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The Phenomenology of Military Sexual Trauma Among Women Veterans

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Abstract

Although researchers have examined health outcomes among survivors of military sexual trauma, knowledge regarding the phenomenology of military sexual trauma among women veterans remains limited. We used a qualitative, phenomenological approach to describe the experience, context, and perceived effects of military sexual trauma among women veterans. Thirty-two cisgender female military sexual trauma survivors participated in interviews, which we analyzed through thematic analysis. The following themes emerged: (1) sexual harassment: "expected," "constant," and "normal"; (2) silencing and disempowerment: "If you want a career, then shut up"; (3) changed attitudes toward the military: "I lost faith"; (4) loss of relational trust: "I can protect me if I'm not involved with someone"; (5) survivor internalization of messages conveyed by military sexual trauma: "If I looked different, none of this would have happened"; (6) coping by escape and avoidance: "I put my head in the sand and hoped it would go away"; and (7) a path to healing through validation and justice: "You'll get through it." Results suggest the importance of increasing stakeholders' knowledge regarding military sexual trauma complexities and contexts. Military sexual trauma survivors should be heard, believed, and supported in pursuing justice. We also suggest cultural shifts and continued efforts to prevent military sexual trauma. *Online slides for instructors who want to use this article for teaching are available on* PWQ's *website at http://journals.sagepub.com/page/pwq/suppl/index*

Keywords

military sexual trauma, women's health, phenomenology, qualitative

Military, political, judicial, and healthcare stakeholders have expressed considerable concern regarding the prevalence and response to sexual violence among service members. Ongoing and extensive initiatives by the Department of Defense (DOD), coupled with a recent investigation of sexual assault (SA) report files at several military bases (Gillibrand, 2017), reflect increasing awareness and efforts to help military sexual trauma (MST) survivors have a voice and be heard when reporting this crime. These initiatives are important in order to facilitate survivor safety and justice. Reports have also highlighted the continued pervasiveness of sexual violence despite policy changes aimed at improving the justice response (Schenck, 2013). This increased focus on sexual violence within the military has been paired with ongoing research and initiatives within the Veterans Health Administration to address the health sequelae of MST. Federal law (38 U.S. Code §1720D) defines MST as "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 harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character" (U.S. Government, 2014).

In the Department of Veterans Affairs (VA), federally mandated MST screening among veterans receiving healthcare services has revealed that approximately one in four female veterans (26.9%) screens positive for MST (compared to 1 in 100 [1.4%] male veterans; Department of Veterans Affairs, 2017). Yet a recent meta-analysis of 69 studies reported higher rates of MST among service members and veterans: 38.4% of women (compared to 3.9% of men) reported experiencing MST. Rates of sexual harassment (SH) and SA of women were 52.5% and 23.6%, respectively (Wilson, 2016). In addition, Morral, Gore, and Schell (2015) estimated that 4.87% of active women service members (7.29% of those in ranks E1-E4) experienced military SA

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over the past year. Also notable, among women who made official reports of SA, 52% experienced some form of retaliation following reporting (i.e., either social or occupational; Morral, Gore, & Schell, 2015). Retaliation following reporting, among other outcomes following sexual trauma, may explain recent theorizing about the construct of institutional betrayal (Smith & Freyd, 2013), in which survivors not only survive sexual trauma itself but also contend with betrayal by the institution expected to help keep them safe.

While political and judicial discourses have focused on contextual and institutional considerations regarding MST, health research has typically focused on understanding the implications of MST for survivors' health. Researchers have found that women who experience MST are at increased risk of a variety of mental health concerns including posttraumatic stress disorder (PTSD), depressive disorders, eating disorders, anxiety disorders, alcohol-related disorders, dissociative disorders, bipolar disorders, and psychotic disorders (Blais et al., 2017; Kimerling, Gima, Smith, Street, & Frayne, 2007; Maguen, Ren, Bosch, Marmar, & Seal, 2012; Surís, Lind, Kashner, & Borman, 2007). Women with a history of MST are also at elevated risk of experiencing various physical health difficulties including liver disease, chronic pulmonary disease, obesity, weight loss, and hypothyroidism (Kimerling et al., 2007), as well as gynecological, urological, neurological/rheumatologic, and gastrointestinal difficulties (Frayne et al., 1999; Turchik et al., 2012). Women who experience SA during their military service are also at particularly increased risk of developing PTSD compared to women who experience SA as civilians (Creech & Orchowski, 2016; Himmelfarb, Yaeger, & Mintz, 2006).

These studies have been critical to understanding the extensive health-related sequelae of MST, yet knowledge regarding women's actual experiences of MST, the contexts in which MST occurs, and women's own perspectives regarding the effects of MST is relatively sparse. Obtaining an understanding from women MST survivors themselves regarding their experiences and perspectives on MST is essential to deepening knowledge to prevent MST and support MST survivors. Furthermore, listening to and understanding women's perspectives align with Fisher (2010) and other feminist theorists' propositions that research must examine women's experiences from the voices of women themselves: "... listen to that voice again, by turning it, echoing it, upon itself, as it were; in undertaking an examination of voice from the feminist and feminine perspectives, with a view to elaborating a feminist phenomenology of voice and vocality" (Fisher, 2010, p. 86). Our approach is also in line with a phenomenological approach to psychological research initially proposed by philosopher and social scientist, Edmund Husserl (1913/1962). Phenomenological analysis allows for a bottom-up and data-driven description of an experience by those who experience it (i.e., What is the experience of MST? What are survivors' perceptions of the effects of MST? In what contexts does it occur?). A phenomenological approach also limits the influence of assumptions on results (Lester, 1999). Furthermore, phenomenological analysis can include interpretation, particularly when paired with a thematic analytic approach (Braun & Clarke, 2006).

