

MILITARY SEXUAL TRAUMA:

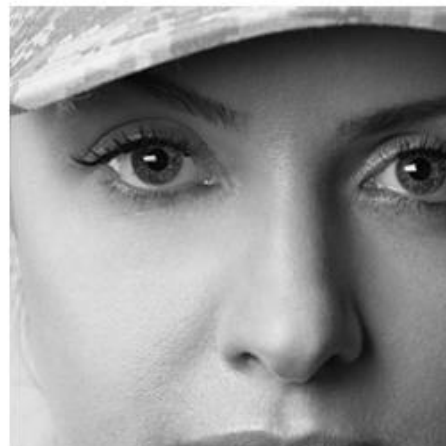
Understanding prevalence,
resources and considerations
to care



INSTITUTE FOR VETERAN POLICY
SWORDS TO PLOWSHARES
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VETS HELPING VETS SINCE 1974



QUICK FACTS

- Only 13 percent of service men and 40 percent of service women who have experienced MST report their military sexual assault.¹
- Trend data show reports of military sexual assault are on the rise, and the estimated gap between reporting and prevalence among service members is at its narrowest since they began tracking sexual assaults in the military. Service members often do not report assaults until they go to providers in the community, long after the assault has occurred and most often after they leave the military.
- The most common effects attributed to military sexual trauma include: emotional extremes and/or emotional disengagement or flatness; difficulties with attention, concentration and memory; re-experiencing and strong emotional reactions to reminders; hyper-vigilance; trouble sleeping; nightmares; dissociation; difficulties with hierarchical environments; drinking and drug use; self-harm; eating disorders; re-victimization; and suicidal thoughts or behavior.
- Sexual assault has a larger impact on PTSD symptomatology than any other trauma, including combat exposure.²
- Sexual assault in the military may be more strongly associated with PTSD and other health consequences than civilian sexual trauma.³
- Among women veterans, under conditions of high combat exposure, women veteran survivors of military sexual trauma had significantly higher post-traumatic stress symptomology compared to women veterans who did not experience military sexual trauma.⁴
- More frequent sexual harassment is associated with post-traumatic stress symptomology as well.⁵
- More severe forms of sexual trauma (e.g., sexual assault but not sexual harassment) are significantly and positively associated with suicidal ideation.⁶
- Veterans cannot receive compensation on the basis of military sexual trauma alone. They must have a compensable health condition, such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, panic attacks, and substance abuse, and prove that disabilities were caused by, or were worsened by, the military sexual trauma the veteran suffered in service. Compensation may not be available if there was a misconduct discharge.

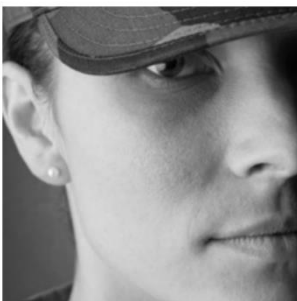


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ilitary sexual assault is a systemic crisis that violates the service and honor of military men and women who survive such a trauma. Unlike other types of service related trauma, military sexual trauma (MST) is an interpersonal trauma, the dynamic of which has many implications for the service member's career, perception of value in service, and moral foundation. Military sexual trauma intersects with all other aspects of service, as well as other traumas of service, and increases the risk for post-traumatic stress disorder and other mental health conditions.

Yet the true prevalence of these sexual crimes is hard to determine because reports of military sexual assault and harassment vary depending on method of assessment, definition of MST used, and type of sample.⁷ Data on military sexual assault and harassment is difficult to unravel because the VA, DoD and other research entities use different definitions and methods in collecting data. We can also assume that MST is underreported and undercounted because service members fear retaliation while in the military, do not seek help, or seek help outside of the military or veteran systems of care.

This issue brief summarizes the various agency definitions, reporting parameters, and access to care; as well as provides policy treatment considerations for care of those who have experienced military sexual trauma.

DEFINING MILITARY SEXUAL TRAUMA

DEPARTMENT OF VETERANS AFFAIRS DEFINITION

Military sexual trauma (MST) by definition is a Department of Veterans Affairs (VA) term, and VA's definition comes from federal law. Military sexual trauma encompasses trauma from both sexual assault and sexual harassment, and its terminology is utilized by the VA to assess healthcare needs and disability claims.

*Department of Veterans Affairs:
Title 38 U.S. Code 1720D*

"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, active duty for training, or inactive duty training."

Sexual assault can include any sort of sexual activity in which someone is involved against his or her will.

- Physically forced into sexual activities.
- Unable to consent to sexual activities (e.g., when intoxicated).
- Pressured into sexual activities (e.g., with threats of consequences or promises of rewards).

COMPLIANCE \neq CONSENT

A common type of assault included in the definition of military sexual trauma is sexual quid pro quo. For instance, in the military compliance with the assault can be a condition of employment, and in this case, a perceived condition to continue to serve their country. An example of this type of trauma can occur during what is called "command rape" when those in a chain of command, who have life and death decisions over a service member, use their position to sexually coerce and harass the survivor.

Very often a service member may confuse, downplay the assault, or take on the guilt that comes from this compliance. It's therefore important as providers and advocates to stress that compliance does not equal consent.

Sexual assaults can include events such as:

- Threatening, offensive remarks about a person's body or sexual activities
- Threatening and unwelcome sexual advances
- Unwanted touching or grabbing
- Oral sex, anal sex, sexual penetration with an object and/or sexual intercourse

MST includes sexual harassment as well as sexual assault. It is important to remember when you are defining the trauma, the VA and the military do it differently. In the military, they don't use the term military sexual trauma, and sexual harassment is handled by a different office than sexual assault.

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

Sexual harassment can involve:

- Threatening, offensive remarks about a person's body or sexual activities.
- Threatening and unwelcome sexual advances.
- Unwanted touching or grabbing.

MST is an experience, not a diagnosis. This is an important consideration. The term describes the trauma from the *act* of sexual violence and harassment. Some veterans are asked, and hopefully not by providers or advocates, whether or not they "have" MST. We need to get out of that mindset and mislabeling. To further complicate the matter, to experience MST means you were either harassed or assaulted, and applying the macro label to describe the experience of both harassment and assault makes differentiating the two difficult, and is as well further mislabeling.

DEPARTMENT OF DEFENSE DEFINITIONS

The Uniform Code of Military Justice (UCMJ) criminalizes rape, sexual assault, and other sexual offenses in Article 120. This is generally similar to sex offenses in the civilian sector.

