of sexual trauma;
- Problems in relationships (feeling disconnected from others, trouble with employers or authority figures, difficulty trusting others); and
- Physical health problems, such as sexual difficulties, chronic pain, weight gain or eating problems, and gastrointestinal problems (U.S. Department of Veterans Affairs, 2016).

Studies on prevalence indicate the significance of the problem. In a national, population-based study of 125,729 Iraq and Afghanistan War veterans who used VA primary care or mental health services between 2001 and 2007, MST was correlated with increased incidence of mental health disorders, including PTSD, other anxiety and mood disorders, depression, and substance abuse disorders (Kimerling et al., 2010). Further, in a study of 185,880 female and 4,139,888 male veterans treated within the Veterans Health Administration in 2003, screening positive for MST demonstrated a relationship between MST and behaviorally linked physical conditions, such as liver disease (alcohol and drug use), chronic pulmonary disease (smoking), AIDS (exposure), and weight-related problems (obesity) (Kimerling et al., 2007).

Females have a constellation of factors that may put them at greater risk for MST. Evidence suggests that females joining the military at a young age (19 years of age or younger), holding an enlisted rank, and those who had been sexually assaulted prior to their military service are at higher risk for MST (Suris & Lind, 2008). Research indicates that sexual assault may lead to PTSD when compared to other traumatic life events and, in female service members, MST is the strongest predictor of PTSD development (as compared to combat in males) (U.S. Department of Veterans Affairs, 2016; Vogt, 2007).

Continued research about MST risk is necessary for many reasons. Understanding interventions that mitigate risk and subsequent MST, or assessments of the occurrence of MST or sequelae, informs practical and structural interventions that improve military readiness. Policies that promote identification of MST and access to effective health care are necessary to support the return-to-readiness of active duty service members who have experienced MST. After military service, there is a VA mandate for health care providers to *explore experiences of MST with every veteran* that has the potential to lead to evidence-based interventions, mitigating the impact of MST sooner and improving long-term health outcomes. Given the VA universal screening program and the growing numbers of women in the military (DoD, 2014), the population of veterans identified as having experienced MST and seeking treatment is expected to increase over time.

Actions Taken to Combat MST

Multiple initiatives were created by military and veteran health care organizations in response to reports that highlighted increasing MST exposure among veteran and active service members. In particular, the association of MST with deployment promulgated development of programs to prevent and mitigate the individual effects of MST. One VA initiative led to the designation of an MST coordinator at every health care facility. The coordinator assists veterans affected by MST to find appropriate services and treatment options. For those disclosing, treatment for MST and MST related services are without financial burden to the service member. Admittedly, the VA was unable to respond to all requests for assistance; consequently, the VA allowed veterans to seek care in the civilian sector (Gellad, 2015). Civilian care providers, unprepared for the uniqueness of veterans' health care issues, can have a powerful impact on a service member reporting MST (Kilpatrick, Best, Smith, Kudler, & Cornelison-Grant, 2011; Koblinsky, Leslie, & Cook, 2014).

Alternatively, negative responses by legal, medical, and other sources may result in increasing mental health difficulties for victims of MST. Further, the reliance on unit cohesiveness, a positive phenomenon in war, is detrimental to a service member's career when there is continuous exposure to the perpetrator. These factors may affect the recovery trajectory for the service member (Street & Stafford, n.d.). Another organization responding to the growing issue of MST is the Service Women's Action Network (SWAN). As emphasized in their summit report (SWAN, 2017), SWAN is changing the perspective with which MST is addressed. By moving attention and discussions beyond reporting procedures and post-MST interventions, SWAN is driving the focus toward prevention and emphasizing policies that prevent retaliation toward MST victims.

Opportunities exist to improve the standard of care related to MST screening among veterans by providers working outside of military installations or veteran's administration hospitals or clinics. While the definition of MST has been standardized among military agencies, this has not been adopted in the civilian sector. To fill the gap, numerous veteran service organizations, such as the Disabled American Veterans and the American Legion, have developed educational materials, programs, and resource lists to assist veterans in finding appropriate treatment for MST and its consequential effects. Understanding the gaps in positive rapid responses to service members who experienced MST, the VA established a Safe HelpLine for both reporting and referral of MST (U.S. Department of Veterans Affairs, 2014). The national screening program established by the VA mandates that VA providers assess service members for MST at each visit. The VA program additionally includes mandatory

training on MST for all VA mental health and primary care providers (VA, 2018).

In contrast, similar training may be absent in the civilian sector. For veterans who cannot or choose not to access VA programs and instead seek care in the civilian sector, the recognition, identification, and treatment of MST and its sequelae are essential (Allard, Nunnink, Gregory, Klest, & Platt, 2011; Savitsky, Illingworth, & DuLaney, 2009).

The Academy's Position

The Academy believes that MST is a continuing and urgent issue of concern among military service members and that reports of violent acts should be able to be made without fear of retribution. The Academy supports a reporting mechanism whereby service members who experience MST can have confidential access to medical-forensic services, including physical examination, testing, treatment, evidence collection, maintenance, and storage regardless of their intention to move their report to an investigation. The Academy also believes that it is essential for all military service members experiencing MST to have full access to resources for immediate, ongoing, and supportive care by skilled and supportive responders using trauma-informed approaches. Further, prevention and intervention for MST requires a multipronged approach and sufficient resources. Last, the Academy supports continued emphasis on research about MST, including long-term sequelae, pre-event risk, and postevent recovery.

The Academy endorses the following recommendations that emphasize care of military service members who have experienced MST, identification of their needs, and provision of resources, a culture of safety, as well as access to qualified health care providers and other sexual assault responders. The recommendations below require policy and resourcing attention at the DoD and VA Secretariat levels as well as cascade throughout military chain of command, health care, legal, and outreach services that need to be better postured to address these recommendations within the military structure and after the service member exits the military. Additional recommendations are aimed toward the civilian health care infrastructure that interacts with service members both during and after their time in the military.

- Promote DoD transparency when reporting the prevalence of MST to the public.
- Support and fund research on prevention, the efficacy of treatment modalities, and long-term consequences of MST.
- Increase availability of forensically trained nurse responders to MST who can offer appropriate treatment and counseling that prevents or mitigates negative physical and mental health outcomes.

- Establish a culture of safety whereby victims can self-identify and report without fear of retribution or regardless of their intent to initiate an investigation.
- Ensure access to adequate resources for victims affected by MST in military and veterans' settings at the point of care when victims report/identify themselves and/or seek treatment.
- Commanding officers, other leaders, and military and civilian health care providers should be socialized to support victims and their individual needs.
- Promote partnerships between civilian health care providers and veterans' agencies to facilitate referral to resources should veterans indicate an interest in treatment for MST or MST-related comorbidities.
- Promote education and engagement with academic institutions and community leaders around MST, assessment, and resources.

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