There is a small body of literature that has begun to explore MST in this more nuanced way that feminist and phenomenological scholars suggest; however, further work is needed. In one foundational study, the authors analyzed interviews with 22 servicewomen who deployed from 2002 to 2011, 7 of whom reported experiencing SA or rape while deployed and the other 15 described their perceptions of servicewomen they knew who had experienced sexual trauma during deployment (Burns, Grindlay, Holt, Manski, & Grossman, 2014). Servicewomen considered MST to be caused by several factors including military culture (men outranking women, sexism), lack of consequences for perpetration, a tendency to blame women for MST, and the fact that deployments are long and highly stressful. Barriers preventing women from reporting abuse included expectations of disbelief following reporting, blame, lack of confidentiality, and the need to maintain unit cohesion. While Burns and colleagues' study yielded important findings, only a subset of participants experienced MST themselves, necessitating understanding of MST survivors' own experiences and perspectives.

Turchik, Bucossi, and Kimerling (2014), on the other hand, focused on gaining an understanding from survivors themselves about barriers to accessing VA MST-related care. They interviewed nine women veterans who experienced MST and found that impediments to accessing VA MST-related care included stigma, avoidance, lack of knowledge, and gender-related barriers. Dichter, Wagner, and True (2016) also used a qualitative approach to better understand the experiences of veteran women who survived intimate partner violence or non-partner SA during military service. Themes included difficulties leaving or staying in the military following intimate partner violence or SA, the military hierarchical structure and leadership asking extensive questions about the intimate partner violence or SA, and "lack of accountability" (p. 12) for perpetrators. This study was important in elucidating broader contextual factors in women's experiences of violence; however, it is relevant to note that intimate partner violence can also include physical violence, psychological aggression, and stalking (Breiding, Basile, Smith, Black, & Mahendra, 2015); thus, only some instances of intimate partner violence (i.e., those entailing sexual violence during military service or training) constitute MST.

While qualitative research conducted exclusively with women MST survivors has been sparse, results from other qualitative studies underscore the need for additional research focused specifically on women veterans' MST experiences. For example, Mattocks and colleagues (2012) interviewed Operation Enduring Freedom and Operation Iraqi Freedom

women veterans about their deployment experiences and ways of coping with post-deployment stress. Participants identified sexual trauma as a major stressful experience. Burkhart and Hogan (2015) examined the transition experiences of women entering, being in, and leaving military service and obtained findings relevant to understanding the context of MST among women veterans who served during or following the Gulf War. Although MST was not an explicit focus, some women described how being a woman in the military entailed chronic stress of SH and abuse. SA was also noted as pervasive, with the consequences of reporting perceived to be worse than the SA itself. Moreover, women described feeling betrayed after being sexually assaulted because the offenders often had been previously trusted (e.g., a superior officer or friend).

These studies provide important contextual information regarding specific aspects of women MST survivors' experiences that warrant further understanding. At the same time, it is important to recognize that only one of these studies (Turchik, Bucossi, & Kimerling, 2014) exclusively interviewed women veterans who had experienced MST, and it aimed to understand a particular facet of MST survivors' experiences (i.e., barriers to using MST-related care). In addition, many of the previously described studies focused on specific cohorts of women (e.g., those who deployed post–9/11) and on specific types of MST (e.g., SA or intimate partner violence during military service). Consequently, a thorough understanding of women veterans' experiences of MST—as it is defined within the VA (to include SH and/or SA that occurred at any point during military service rather than only while deployed)—remains limited. To our knowledge, the study by Burns and colleagues (2014) is the only study that has broadly examined women veterans' "experiences with and perceptions of" MST (p. 345), yet it focused specifically on SA or rape while deployed. On the other hand, the other qualitative studies mentioned above had more specific foci and accordingly were not aimed at fully describing the experiences of MST among women veterans more broadly.

In the current study, we aimed to build upon the existing literature by describing the phenomenology (i.e., experience, context, and perceived effects) of MST among women veterans. We used thematic analysis for additional interpretation and presentation of complex findings (Boyatzis, 1998, p. x).

Method

Participants

The principal inclusion criteria for participation was a self-reported history of MST, as it is defined within VA (U.S. Government, 2014). Research staff assessed this by asking the standard VAMST screening questions: "While you were in the military . . . (1) did you receive any uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or inappropriate verbal remarks? (2) did anyone ever use force or the threat of force to have sexual contact with you against your will?" Veterans with affirmative responses to either or both questions were considered to have a history of MST, which was confirmed with further elaboration during the study visit (upon interview with a licensed clinician). To be included, individuals also had to be 18–65 years old and eligible to receive care in the local VA healthcare system, which was in the Mountain West. Individuals were ineligible if unable to respond to questions regarding informed consent, currently experiencing highly severe psychiatric symptoms (e.g., active psychosis, mania, or acute suicidal intent) or significant cognitive impairment that would preclude participation, or if a licensed clinician on the research team otherwise determined that participating would be harmful to the individual. We enrolled all genders in this study (see Monteith, Gerber, Brownstone, Soberay, & Bahraini, 2018 for phenomenological findings with the cisgender male sample) but analyzed cisgender male and cisgender female samples separately. In this article, we focus exclusively on the cisgender female sample. The local institutional review board approved this study.

We used gender-specific and gender-neutral flyers to advertise the study. We recruited participants from the local VA Medical Center, VA community-based outpatient clinics, and the surrounding community. Participants were recruited to take part in a study about "MST," "unwanted sexual experiences during military service," or SH or SA "while in the military." We also mailed letters describing the study to veterans who had expressed interest in learning about new research opportunities.

Veterans who expressed interest in participating were screened for eligibility by answering screening questions in person or by telephone about their history of MST and to assess the other eligibility criteria described above. Although we briefly reviewed participants' VA medical records to confirm study eligibility (e.g., age, eligibility to receive VA care), we relied upon participants' self-report of MST history during the phone screen and did not require MST to be documented in participants' VA medical records. We screened 61 women veterans, 32 of whom were eligible, showed up for the study visit, and consented to participate. The primary reason for women's ineligibility was screening negative for MST. Table 1 includes sample characteristics.

Procedures

Thirty-two women veterans with a self-reported history of MST participated in an in-person visit at a VA medical center or VA community-based outpatient center for informed consent, a qualitative interview, and additional measures (not described here).[1] Given the focus of the parent study on suicidality and the potential for distress when discussing trauma, we concluded the visit with a safety assessment and

Table 1. Participant Characteristics.