The Sexual Assault Prevention and Response Office (SAPR) is the entity within the Department of Defense (DoD) that oversees sexual assault policy and addresses the sexual criminal offenses.

Exclusions to SAPR areas of responsibility include:

- Sexual harassment, which is handled by the DoD Office of Diversity Management and Equal Opportunity (ODMEO).
- Military sexual trauma (MST), which is a term that encompasses trauma from both sexual assault and sexual harassment, is terminology used by the Department of Veterans Affairs to assess healthcare needs and disability claims.
- Intimate partner sexual assaults and child sexual assaults are handled by the DoD Family Advocacy Program (FAP).

Uniform Code of Military Justice (UCMJ) Articles 120 and 125, and attempts in Article 80.

Address the criminal offenses of rape, sexual assault, aggravated sexual contact, abusive sexual contact, and non-consensual sodomy.

Department of Defense Directive 1350.2.

Criteria for sexual harassment and gender discrimination complaint processing.

SURVIVOR + PERPETRATOR IDENTITIES FOR REPORTING PURPOSES

The identity of the perpetrator does not matter when defining both military sexual trauma and the DoD's definition of military sexual assault, only the military status of the survivor matters. It also doesn't matter whether the service member was on or off duty at the time, or whether or not they were on base. This can, as you may guess, affect how the identity of the perpetrator is defined, since if they are off duty and off base when then the assault occurs, there may be an increased likelihood of the perpetrator being a civilian.

If these experiences occurred while they are on active duty, active duty for training, or inactive duty training (authorized training performed by a member of a Reserve component), they are considered by the VA to be military sexual trauma.

PERPETRATOR PROFILES

Perpetrators of these sexual crimes are likely to wield control over the survivor, and can continue to control and violate since they are most likely to be a member or a superior in their unit. They may be in the survivor's chain of command and outrank the survivor. "Command rape," whereby a service member is assaulted by someone in their chain of command, is a common form of military sexual assault.

Commanders and fellow service members may blame the survivor or try to excuse or downplay the assault, perhaps trying to convince him or her that what happened was not a big deal and not worth causing upheaval in the unit.

SURVIVOR PROFILES

moral injury (veterans)

the pain that results from damage to a veteran's moral foundation. In contrast to post-traumatic stress disorder, which springs from fear, moral injury is a violation of what veterans consider right or wrong. Transgressions can arise from individual acts of commission or omission, the behavior of others, or by bearing witness to intense human suffering or the grotesque aftermath of battle.

Sexual trauma can transgress deeply held beliefs and social constructs that undergird a service member's military identity. Survivors feel an intense betrayal of loyalty as respect for service and chain of command is violated. This makes the service member question their value in service and also creates huge dilemmas when they simply **must** trust their fellow service member for the sake of unit cohesion and safety, especially if they are deployed in a hostile environment. Because service member culture is akin to family, MST is often said to be similar to familial sexual trauma.⁸

Moral injury among survivors of military sexual assault occurs as a result of the violation of military principles and the retaliation for reporting. Loyalty, duty and deeply held beliefs related to service are dishonored, and further violated when those who are supposed to support the service member instead retaliate. Unquestioning discipline and obedience to lawful orders may make survivors feel undutiful or disloyal when reporting the

assault.⁹ The intense shame, guilt, and disbelief can further isolate the survivor and hinder them from seeking care. This may be further internalized if they experience retaliation or reprisal for reporting the assault.

Service members cannot simply quit their job, file an employment discrimination complaint, or even sue their employers for experiencing an assault or being harassed. Very often the trauma occurs shortly after they join the military when the notions of service and command are not completely understood. They are also most likely to be far from friends and family at the time of the assault. If the perpetrator is in the survivor's chain of command, it may be impossible to report; especially given command has the discretion whether or not to take action against perpetrators of the crime. Most survivors believe with good cause that their case will not be taken seriously, or they fear retaliation and reprisal and are thus reluctant to report.

There is a lack of formal protections for survivors who do report. The peer alienation and bullying that many survivors endure after reporting is almost routine, and collateral consequences related to the assault (i.e. survivors receiving infractions for underage drinking related to the assault) or subsequent infractions may be harnessed by commanders as a way to harass, isolate and extract survivors from their units. Survivors who do file an unrestricted report may request an expedited transfer, which allows them to transfer to another unit or move to another location and away from their perpetrator in their unit. They must however submit the request to their commander, who may disapprove the transfer. This option also further labels the survivor among their unit as a victim. Further, this choice requires the survivor to upend her circumstances, interrupt career, and leave whatever supports exist within the current unit assignment.

Survivors often feel that they need to make an extremely difficult choice of their military career or justice. Their professional identity depends on concealing the assault, or risk losing their career, their military friends, and their military identity. This is a huge problem given research identifying social support as the most consistent and best predictor of recovery after trauma.¹⁰ They may also be concerned about perception of mental health and being fit to serve. As a survivor of military sexual assault mentioned, "military service is not the trigger – sexual trauma is the trigger."¹¹

COMMAND RAPE



Suzanne Swift, a former specialist with the 54th Military Police Co., said three sergeants began propositioning her for sex shortly after she arrived in Iraq in February 2004. When Suzanne complained to an Army equal opportunity officer, her complaints were ignored. For rejecting the advances of two of the noncommissioned officers, Swift said she was publicly humiliated and forced to do extra work.

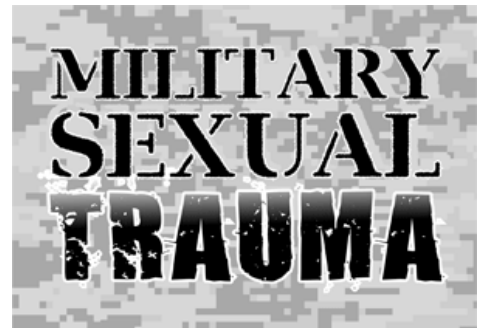
Her squad leader began coercing her into sex by threatening to send her on combat patrol without protective gear. "In a combat situation, your squad leader is deciding whether you live or die. If he wants you to run across a minefield, you run across a minefield," she said. Swift drove a Humvee in Karbala, a city southwest of Baghdad. On combat patrol, she was frequently assigned to visit Iraqi police stations, often the targets of insurgents. Suzanne did not report the command rape until after she came home and went AWOL before her unit was set to redeploy to Iraq. This case illustrates the hard fact of military life, especially during the early years in Iraq: commander coercion, cases that go unreported, lower-ranking service members are especially vulnerable and fear reprisal if they don't comply or report the crimes, and sexual quid pro quo assaults.¹²

MEN VS. WOMEN SURVIVORS

There is a misconception that military sexual assault is a women's issue, as only happening to military women by military men, and it has often been treated as such by the media and military, and even by providers. This does a disservice to veteran men who survive this trauma. Continued mislabeling makes it even more difficult for men to come forward and seek services. Further, the reported incidence among men has at times surpassed that of women:

1 in 20 women experienced at least one sexual assault in 2014, which is approximately 8,600 women, while 1 in 100 men experienced at least one sexual assault in 2014, approximately 11,400 men.¹³

Stigma continues to haunt men who survive military sexual trauma. At most, 13 percent of men report their assaults, whereas at least 40 percent of women report. Fewer men seek services from the VA for MST in spite of their high incidences of sexual assault. Prior to the repeal of Don't Ask, Don't Tell, which disallowed lesbian, gay and bisexual service members from serving openly, men who survived military sexual assault may have been discharged for homosexual conduct if the perpetrator was a man. They may have even been less than honorably discharged, which further stigmatizes them and devalues their service.



REPORTS AND PREVALENCE OF MILITARY SEXUAL ASSAULT



To understand the scope of sexual violence in the military, let's make sense of the statistics. The data on military sexual assault and harassment tell their own story, yet multiple data sources tell a very different narrative. It is also a challenge to look at the numbers without acknowledging the inhumanity of what they describe; that behind each case is a survivor whose loyalty and value in service has essentially been shattered.

MILITARY REPORTING

Military reporting data is handled by the Department of Defense Sexual Assault Prevention and Response Office (SAPR).

In 2014 there were 6,131 reported sexual assaults. 1 in 4 were "restricted reports," whereby the survivor reports the assault for purposes of receiving treatment but does not identify the perpetrator or pursue justice

for the crime. So the perpetrator is never censured, and continues to serve in the military in proximity of the survivor.

An unrestricted report does identify the perpetrator and triggers at least an initial investigation. However, commanders have discretion as to extent of the investigation and whether to pursue prosecution and/or punishment. Commanders considered court-martial or other legal action for only half of the unrestricted reported cases. Of those 2,625 cases:

- 628 were outright dismissed, and 477 were relegated to non-sexual assault-related offenses.
- Of the 1,550 perpetrators charged (38 percent of reported cases), commanders decided not to prefer court-martial charges for 552 (36 percent of those charged, 12 percent of reported cases), instead deciding 318 for non-judicial punishment, 111 for an administrative discharge, or 123 for other "adverse administrative actions."
 - Of the remaining 998 preferred by commanders for court-martial charges:
 - 176 were dismissed by commanders prior to trial,
 - 97 perpetrators were discharged in lieu of a court-martial, and
 - 137 remained pending at the end of fiscal 2014.
 - Of the 588 sexual assault cases that went to trial:
 - 26 percent of alleged perpetrators were acquitted of all charges;
 - 434 were convicted, although 117 received punishments other than jail time, (which most often include punitive discharges, reduction in rank, fines, restrictions or hard labor.)
 - In the end, only 317 convicted service members were incarcerated on a sexual assault charge.

WHO IS UNCOUNTED?

Charges were filed in 38 percent of reported cases in 2014.

1 out of 4 convicted cases ended in acquittal.

Conviction rates decreased from previous years: 19 percent (175) of cases were brought against the accused ended in a conviction.

Military reports exclude numbers of intimate partner sexual assaults, and exclude civilian survivor reports that involve a service member as the alleged offender, which are investigated, but are not officially counted in SAPR reports. They also don't include reports of sexual harassment. *Essentially, their reports don't tell the whole story.*

Senator Kirsten Gillibrand, who has spearheaded legislative efforts to reform the military justice system's response to sexual assault, just released a Snapshot Review of Sexual Assault Report Files¹⁴ at the four largest military bases in 2013. Her conclusions show 32 percent of reports were by civilian women survivors, and 21 percent by civilian military spouse survivors, both uncounted in the SAPR reports.

The SAPR reports include the service member or service members as either the survivor or the alleged suspect, yet while civilian survivors are not included in the report, civilian

perpetrators are. They also strangely count reports of incidences occurring prior to the service member joining the military (135 in 2014). And finally, they carry over subject dispositions and investigations from the previous year that are still ongoing. So when you look at this data, keep in mind the complexities – it is not just service member on service member crime, and it is not the full account of sexual crimes in the military.

PREVALENCE OF MILITARY SEXUAL ASSAULT AND HARASSMENT

In 2014, an independent assessment conducted by RAND National Defense Research Institute of sexual assault, sexual harassment, and gender discrimination in the military found:

*20,000 service members experienced at least one sexual assault which includes either rape, and attempted rape, and non-penetrative crimes during 2014.*¹⁵

*In the civilian world, they say every 2 minutes (107 seconds), another American is sexually assaulted.*¹⁶ *With military sexual assault, 20,000 in 2014 equates to 1 every 30 minutes.*

An estimated 26 percent of active-duty women and 7 percent of active duty men experienced sexual harassment or gender discrimination in the past year.

Their sample of 560,000 U.S. service members includes assaults by other service members, civilians, *spouses* or others. So while SAPR doesn't include intimate partner cases, RAND does.