Characteristics	Frequency/Median	Percentage/Range
Age[a]	42.72	13.75
Race		
Caucasian	19	59.4%
African American	6	18.8%
Native American	2	6.3%
Multi-racial	5	15.6%
Ethnicity		
Hispanic	4	12.5%
Non-Hispanic	28	87.5%
Marital status		
Married	13	40.6%
Single	8	25.0%
Co-habitating	1	3.1%
Widowed	1	3.1%
Divorced/separated	9	28.1%
Sexual orientation		
Gay/lesbian/queer	3	9.4%
Heterosexual	28	87.5%
Other	1	3.1%
Employment		
Employed	7	21.9%
Unemployed	15	46.9%
Retired	4	12.5%
Disabled	6	18.8%
Currently homeless		
Yes	1	3.1%
No	31	96.9%
Lifetime homelessness		
Yes	9	28.1%
No	23	71.9%
Branch[b]		
Army	26	81.3%
Air force	3	9.4%
Navy	4	12.5%
Marines	2	6.3%
Service era[b]		
OEF/OIF/OND	17	53.1%
Desert Storm	6	18.8%
Post-Vietnam	14	43.8%
Vietnam	4	12.5%
Classification		
Enlisted	31	96.9%
Officer	1	3.1%
Deployed		
Yes	17	53.1%
No	15	46.9%
Combat		
Yes	13	40.6%
No	19	59.4%
Years of service	5.92	<1 to 30
Years since discharge	7.58	<1 to >35

Note. $N = 32$. OEF/OIF/OND = Operations Enduring Freedom, Iraqi Freedom, or New Dawn.
[a]Mean and standard deviation reported. [b]Not mutually exclusive.

debriefing. All participants received US$50 compensation and information regarding MST-related care at the end of the study visit.

The research team developed an interview guide for this study based on their clinical and research experience working with MST survivors (available upon request and described in Monteith, Brownstone, Gerber, Soberay, & Bahraini, 2018). We incorporated feedback from other researchers with knowledge of the interview topic and study aims when developing the interview guide. We began the interview by asking participants about their overall experience being in the military, then asked about participants' experiences of military SH and SA (e.g., descriptions, when it occurred, by whom, if reported, and the response to reporting). Subsequent questions sought to elicit participants' perceptions of the effects of MST on their lives; these questions began broadly and then inquired about effects on different domains (e.g., how participants viewed themselves, their emotions, their attitudes toward the military, ways in which they coped, their bodies, and sleep). Additional questions queried the experience of MST in relation to suicidality and perceptions of VHA care but were beyond the scope of the present aims and thus were not analyzed for this article (Monteith, Bahraini, Gerber, et al., in press). Cisgender female psychologists or master's-level counselors conducted all interviews, which were audio recorded.

Data Analytic Plan

We analyzed audio recordings of interviews using an inductive and team-based thematic analysis approach that involved searching for patterns and themes within the interviews (Braun & Clarke, 2006). As discussed by Neal, Neal, VanDyke, and Kornbluh (2015), coding directly from audio recordings has some advantages including the ability to ascertain non-verbal information (e.g., emotional tone, sarcasm). Similarly, Markle, West, and Rich (2011) proposed that coding data in its original form instead of after transcription can allow for "more informative reporting" (p. 1). Neal and colleagues (2015) suggested a systematic approach called Rapid Identification of Themes, which allows a team to develop a codebook in a more holistic manner that also factors in information gleaned during audio coding (e.g., vocal tone, affect). Neal and colleagues (2015) proposed that using this approach to code from audio is a valid and reliable means of coding qualitative interview data. In line with Rapid Identification of Themes methods, we generated themes from audio coding and then created a codebook that coders used to enhance consistency.

Our process began with bracketing; we discussed how our pre-existing biases and identities could influence coding (Braun & Clarke, 2006; Carpenter, 2007). Coders discussed biases likely to emerge as a result of all three coders identifying as cisgender, women, and feminists, which (as discussed by our team) could affect our emotional responses to narratives in which women veterans experienced sexual trauma almost always perpetrated by men. We also discussed the strengths that emerged from our team members holding a

variety of identities pertaining to veteran background (one team member), racial/ethnic minorities (two team members), and sexual orientation minority status (one team member). We acknowledged ways in which this diversity of identities could allow for fewer blind spots regarding unique experiences among participants based upon multicultural identities. Our team also discussed a mutual bias that SA is "worse" or has more pronounced negative effects than SH.

The three coders independently reviewed full audio files of the same three interviews. Each coder generated a summary memo for each interview with in vivo codes, partial transcriptions (e.g., salient quotes), and memos. We used these summary memos to begin generating the codebook. After all three coders reviewed and discussed the first three interviews, at least two coders coded each subsequent interview and met for consensus regarding codes in each interview. We revised the codebook (available upon request) during weekly consensus meetings until we achieved theme saturation, which occurred after reviewing 14 interviews. During consensus meetings while coding the first 14 interviews, we added and combined codes as they emerged in the analytic process and developed an organizational system for the codes according to the content that emerged: contextual codes, MST characteristics, and sequelae. Using the codebook, two reviewers independently coded each remaining interview.

Following coding, we held weekly meetings to achieve consensus on codes for each interview. A third reviewer was available for further discussion and to resolve coding discrepancies although this was not needed. We continued to use partial transcriptions and memos to track quotes pertaining to the codebook, as well as broader themes and impressions. We used these tools during consensus meetings to track our impressions and allow for interpretive discussion. After coding all interviews, coders met to achieve consensus on broad themes, also referring back to raw data during consensus to confirm quotes and impressions.

Findings

Below, we begin by presenting two de-identified case vignettes to provide a more holistic perspective on women's MST experiences and its potential aftermath. We then report summaries and interpretation of themes that emerged in our analytic process, using de-identified quotes from various participants that further describe and contextualize these themes. We convey the salience of various themes within the sample with words such as "many," "most," and "some" to broadly indicate the relative frequency of a given theme. We also provide information on the type of MST experienced by each person quoted for additional context, while de-identifying all information with pseudonyms for each participant.