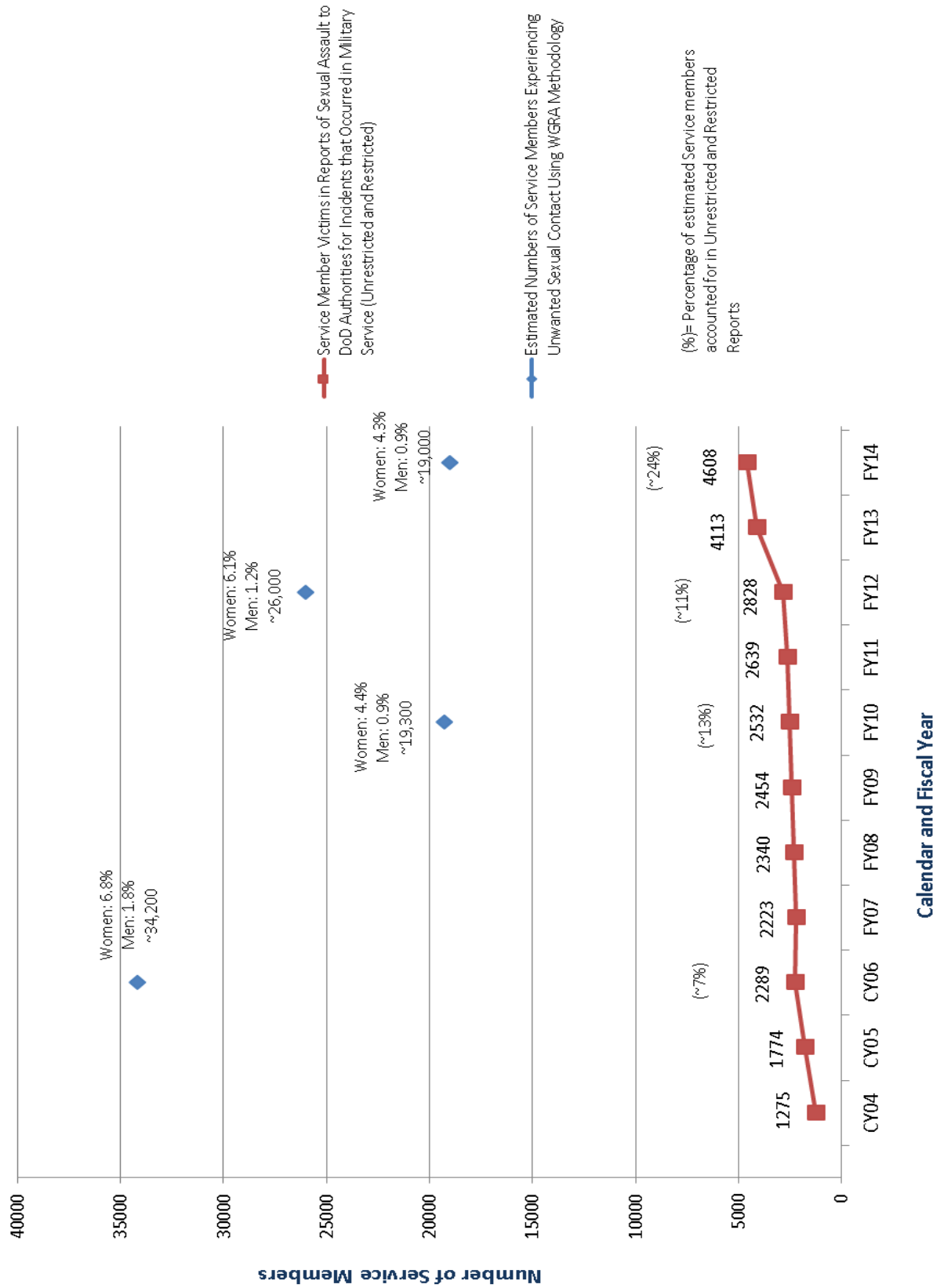
REPORTING VS. PREVALENCE

Trend data show reports are on the rise, and the estimated gap between reporting and prevalence among service members is at its narrowest since they began tracking sexual assaults in the military. But while assaults are estimated to be lower than 2012, they are the same as 2010.



SO HOW MUCH PROGRESS IS THE MILITARY MAKING?

SEXUAL ASSAULT REPORTS VERSUS PREVALENCE



76 percent do not report the assault: 13 percent of men and 40 percent of women.

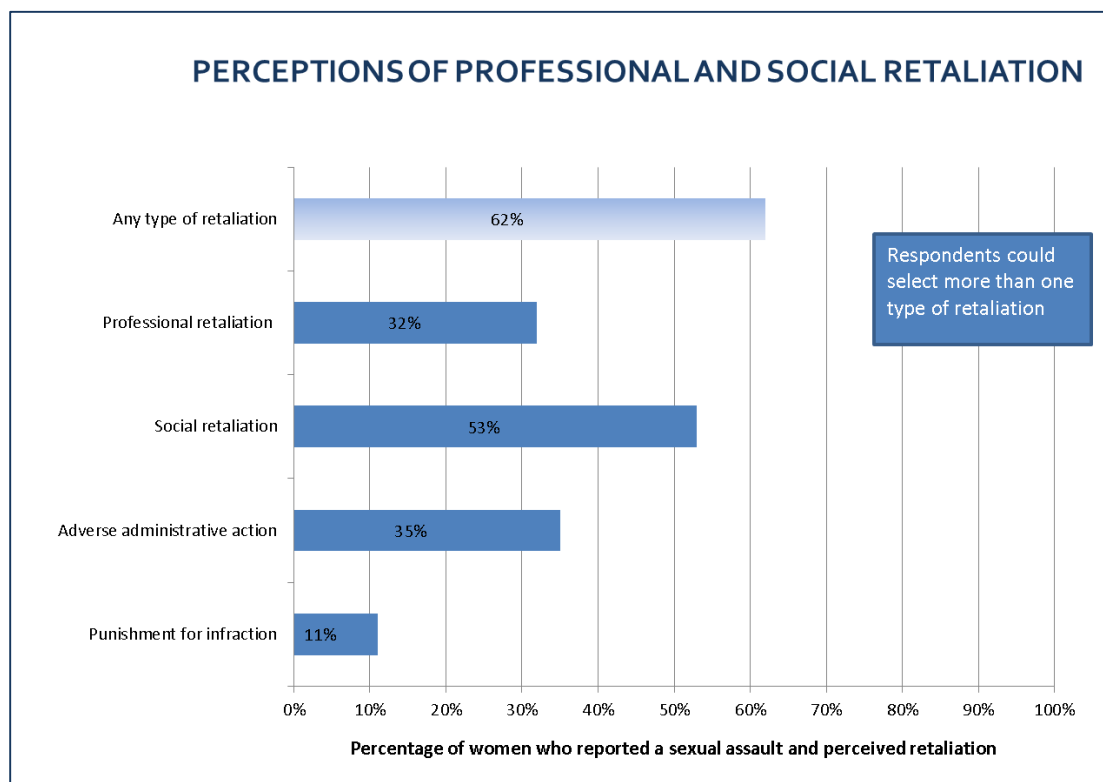
Often, they may not report until they come to providers in the community, long after the assault has occurred and most often after they leave the military.

RETALIATION AGAINST SURVIVORS

A 2014 Human Rights Watch investigation found both men and women military personnel who report sexual assault are 12 times more likely to experience some form of retaliation as to see their attacker convicted of a sex offense.¹⁷ Retaliation against survivors cited in the report included threats, vandalism, harassment, poor work assignments, loss of promotion opportunities, disciplinary action including discharge, and even criminal charges.

In addition, a RAND report on women service members, citing 62 percent were retaliated against after reporting, including 53 percent social retaliation, 32 percent professional retaliation, 35 percent adverse administrative action, and 11 percent punishment for infraction.¹⁸

Worse, retaliation for making a report is going unpunished. This requires more than a reprimand; it calls for a complete cultural overhaul. Military services must create avenues for protecting survivors, showing continued respect for their service and promoting that respect among their fellow service members.



REPORTING ABCS

Survivors of military sexual assault and harassment have two reporting options: restricted and unrestricted.

UNRESTRICTED REPORTING ABCS

- a. Any report made through traditional reporting channels, i.e. victim's chain-of-command, civilian police
- b. Access to medical care, counseling, and Victim Advocate support
- c. Limited confidentiality: details of allegation will be provided only to those who have a legitimate need-to-know
- d. Full investigation enhances opportunity to hold perpetrator accountable
- e. Victim may request expedited transfer, military protection order
- f. Limitations: Cannot change to restricted reporting, may not be enough evidence to convict perpetrator, investigation/court proceedings may be lengthy

RESTRICTED REPORTING ABCS

- a. Enables military members to report sexual assault to specified personnel without triggering investigation (SARC, VA, chaplain, medical).
- b. Confidential protection of information; chain of command is **NOT** notified
- c. Provides access to medical care, counseling, and Victim Advocate support
- d. Intended to give victim additional time and increased control over release and management of personal information
- e. Empowers victim to gain valuable information and support needed to make informed decision about participating in criminal prosecution
- f. Limitations: Does **not** allow for expedited transfers, military protection orders, or ability to hold perpetrator accountable; there are also limitations on holding evidence
- g. If a *sexual assault is reported through chain of command*, restricted reporting is not an option!

SEXUAL ASSAULT RESPONSE COORDINATORS

Sexual Assault Response Coordinators (SARC) are positions created to implement and manage the sexual assault prevention and response program at the installation level. At the military service's discretion, the SARC may be a military member, DoD civilian employee, or DoD contractor.

MAIN DUTIES:

- Prevention/risk reduction education.
- Victim care 24/7 and case management.
- Select, train, and supervise victim advocates.
- Reports to military service-designated senior commander.

SPECIAL VICTIMS COUNSEL PROGRAM

In early 2014 the military established the Special Victims Counsel Program (SVC) to be available where members serve and where incidents are investigated and prosecuted. The SVC qualifying offenses are defined as child abuse (involving sexual abuse and/or grievous bodily harm), domestic violence (involving sexual assault and/or aggravated assault with grievous bodily harm), and adult sexual assault offenses (not involving domestic offenses).¹⁹ Personnel who are part of the SVC include Military Criminal Investigative Organization (MCIO) investigators, judge advocates, Victim Witness Assistance Program (VWAP) personnel, and paralegal support personnel. There hasn't been much data as to the effectiveness of SVC, but providing this counsel is a huge step forward.

WHAT CAN SVC DO FOR SURVIVORS OF SEXUAL ASSAULT?

- SVCs will cover the full scope of their representation the first time they meet with their clients.
- Provide advice to clients and advocate their interests to investigators, trial counsel, defense counsel, and commanders.
- Attend interviews (telephonically and in person) victims have with investigators, trial counsel and defense counsel.
- Explain questions their clients have about the investigatory and military justice processes.
- Help protect survivors' privacy interests.

IMPACT

The impact of military sexual trauma extends far beyond time in service. Veterans who have survived such horrific trauma have emotional wounds that intersect with, and are very often the primary cause of mental health conditions. That said, service members have shown remarkable resiliency after such trauma and its repercussions to their career and livelihood. Many recover and continue their military career.

This interpersonal trauma can also result in future interpersonal difficulties and a possible avoidance of relationships. Survivors may have difficulties with parenting as well.²⁰ They may have trouble seeking and maintaining employment, possibly due to their problems with insomnia, dissociation, difficulties with

hierarchical environments, or self-harm behaviors. The economic effects of difficulties maintaining employment can extend into homelessness as well.

THE MOST COMMON AFTER-EFFECTS ATTRIBUTED TO MILITARY SEXUAL TRAUMA INCLUDE:



- Emotional extremes and/or emotional disengagement or flatness
- Difficulties with attention, concentration and memory
- Re-experiencing and strong emotional reactions to reminders
- Hyper-vigilance
- Trouble sleeping, nightmares
- Dissociation
- Difficulties with hierarchical environments
- Drinking and drug use
- Self-harm
- Eating disorders
- Re-victimization
- Suicidal thoughts or behavior

MENTAL HEALTH DIAGNOSES MOST COMMONLY ASSOCIATED WITH MST (VA USERS):

- PTSD: 55.9 percent of women, 53.3 percent of men
- Depressive disorders: 49.2 percent of women, 37.9 percent of men
- Substance use disorders: 7.0 percent of women, 15.3 percent of men
- Schizophrenia + psychotic disorders: 4.9 percent of women, 11.2 percent of men
- Other anxiety disorders: 14.3 percent of women, 11.2 percent of men
- Bipolar disorders: 12.0 percent of women, 9.8 percent of men

PHYSICAL HEALTH ISSUES ASSOCIATED WITH MST:

- Chronic pulmonary disease
- Issues related to eating disorders
- Liver Disease
- Women: Obesity, weight loss, hypothyroidism

INTERSECTION/CAUSATION WITH PTSD

Research has shown that sexual assault has a larger impact on PTSD symptomatology than any other trauma, including combat exposure.²¹ Research also suggests that sexual assault in the military may be more strongly associated with PTSD and other health consequences than is civilian sexual trauma.²² Among women veterans, under conditions of high combat exposure, survivors of military sexual trauma had significantly higher post-

traumatic stress symptomology compared to women veterans who did not experience military sexual trauma.²³ Women are at higher risk for post-traumatic stress disorder stemming from military sexual trauma than veteran men.²⁴

More frequent sexual harassment is associated with post-traumatic stress symptomology among both men and women,²⁵ however more severe forms of sexual trauma (e.g., sexual assault but not sexual harassment) are significantly and positively associated with suicidal ideation.²⁶

HOMELESSNESS AND MST



A disproportionately high number of homeless veterans have a history of MST—significantly higher than stably housed veterans.²⁷ Women veterans themselves agree that military sexual trauma and homelessness go “hand-in-hand.” There is a web of vulnerability particularly for survivors, and many inter-related factors at play that sexual trauma appears to exacerbate. Fear of reporting, or the after effects of reporting the abuse can lead to social isolation because of heightened stigmatization. Homeless women veterans who reported military sexual assault have greater severity of PTSD and other psychiatric symptoms.²⁸ Coping mechanisms such as drugs and alcohol can lead to further problems. As mentioned, there are economic consequences of surviving trauma, which can lead to poverty and homelessness.