Case Vignette 1: Shelby

Shelby experienced both SA and SH during her military service. She was persistently pressured by a higher-ranked service member to "go out," and he threatened to lower her pay if she refused. He also "beat [her] up . . . touching, grabbing at [her] clothes," and this persisted for months. Shelby also survived a horrific gang rape by several men. Afterward, a ranking woman instructed her to stay in her room and asked that no men enter the space. Later, however, Shelby felt that she "couldn't report" being raped due to "not knowing anyone," and elaborated that she felt supported by the ranking woman mentioned above and another higher ranked man, but "kind of felt lost" when they were transferred. She "blocked the rape for [years] . . . not thinking about it. Stick your head in the sand. It didn't happen to me." Shelby used a variety of avoidance strategies for this purpose, including "drinking heavily," "driving fast," "shopping," and "[eating] the pain away" (resulting in significant weight fluctuation). She also described pronounced self-blame, which led her to assume that a romantic partner would not want to be in a relationship with her if she disclosed the SA: "These feelings of someone not wanting you because you were too immature, too stupid to know that could have happened."

Shelby's experiences were similar in many ways to some of the experiences described by other women in this study—except that she described feeling more supported immediately following the assault than other participants generally did. As we will discuss below, it was unusual for participants in the current study to describe feeling supported by others after being sexually assaulted.

Case Vignette 2: Malia

Malia also experienced both SA and SH during her military service. A higher-ranked individual repeatedly tried to get her "to sleep with him." He temporarily stopped sexually harassing her when she reported it; however, she stated that the military "still didn't do anything because he was [senior] and they trusted his word over mine even though I had a witness." The harassment resumed when she and the perpetrator were both re-assigned to the same location. Malia explained: "Not only was it that I had to deal with him, but I had to deal with him after I got raped." In addition, Malia had been raped by a civilian on base. She stated: "He [the civilian] was partying with us . . . we flirted a little bit . . . days later, we ended up going [out] . . . [a woman friend] ended up helping me into my room and she kept my key . . . later that night, I was out cold and I woke up to him on top of me and he was raping me . . . she let him into my room while I was sleeping and I never expected to wake up in my own room to that happening . . . " She reported the rape, but "they couldn't do anything because he was civilian . . . they said that if he ever came on post, they would press charges and arrest him, but they never did. He would go on post and taunt me. Not only

that, but I found out later that he raped several other girls that night and that the [person] on duty let him past the doors and into the barracks and . . . did nothing."

Malia described developing PTSD from the SA: "The funny thing is that I have PTSD, and it's not even because I went to war; it's because I was raped." She described becoming hypervigilant. Not long after being sexually assaulted, she "pulled [her] weapon on someone and almost shot him because he touched [her] . . . . I was not allowed to have a weapon with me the rest of my service." Malia also struggled with suicidal ideation and attempted suicide. She described coping with her distress through risky sexual behaviors. Due to some of these difficulties, Malia was psychiatrically hospitalized "[where] they couldn't do anything with me." Shortly thereafter, she was discharged due to mental health difficulties. Malia described subsequently hating the military and suffering loss of self-esteem. She experienced shifts in her body image as well as sleep problems. She also encountered ongoing difficulties with intimacy that led her to be isolated: "I don't have relationships with others. I don't have friends. And the guy that I see . . . I distance myself from him even though I love him."

Many of Malia's experiences share similarities with those described by other women MST survivors interviewed for this study. For example, the chronic nature of the SH, her changed attitudes toward the military after being sexually assaulted, and the effects of these events on her view of herself were also voiced by other women. We describe next the seven themes identified from the interviews.

Theme 1: Sexual Harassment: "Expected," "Constant," and "Normal"

It was clear that certain types of SH (e.g., verbal remarks, unwanted sexual attention) had occurred so commonly that many women struggled to identify a specific number of such experiences: "I don't want to say it was a daily occurrence, but it was just about, especially when I had first come in when I was younger" (Maria, SH, SA). Many participants commented on the "expected," "constant," and "normal" nature of SH in the military context: "Always that looking up and down, undressing with the eyes" (Noel, SH, multiple SAs); "It's horrible, but it's pretty much every day" (Kelsey, SH, multiple SAs). Many women described SH as a daily and omnipresent experience, which aligned with findings by Burkhart and Hogan (2015).

Furthermore, the majority of women described feeling objectified by the SH. Noel, who survived multiple SAs while serving in the military, described this as: "I was a thing . . . everyone had to have a piece of me." For Caitlyn (SH, multiple SAs), the sexual objectification "made [her] feel like [she] was just an object, a sexual object." Some women related this objectification to not being seen as colleagues worthy of respect: "I felt worthless . . . it didn't matter how hard I worked, it was always about what my body looked like" (Maria, SH, SA).

Women who described being sexualized and objectified (rather than treated as equals, peers, or colleagues) often described a struggle to find community, interpersonal support, and belongingness. This struggle has profound implications in a military context, particularly for service members deployed to warzones, where unit cohesion is critical for safety and survival. Some women described difficulties maintaining friendships if sex was not involved, as men would communicate lack of interest in platonic relationships with women: "It comes back around to the sex . . . 'if we can't have sex, I don't need more friends' [participant quoting hypothetical serviceman]" (Sarah, SH, multiple SAs). Some women further described receiving messages early in their military careers that they were expected to have sexual relations with men unless they worked harder than everyone else or made it clear that they identified as lesbian/gay. Yolanda (SH and attempted SA) further described these messages when quoting a military leader who told her: "There are two ways to make it, either on your back or on your feet. Either way, you are going to be called a whore or a dyke."

As such, a major means of establishing connection and community was maintaining a somewhat surrendered attitude regarding sexualization: "In order to keep them as my friend, this is what I have to do . . . going out drinking with my guy friends . . . would set the stage for anything to happen . . . it was just how things were . . . . It became a way of life. If you wanted to be in with the cool kids, you would make these jokes and laugh at these jokes [i.e., jokes involving sexual harassment]" (Barbara, SH, multiple SAs, attempted SA). Some participants described the difficulties of wanting friendships and not being able to establish friendships without rumors and expectations surrounding sex: "It was hard because you know you're going to have guy friends and people are going to assume other things" (Martha, SH, multiple SAs). This backdrop of struggling for connection and support in an environment dominated by men who objectified and sexualized women was an important contextual finding.

Theme 2: Silencing and Disempowerment: "If You Want a Career, Then Shut Up"

The act of MST appeared to communicate and reify power differentials between MST perpetrators and survivors at times when women possessed the least power and were especially vulnerable. Women tended to experience MST near the beginning of their military service. Many reported that the first time that they were sexually assaulted during their military service was soon after their military careers commenced, such as during basic training, advanced individual training, or their first deployment: "I was sexually assaulted at my first duty station, and after that, he taunted me every day, and after that, I got moved into a different unit where inappropriate gestures and invitations kept piling . . . "

(Jackie, SH, SA). Noel explained that she first experienced MST while in the "recruiters' office . . . I wore my very best dress, wanted to look presentable . . . after I had been sworn in, a recruiter asked me to meet him . . . and he began kissing me . . . " (SH, multiple SAs). Many survivors, like Noel, appeared to be targeted at vulnerable times of least acquaintance to military culture when a sense of empowerment would be difficult to hold.

In addition, women's descriptions of the gender and rank of perpetrators reflected striking power differentials. Almost half of participants described their perpetrators as higher ranking. Moreover, men had perpetrated all but one SA, and the sole SA perpetrated by a woman was a rape perpetrated by a man and woman together. Similarly, SH perpetrators were typically higher ranked men who were often directly in charge of the survivor. Thus, women who experienced SA or harassment typically held less power than the perpetrators due to being of lower rank and lacking gender privilege. Gender stereotyping may have contributed to this lack of gender privilege, as stereotyping can include the belief that femininity will lead to worse performance and less ability to lead (Boldry, Wood, & Kashy, 2001). As such, women were often aware that perpetrators had the power to harm their careers given perpetrators' relative power and privilege. For example, Betty (SH, SA) was pursued by a higher ranking man in her chain of command; when she refused his sexual advances, he punished her by assigning her worse duties.

One effect of this dynamic was silencing and fear. Many women in our sample did not formally report MST sometimes due to a feared consequence that perpetrators would use their power to retaliate. Deana (SH, SA) shared the following regarding retaliation threats made by her higher ranking male perpetrator: "He threatened to destroy me . . . my military or personal life if I told anyone . . . 'if you want a career, then shut up.'" Similarly, the officer who sexually assaulted Chelsea threatened physical violence as a means of silencing her. After he and other soldiers sexually assaulted her: "He told me that if I ever told anyone, he would kill me." The power differentials in MST and its aftermath (e.g., threats made to women's careers and safety if they reported SA) seemed to function as a means of silencing some women who experienced MST. Furthermore, such threats were facilitated by perpetrators' powerful positions.

Women also described a sense of powerlessness in the aftermath of MST—not just in terms of reporting what they had experienced, but also with respect to the outcomes of reporting and finding out what had happened to the perpetrator, if anything. Samantha was removed from her base after reporting: "I did report it to my chain of command . . . they were upset and they moved me . . . upset with me, they wanted me to keep quiet" (SH, multiple SAs). Many women who reported their sexual abuse stated that they never found out whether reporting led to disciplinary action against the perpetrator or indicated that there were no consequences for the crime. Rather, some said that the responses had focused on providing medical intervention, or relocating the survivor without informing them of consequences to the perpetrator: " . . . He ended up moving me out of that [occupational setting] into a lesser job, and nothing ever transpired as far as [the perpetrator] was concerned . . . " (Betty, SH, SA). As described above in Vignette 2, Malia also experienced relocation to a "mental health ward," where, per her report, treatment was not helpful. Similarly, Carmen (SA), who had planned to have a long military career, stated: "Once I reported what happened, I was sent over where soldiers go who are in limbo . . . received counseling . . . gave me a medical discharge . . . " She described being vaguely assured that leadership had "taken care of the other [perpetrator]" without receiving sufficient details to know whether the perpetrator had actually experienced any consequences. She experienced the mental health intervention as punishment for reporting the SA.

Power differentials and hierarchy, in these instances, were communicated through lack of justice served on behalf of the survivor and the response to survivors' efforts to speak out about the MST (i.e., not fully hearing or responding to survivors). Veronica, whose reports of SH were "falling on deaf ears," lamented the military's handling of her complaints: "The good ol' boys' club covers up for everybody." Of note, our findings align with those reported by Burns and colleagues (2014), who reported that military culture (particularly promotion of sexism) contributes to the occurrence of MST and that women were often not taken seriously (or feared not being taken seriously) when reporting or considering reporting MST.

Theme 3: Changed Attitudes Toward the Military: "I Lost Faith"

Many women described changes in their attitudes toward the military institution following MST. For example, Deana described that MST conflicted with her previous attitude toward the military: "Because I thought that the military was an honorable organization, the idea that something like that could happen there, especially from someone who was in charge, that just threw me to the ground." Kelsey also explained her disappointment with the military: "I felt like the military didn't do a good enough job . . . the military creates this culture where it's okay to haze people, where it's okay to treat women and even homosexuals a certain way." Malia (Vignette 2) described "hating the military" and that being in the military was "a dark part" of her life. In addition, Maria (SH, SA) shared: "I don't look at the uniform and feel a sense of pride, I look at the uniform and think oh, America is so clueless . . . I lost faith . . . I would never have a child of mine join the military."