Once homeless, re-traumatization can likely occur. They may also have trouble trusting potential helpers and are less likely to seek services. Current service systems to provide trauma survivors with housing are inadequate. There is a shortage of gender-specific housing, and veterans with families are also challenged to find adequate housing for the entire family. Many military sexual trauma survivors would rather live on the streets than in a housing program with veteran men or women who may be perceived as threatening. Those who had experienced a military sexual assault were more likely to report interest in treatment, and treatment focused on safety was reported as especially attractive.

VA RESPONSE

The VA has implemented system-wide screening of every veteran enrolled at the VA. The VA found 1 in 5 women and 1 in 100 men have experienced MST.

These numbers group together sexual assault and harassment, and like RAND but unlike SAPR, include intimate partner cases. These data only tell a story of those who have been able to seek VA healthcare; they cannot be used to make an estimate of the actual rates of sexual assault and harassment among all veterans.



Military sexual trauma is not only an under-reported crime, but survivors often do not know how to access services that can help them. Survivors, both men and women, are eligible for free MST counseling and treatment both at Vet Centers and VA hospitals, regardless of their length of service and discharge type. The veteran does not need to have reported sexual assault or harassment during their military service.

Veterans can receive healthcare from the VA if they have experienced MST regardless of their discharge, yet they have a difficult time proving service-connection, especially if they

did not report at the time. The process of seeking benefits can be particularly re-traumatizing as they must recall and discuss the events.

Every VA healthcare facility has a designated MST coordinator who serves as a contact person for MST-related issues, as well as a full-time women veteran program manager. This person can help veterans find and access VA services and programs. He or she may also be aware of state and federal benefits and community resources that may be helpful.²⁹

The staff at VA medical centers are most likely trained in MST or issues surrounding sexual assault and harassment in general. However, there is no guarantee that they have received any cultural competency training on military culture. In treating military sexual trauma, at least a basic understanding of military terms and cultures is helpful, not only because sexual trauma is unique in a military setting, but also to establish the veterans' trust and confidence.

The treatment of service members who have experienced MST and have combat or assault related PTSD creates additional barriers to care. As mentioned, it is not uncommon for women who report rape in the military to be met with retaliation. This can be social in that the survivor's allegations disrupted unit cohesion and lead to isolation, or it can result in retaliatory punishment and even discharge for the survivor. In the former case, any reliance on institutional care related to service may be shattered. In the latter, the veteran may lose her eligibility for VA services because of the bad discharge. This is nothing to say of the betrayal, psychological, and emotional trauma related to MST.

In addition to eligibility barriers, there are significant cultural barriers for those seeking care at the VA and through traditional veteran serving organizations. A waiting room or group therapy filled with men can be uninviting at best, and for those who experienced harassment or sexual assault, it may trigger trauma and be unbearable.

SERVICE-CONNECTION

Establishing "service-connection," or the nexus between the injury and military service in order to receive VA benefits, is not automatic, instead the veteran must file a claim with the Veterans Benefits Administration (VBA) which then approves or denies the claim in whole or in part. The VBA, not the Veterans Health Administration (VHA) makes the determination of the existence and degree of injury or illness and the level of care and/or benefits the veteran may receive.

Note: Veterans cannot receive compensation on the basis of military sexual trauma alone. They must have a compensable health condition, such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, panic attacks, and substance abuse, and prove that disabilities were caused by, or were worsened by, the military sexual trauma the veteran suffered in service. Compensation may not be available if there was a misconduct discharge.

It is imperative that you encourage your clients to get assistance in filing these claims which are complex, especially when addressing multiple physical and mental health issues. While this is supposed to be a non-adversarial process, it is incumbent on the veteran to prove that their injury or illness exists. Most counties have a Veteran Service Office (VSO) which assists with claims, there are also non-profit VSOs which provide assistance. In addition, attorneys who are registered with the VA may assist clients on a pro bono basis. Pro bono panels and clinics connected with law schools have sprung up in recent years.

Claim assessment is a two-step process. First, the VBA determines whether the injury exists and whether it occurred or was exacerbated during service. Next, they assign a service-connected rating from 0 to 100 in increments of 10. The rating measures the level of disability compensation and the level of health and supportive services the veteran may access. The scope of health services available may be limited to treatment directly related to the service-connected issue.

Every veteran who applies for service-connection must go through a compensation and pension (C&P) examination with a VA doctor (or one designated by the VA) during the determination process.

Every veteran who applies for service-connection must go through a compensation and pension (C&P) examination with a VA doctor (or one designated by the VA) during the determination process. In cases where the woman is claiming multiple injuries, multiple C&P exams may be necessary. These exams can be extremely stressful, as it is part of the process of ‘proving’ their claim. We encourage you to sit down and prepare clients for this appointment. Encourage clients to arrive for their appointment early so that they have time to gather their thoughts. Veterans should be truthful and not exaggerate or lowball symptoms. Veterans can be particularly loath to express their trauma which runs counter to their identity as warriors and because they do not want to be perceived as ‘complainers’ within the ‘suck it up’ culture of the military.

NOTE: Veterans do not have to file a claim and secure service-connection in order to receive counseling and health services from the VHA for PTSD, physical or mental health injury resulting from military sexual trauma. They do have to file a claim to receive disability compensation for those conditions.