Many women indicated that part of their reason for "losing faith" in the military was that MST had harmed or impeded their careers. For example, women described lack of promotion, as well as being demoted, punished, and prematurely

discharged from the military. Sasha (SH) described how her career had been adversely affected after refusing dates with her boss: "He put innuendos on my [evaluations] where I couldn't get promoted." Eleanor, who was sexually harassed by her co-workers and an officer, told another military leader about what had occurred, and he punished her and their company: "After talking to him, he punished the whole company . . . he would pick me for all the tasks that no one wanted to do." Maria had planned to pursue a lifelong career in the military but was unable to do so because of the severity of the constant SH that she experienced and the ensuing legal battles: "I wanted to do 20 years. It all fell apart, just like that. Even though I was just in my office working." As a result, she switched career paths; however, she suffered for doing so, being considerably "behind" in her occupation. Carmen, whose SA resulted in a medical discharge, stated: "I'm almost embarrassed to tell people I'm a veteran because it was taken from me."

Many women described that in addition to the distress associated with the MST itself, they experienced a sense of loss regarding the organization that they had devoted themselves to and previously held in high esteem. Women's descriptions of lost "faith" in the military aligns with the existing literature on institutional betrayal in the context of MST (e.g., Monteith, Bahraini, Matarazzo, Soberay, & Smith, 2016; Smith & Freyd, 2013).

Theme 4: Loss of Relational Trust: "I Can Protect Me If I'm Not Involved With Someone"

Many women in the present study described loss of trust as a common, immediate, and longstanding response to MST. In particular, many participants stated that following MST it became difficult to experience "trust," particularly with men. For example, Gwen (SH, multiple SAs) stated: "I don't trust men, so I haven't been with anyone in [many] years . . . not interested in having any kind of relationship with anyone." Experiencing MST from a previously trusted individual seemed to make it particularly difficult to subsequently trust others. Betty (SH, SA), who was sexually assaulted by multiple men (including one in a particular position of trust) described: "My relationships have never really been the same with men . . . I'm still single and I have a really hard time staying in a relationship . . . I have a hard time trusting men in an intimate relationship, so my relationships don't last very long." Many women in our sample expressed that they had initially trusted the men who sexually assaulted or harassed them. Such trust had been based upon leadership roles held by perpetrators, friendships with perpetrators, or having common friends. For Sasha, who was sexually harassed by her boss for years, the harassment began with a seemingly benign invitation to share a meal: "My boss asked me to go to a restaurant to eat, I guess he thought that was a date." She initially believed that the meal invitation was friendly and not a cause for concern, but learned that this was not the case.

Although some participants specifically referred to difficulty trusting men following MST, others reported difficulty trusting people in general. Some women described avoiding intimacy and lacking interest in friendships and relationships: "Other than what I'm supposed to perform in the military, no girl friends, no guy friends . . . no longer wanted to be around people period" (Vignette 1; Shelby). Jessica (SH, multiple SAs) described that she "kept to [her]self, very withdrawn." Isolation was sometimes described as a protective response to prevent future sexual trauma and seemed to function as an attempt to protect oneself in the context of previous violations of trust: "I can protect me if I'm not involved with someone else" (Deana, SH, SA).

Of note, women's loss of relational trust following MST may have also related to the fact that many women described lack of support or intervention by bystanders, particularly women. Some participants indicated that other servicewomen had facilitated their MST—or failed to intervene while MST was happening—despite knowing that a SA was taking place. Of note, no participants discussed bystanders who were men in this way. In Malia's experience (Vignette 2), a fellow servicewoman had provided the perpetrator access to her bedroom (where she was sexually assaulted) and did not intervene while she was being sexually assaulted: "It's just nobody helped . . . the girl that let him in . . . all she could say the next day was 'I'm really sorry' . . . told me 'all I remember that night was you screaming.'" Martha (SH, multiple SAs) also reported that a fellow servicewoman did not intervene when she was being sexually assaulted despite hearing it happen: "Later on, my roommate . . . asked if everything was alright and I was like 'no.' She was like 'well, we heard you saying no, but we didn't really pay attention . . . we didn't really think anything of it 'till later.'" These additional examples of interpersonal trust violations likely also contributed to generalized loss of relational trust among women in the current sample. Louisa's statement (SH, attempted SA) exemplified women's difficulty trusting others after MST: "Sometimes it's the people you know, they're the ones you have to watch out for."

Theme 5: Internalization of Messages: "If I Looked Different, None of This Would Have Happened"

Women appeared to internalize experiences of MST, objectification, trust violation, and powerlessness in terms of the attitudes and responses that they developed toward themselves, their bodies, and their femininity. This manifested in lowered self-esteem, self-blame for MST, and exacerbation of body dissatisfaction, as described below.

Lowered self-esteem and self-worth: "My self-esteem was so low." Being objectified and treated as expendable by others seemed to lead some women to change their beliefs about themselves. The majority of participants described a severe decrease in their self-esteem after being sexually assaulted or harassed. Malia (Vignette 2) related that MST "lowered [her]

self-esteem." Others referred to decreased confidence: "I don't have the confidence I used to have" (Betty; SH, SA); "It took confidence away from me" (Samantha; SH, SA). Some women indicated that lack of confidence following MST led them to believe that they were undeserving of good things even after their military service had ended. For example, Maria (SH, SA) stated: "My self-esteem was so low after the first two assaults . . . led to my willingness to be in an abusive relationship." Chelsea (multiple SAs) similarly described: "[I had] an abusive husband . . . didn't really believe that I deserved anything . . . I knew I was not worthy of friendship, love." Carmen (SA) also stated: "[It] made me believe that I deserved what I got and that's what I deserved elsewhere, and after that, it made me think that's the only kind of person I could be with, people who hurt me." Another woman spoke about her low self-esteem following MST: "I think initially it made me feel like there was no value to anything I said . . . like my saying no . . . it didn't matter . . . felt as though everything I said or did didn't matter" (Kelsey, SH, multiple SAs).

Self-blame: "I thought it was my fault." Participants also appeared to internalize messages from MST (and the related objectification) by blaming themselves for being sexually assaulted or harassed (i.e., faulting themselves or aspects of their bodies that "caused" the MST to occur). Some blamed their own physical appearance for "causing" the MST: "I hate myself . . . can't help but think that if I looked different, none of this would have happened. If I was super skinny or didn't look like I do, nobody would have found me attractive, I wouldn't have been harassed as much." (Maria, SH, SA). Other women blamed themselves due to drinking alcohol before the MST occurred: "I thought it was my fault for drinking . . . too immature, too stupid to know that could have happened" (Vignette 1; Shelby). Others had more general self-blame in which they related MST to the quality of their own judgment: "I saw myself as being naïve, ignorant . . . got into situation that I should have known better" (Kelsey, SH, multiple SAs). These "should" statements were a common way in which participants blamed themselves for having experienced MST. One manifestation of self-blame appeared to be shame. Kelsey (SH, multiple SAs) said: "Had to keep it all inside . . . felt dirty, shamed, I thought it was my fault . . . I felt like I was this unclean lepers, damaged thing." Noel (SH, multiple SAs) also described: "I felt shame and embarrassment for being in that situation."

Furthermore, several women shared that they believed their bodies (e.g., appearance, femininity) were "to blame" for MST and, in turn, that they needed to hide their bodies for protection following MST. Joan (SH, attempted SA), for example, described feeling concerned about what "vibe" she put off to others and related that to the potential of subsequent sexual violence: "I'm self-conscious about showing skin." For Joan, this desire to hide as a means of protection led her to change her appearance (e.g., cutting her hair off, taping down her breasts) to prevent future SAs. Of note, as Joan described her experience of SH, she made the following comment: "This is when I actually looked like a woman." Other participants tried to gain weight following MST to prevent future victimization: "I think I've put on weight. Don't really take care of myself. Don't wear makeup. I guess I just don't want to be attractive" (Caitlyn, SH, multiple SAs). Self-blame related to protective responses following MST and also suggested internalization of negative messages associated with MST.

Body dissatisfaction: "I hate my body now." Some participants described shifting perceptions and judgments of their bodies following MST, which also suggests potential internalization of the devaluing and objectifying messages conveyed by experiencing MST: "I hate my body now" (Samantha; SH, SA); " . . . very self-conscious about [my body], don't think I could ever be skinny enough . . . I don't like my body. I have a bad body image . . . my husband can tell me I look beautiful and I think 'yeah right'" (Veronica, SH, SA). Some women also made comments that suggested that their low self-esteem had increased their body dissatisfaction or led to self-hatred of feminine body features, commenting: "I never thought about my body, but my husband would say I always hide my face" (Kelsey; SH, multiple SAs); "[I] couldn't look myself, my face, in the mirror (Deana; SH, SA)." Sasha (SH) also described MST as having an influence on her body dissatisfaction: "Always think I'm either underweight or overweight . . . still not okay with my image, how I look, how I talk, how I act." Of note, these quotes were in response being asked how MST had affected their "feelings about their body."

Participants' body-esteem may have been influenced by the pervasive sexual objectification that they encountered. As described above, some women in this sample described being seen as sexual objects throughout their military careers. For example, one participant (Penelope; SH) described this as being treated like "pieces of meat." It is possible that this objectification by others during a period of relative youth and vulnerability contributed to increased self-objectification, or internalizing an observer perspective of their own body (Fredrickson & Roberts, 1997). Experiences of sexual objectification in adolescence are related to objectified body consciousness (self-objectification); therefore, it is possible that a similar relation may exist in the military between sexual objectification and acquisition of increased objectified body consciousness (Lindberg, Grabe, & Hyde, 2007).

Theme 6: Escape and Avoidance: "I Put My Head in the Sand and Hoped It Would Go Away"

Many participants described coping behaviors and other efforts aimed at helping them escape memories and emotions related to MST. Shelby (Vignette 1) described this as: "I put my head in the sand and hoped it would go away." Many

participants also described risky coping behaviors as means of escape: “I used to use alcohol a lot to suppress thoughts” (Betty; SH, SA). As mentioned above, Shelby (Vignette 1) turned to problematic drinking and emotional (possibly binge) eating after being sexually assaulted, which resulted in weight gain. Other women reported engaging in risky sexual behaviors as means of coping with MST. Gwen (SH, multiple SAs) described a change in her sexual behavior following MST: “I was very promiscuous after that, but it was with somebody that I wanted to be promiscuous with, not somebody that forced me.” Dietary restriction, risky driving, compulsive shopping, and marijuana use were other coping behaviors described following MST, albeit by fewer participants. Carmen (SA) reported her tendency to escape by numbing herself: “I definitely numb out more than I should.” Referring to the disordered eating symptoms that she developed following MST, she noted: “I will be more likely to turn toward addictive behaviors. I developed eating disorders after that . . . I definitely numb out more than I should. I stop eating.”

Theme 7: Healing Through Validation and Justice: “You’ll Get Through It”

A small but notable minority of women in our sample described validating, supportive, and empowering experiences that seemed to be distinct from what the majority of other participants described. For example, a few women who reported MST spoke positively regarding military leadership’s response to their report and described supportive interpersonal responses that were helpful. A few participants described empowering institutional responses that involved hearing and believing the survivor’s report, and also openly serving justice to the perpetrator. Louisa said: “I reported it and then [another survivor with the same perpetrator] reported it too . . . a whole trial happened and he actually got kicked out of the military.” Thus, Louisa was heard in her report of SA and also informed of the justice response. Of note, she described several positive outcomes following MST, including seeking treatment and finding a sense of purpose. And Laurie (SH) related: “Yes, I reported it. I want to say that he had administrative action and he ended up getting removed from the military.” She did not describe experiencing any negative long-term outcomes from the MST. Helpful components of these institutional responses appeared to involve the survivor being believed and informed about the disciplinary action taken against the perpetrator.