EVIDENTIARY AND DIAGNOSTIC REQUIREMENTS FOR CLAIMS

In July 2010, the VA issued a new regulation that relaxed its evidentiary standards for PTSD claims, making it easier for veterans who were not in official combat roles or who have no evidence of being in combat, to win PTSD claims and receive disability benefits. Under the new rule, the VA does not require corroboration of the stressor if the veteran was deployed to a location where such trauma occurs and the VA doctor confirms that the stressful experience recalled by the veteran adequately supports a diagnosis of PTSD, with symptoms

related to the stressor. A veteran's testimony that s/he experienced a stressor related to fear of hostile military or terrorist activity consistent with the places, types and circumstances of the veteran's service is sufficient evidence, without having the burden of showing verification of their stressor. A VA psychologist or psychiatrist, not a private clinician, must confirm that the stressor is adequate to cause PTSD and that the veteran's symptoms are related to the stressor to win a PTSD claim.

The PTSD reform did not, however, extend to cases in which the traumatic stressor is rape or other military sexual trauma. These instances can also be very difficult to document because of lack of reporting, lack of investigation, lack of prosecution or retaliation against the veteran for reporting while still in the military. Veterans, however, can present evidence related to behavioral changes around the time of the sexual assault such as depression, fear, weight loss or gain, withdrawal, isolation, and other changes. Statements from fellow service members, friends, family and others attesting to such evidence are permissible.

A diagnosis of PTSD in accordance with the DSM-V is required to have been made by a licensed psychiatrist or PhD level psychologist. A multi-axel assessment and Global Assessment of Functioning Scale (GAF) score is required for a thorough evaluation. The lower the GAF score, the higher the level of social and industrial impairment. In addition to testing and assessment, social workers and other behavioral health providers should familiarize themselves with the process in order to assist clients going through this difficult and time-consuming process. You can also submit a report or opinion letter to the VA that describes the level of social and industrial impairment of the patient, keeping in mind the rating formula the VA applies in 38 C.F.R. § 4.130, DC 9411.

COMMUNITY RESPONSE

Community providers such as rape crisis centers, private hospitals and clinics have excellent and diverse care options for trauma survivors. Like the VA hospitals, they too may not be trained in military culture or even in the issues of military sexual trauma. Many community providers are also under the impression that veterans do not need their services because they have the VA. However, not all veterans are eligible for VA medical services and many veterans may prefer to seek



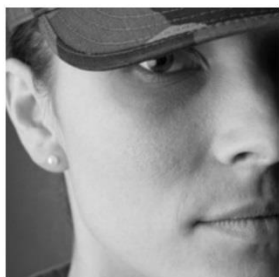
treatment outside of the VA because of the patient populations or the cultural reminders of military service. MST survivors who are in the Guard or Reserve may also fear an impact on their career if they seek VA care. In fact, 76 percent of women and 72 percent of veteran men seek services outside of the VA.³⁰ Further, veterans may have good practical or personal reasons for choosing community based resources, and they should not be discouraged or turned away simply because prior service might make them eligible for VA care.

Community-based veteran service organizations (VSOs) often have excellent advocacy and direct services in place, however as the majority of their historical clientele have been male, they too may not be prepared to adequately provide for our women warriors. They may not be culturally sensitive to sexual trauma and in some cases retain outdated cultural myths regarding gender and sexual assault.

UNIQUE TREATMENT CONSIDERATIONS FOR MST SURVIVORS



Military culture has been recognized as a distinct sub-culture of American civilian society. Thus, in order to effectively reach veterans, practitioners need to explore the culturally-based constructs of the warrior mentality or worldview. Mental health workers need to consider how military cultural values held by veterans interact with perceptions of trauma and affect their help seeking behaviors in general.³¹



It is imperative for behavioral health providers to establish trust with their clients. Veterans who have experienced trauma may have special circumstances that may require unique treatment strategies. Veterans have been trained in the military to be hyper-vigilant, aware of their surroundings and to defend themselves. They may maintain a highly alert and possibly a nervous emotional state, and may find it difficult to feel relaxed and safe with a new provider. Your role is to help them feel safe and be able to turn off that hyper-vigilance they have learned to maintain. In order to achieve this, providers need a working understanding of its source.



It is important as a treatment provider and advocate to distinguish the veteran from the trauma they have experienced. Often to be a “victim” is counter to being a “warrior”. Veterans may struggle with this and it may impact the way they seek and receive treatment. Providers should recognize that bravery and courage to endure such a trauma and serve her country honorably is part of her identity, even if she is unable to confront the memories proudly. Because of this, recalling events may leave them confused about their veteran identity. They may be prideful of their service even if that service placed them in a traumatic situation, but angry that they were perhaps forced out of the military because of sexual trauma and subsequently further victimized.



Also, while the clinical diagnostic code for PTSD is a mental health disorder, it can be contrary to anti-stigmatization efforts and care to call a response to extremely traumatic events a disorder, especially when discussing it with your patient. While we aren’t advocating for a different diagnosis, we do advise you to be aware of the

stigma associated with having a disorder and how that might affect treatment.

Many organizations find it difficult to create a welcoming direct service office environment for women veterans, particularly when they serve men or whole families as well. Veteran serving organizations in particular fear they may re-traumatize a woman veteran who has been sexually assaulted by a male service member when they walk through the office door and are surrounded by men who have served in the military.

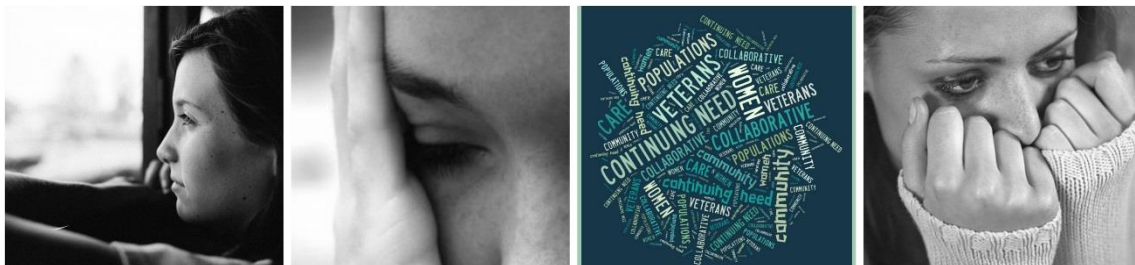
Your office itself may also be uncomfortable for someone who has experienced trauma. If you have personal items that allude to your family life and your client is discussing that they may never trust a partner enough to get married and have a family, this may be a painful reminder. They may feel further disconnected from you because of this and be distrustful.

WAYS TO BECOME CULTURALLY AND TRAUMA INFORMED:

- Isolation, distrust of institutions and high attrition rates make establishing relationships quickly paramount. To overcome these obstacles, ensure that clinical as well as intake and other staff engage in cultural competency training. Ensure knowledge of eligibility criteria and access to referral resources. Whenever possible, provide warm hand-offs to referrals.
- Consider creating a veteran working group or steering committee to empower veteran clients. Ask “alumni” of your program for their feedback, about safety, cultural competency, and treatment considerations. Have a veteran lead the project if possible.
- Identify or seek out veterans within behavioral health organizations to act as coordinators and counselors for veteran clients. Establish a veteran peer group or group therapy cohort. Engage in alternative therapies within your organization or community such as equine therapy.
- Providers are also strongly encouraged to work with staff at a local VA medical center, Vet Center and/or community-based out-patient clinics (CBOCs). While there are still barriers to VA, they have expertise in service-connected injuries and illnesses and can provide comprehensive medical care. Note that Vet Centers are specifically tasked with counseling combat veterans and survivors of MST, regardless of discharge. Securing medical care may present more challenges.

TREATMENT CONSIDERATIONS FOR CLIENTS WHO HAVE EXPERIENCED MILITARY SEXUAL TRAUMA:³²

- It is important to make sure that the veteran seeking care is made to feel safe, and it is important for you as the provider to explore what feeling safe may mean to them. Be sure to discuss confidentiality and resources you can offer, and try to understand their experiences as unique compared to civilian clients.
- Consider the impact that veteran’s trauma history might be having on his/her behavior.
 - Begin by assuming there’s a healthy need being met.
 - Think about the role that feelings of helplessness, vulnerability, or of being unsafe might be playing.
 - Discuss what you can do to restore his/her feeling of being in control.
- Use your relationship as a tool.
 - Model power-sharing and positive regard in relationships.
 - Provide predictable, consistent, and respectful interactions.



CONCLUSION

One thing is for certain: while the data tell us very different stories, understanding the prevalence of military sexual assault is crucial in order to respond to the systemic crisis and provide much needed support. Survivors of military sexual trauma must navigate cultural and bureaucratic obstacles to care and have unique treatment needs which require a coordinated, trauma and culture informed approach to care. Finally because the majority of veterans seek care outside the VA, civilian providers must be prepared to support veteran survivors.



RESOURCES

CALIFORNIA MILITARY DEPARTMENT

SEXUAL ASSAULT PREVENTION AND RESPONSE PROGRAM

Provides support to members of the California Army and Air National Guard who have experienced sexual assault.

www.calguard.ca.gov/J1/Pages/Sexual-Assault-Prevention-and-Response.aspx

CALIFORNIA VICTIMS COMPENSATION PROGRAM

- **SURVIVORS OF MILITARY SEXUAL ASSAULT** may be considered for eligibility for compensation with the Victim's Compensation Program, regardless of whether or not they reported the assault.
- **SOME EXPENSES** that may be covered include mental health treatment.
- **BOTH VICTIM AND PERPETRATOR** had to be serving in the military when the crime occurred.
- **SOME DOCUMENTATION** to establish military service is required.
- **EFFECTIVE** January 1, 2015.

VETERANS HEALTH ADMINISTRATION

MST SUPPORT - All treatment for physical and mental health conditions related to MST are:

- Free of charge.
- Unlimited in duration.
- Do not require VA Healthcare eligibility or a disability rating.
- Do not require documentation of MST experience.

MST COORDINATOR

- Located at every VA Healthcare System.
- Contact person for any MST-related issues.
- Assists survivors with accessing relevant VA services and programs.

VETERANS BENEFIT ADMINISTRATION

WOMEN VETERAN COORDINATORS AT EACH VA REGIONAL OFFICE

- Function as the primary contact for women Veterans.
- WVCs provide specific information and comprehensive assistance to women veterans, their dependents, and beneficiaries concerning VA benefits and related non-VA benefits.
- Assist with intake, development, and processing of military sexual and personal trauma claims.
- Train Veteran Service Representatives on military sexual trauma claims.

VET CENTERS

Vet Centers offer a wide range of psycho-social services to eligible veterans and their families. Veterans and families are eligible for services at Vet Centers if the veteran served in any combat zone and received a military campaign ribbon (Vietnam, Southwest Asia, OEF, OIF, OND, etc.), or is a survivor of military sexual trauma. They do not need to be enrolled at the VA, and do not need to have an honorable discharge.

SERVICES INCLUDE:

- Individual and group counseling for veterans and their families.
- Family members of combat veterans are eligible for counseling services for military-related issues.
- Bereavement counseling for families who experience an active duty death.
- Military sexual trauma counseling and referral.
- Outreach and education, community events, etc.
- Substance abuse assessment and referral.
- Employment assessment and referral.
- VBA benefits explanation and referral.
- Screening and referral for medical issues including TBI, depression, etc.

Vet Centers are limited and not always located close to the veteran. To locate a Vet Center call during normal business hours at (800) 905-4675 (Eastern) and (866) 496-8838 (Pacific).

HOTLINES

VETERAN CRISIS LINE 800-273-8255 or 800-273-TALK

DOD Safe Helpline: 877-995-5247 or [safehelpline.org](https://www.safehelpline.org)

WORK & FAMILY HOTLINE (800) 880-8047



RESOURCES IN COMMUNITY

BATTERED WOMEN'S JUSTICE PROJECT *(Military and Veteran Program)*

www.bwjp.org

COMMUNITY SERVICE PROGRAMS, INC. PROJECT HER

www.cspinc.org/ProjectHER

LEGAL AID SOCIETY-EMPLOYMENT LAW CENTER

www.las-elc.org, www.las-elc.org/veterans-and-military-families-employment-project

PROTECT OUR DEFENDERS

www.protectourdefenders.com

RAPE, ABUSE, AND INCEST NATIONAL NETWORK (RAINN)

www.rainn.org

SERVICE WOMEN'S ACTION NETWORK (SWAN)

www.servicewomen.org

VERITY

www.verity.org



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MILITARY SEXUAL TRAUMA:

Understanding prevalence, resources and considerations to care



SWORDS TO PLOWSHARES

Institute for Veteran Policy
1060 Howard Street
San Francisco, CA 94103

Megan Zottarelli, Author
Amy Fairweather, Esq., Director

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