A few women noted that they received supportive and validating responses from other service members that appeared to also be beneficial to their healing process. Maria (SH, SA) stated the following regarding support from other service members: “My [fellow service members] have been supportive and stood by me.” Feeling supported empowered her and helped her to find purpose, which she described as seeking justice and fighting for other women. A few participants also reported occasional support from women superiors outside of formal reporting scenarios. This was described earlier: Shelby (Vignette 1) was helped by a higher-ranking woman after being sexually assaulted. The woman “told me to stay in my room. I was just panicked, crying, and she asked that no one, no males come into that room.” Although rare, a few women also described supportive responses by servicemen. Yolanda, who later advocated for MST survivors, reported the following regarding a supportive officer: “He was tasked with escorting me to community mental health . . . he goes, ‘with all this crap that’s going on, if they demote you, if they charge you, don’t worry about it, you’re a strong person, you’ll get though it . . . I’ve been there’” (SH, attempted SA). Similarly, Joan, who was sexually harassed while deployed overseas, recalled feeling protected by her fellow servicemen: “I was very secure because I slept in the same tent as my fellow soldiers and they kept me in the back corner so no one could come and grab me . . . ” Joan, like many other women in our sample who experienced validation and perceived justice following MST, did not describe MST as having as extensive, detrimental, or lasting effect, compared to women who did not experience validation or support. Supportive responses, as exemplified in these examples, involved hearing and believing survivors and their experiences, and communicating an interest in protecting the survivor.

Another subset of participants described receiving helpful support from romantic partners, friends, and family external to the military institution. Louisa (SH, attempted SA) explained: “I talked to my best friend about it,” which likely helped with her recovery process. After an initial period of struggling with “self-destructive behavior” immediately following the MST, she described finding meaning in her life. Barbara (SH and SA) explained that meeting her husband was a “turning point” in her recovery, after which she began to seek friendships and return to being the “genuinely happy person” she experienced herself as being prior to MST. Eleanor (SH) received support through friendships and her romantic relationship. When asked how she coped, Eleanor stated: “I would talk to people like my friends, other people that would hear everything going on . . . they would just tell me ‘yeah, I know’ . . . I would talk to my husband about it.” Eleanor described being recovered from her MST experience: “I just don’t even really think about it now.” Interpersonal and institutional responses appeared to be salient for individuals who had more positive recovery outcomes.

Discussion

We sought to examine the phenomenology of MST among women veterans using an inductive analytic approach that drew upon women’s own words. This is the first study, to our knowledge, to explore with an open-ended and inductive method, the phenomenon of MST among women veterans. We build on seminal qualitative work in this area (e.g., Burns

et al., 2014; Mattocks et al., 2012). The following themes emerged: (1) SH: “expected,” “constant,” and “normal”; (2) silencing and disempowerment: “If you want a career, then shut up”; (3) changed attitudes toward the military: “I lost faith”; (4) loss of relational trust: “I can protect me if I’m not involved with someone”; (5) survivor internalization of messages conveyed by MST: “If I looked different, none of this would have happened”; (6) coping by escape and avoidance: “I put my head in the sand and hoped it would go away”; and (7) a path to healing through validation and justice: “You’ll get through it.”

These themes describe a context in which SH was a normative experience that women endured across multiple domains. Goffman’s concept of “total institution” can be used to better understand this, as servicemembers often “eat, work, and play” in one “sphere,” particularly in certain contexts (e.g., deployment; Goffman, 1961, p. 314). Furthermore, in a “total institution,” women in our study may have had to adjust their own responses to MST (e.g., to become somewhat accustomed to an environment with frequent SH) in order to ensure survival and continue to have careers. This also may have set the stage for internalized self-blame attributions regarding MST: If the survivor could identify actions or supposed character traits of their own that could have (in theory) explained why they had been sexually assaulted or harassed, such self-blame may have allowed them to maintain a sense of safety despite living within a context in which sexual violence was likely to occur. This conceptualization aligns with Janoff-Bulman and Frieze’s (1983) work on the function of self-blame, as well as betrayal trauma theory (Freyd, 1994).

Strengths and Limitations

Due to our methods and the small sample size, we are not able to draw inferential conclusions about the broader population of women survivors of MST. Rather, our sample-level findings can inform hypotheses and foci of future research. In addition, the small sample and focus on women veterans, aged 18–65 years, within a single regional VHA system, and eligible for VA care, limit generalizability. Future MST research should include older women veterans and women who are not eligible for VA care. One strength of this study is the wide range of service eras and years since discharge represented. However, due to this wide range of service eras, our findings among participants who served long ago do not reflect recent changes in SA prevention and response within the DOD.

Accuracy of self-reports regarding MST could also be limited by misremembering or forgetting aspects of traumatic experiences (DePrince & Freyd, 2004). It is possible that participants may have struggled to report on certain recollections due to memory limitations, particularly given how much time had passed since some participants’ MST incidents; for example, a subset reported abuse that occurred during the Vietnam era. Another limitation was that our interviews had a broad focus, which addressed a wide range of topics. A more focused interview could have provided greater elaboration within a smaller range of topics. Qualitative approaches are subjective in nature (as noted, the qualitative team acknowledged biases as part of bracketing prior to coding). Although we established consensus regarding coding of each interview, it is possible that thematic findings would have differed with another team of coders who carried different sets of multicultural identities, personal belief systems, or biases. Also, despite our rationale for coding from audio recordings (i.e., being able to factor in nonverbal data, such as crying, changes in vocal tone), audio coding runs the risk of potentially missing details not captured in written form through transcription.

Future Research

In light of the DOD’s intensive efforts to improve the prevention and response to MST, a next step for future research would be to examine if, how, and in what ways, experiences change over time for women survivors of MST. Longitudinal studies could examine how the effects of MST unfold over time in, perhaps, different ways for different groups of individuals. For example, women who experience a validating response and sense of justice may have a different trajectory of mental health and interpersonal relationships over time compared to those who experience loss of relational trust and disempowerment. In addition, experiences of older women veterans, or those who are not comfortable discussing their MST experiences in a study of this nature, likely differ from other groups of MST survivors. It will be important for future researchers to examine how intersections of various cultural identities (e.g., socioeconomic status, gender identity, age, race, ethnicity, and sexual orientation) may impact the MST experience.

In future qualitative research on MST, researchers should use more in-depth interviews focused on specific domains that can be influenced by experiencing MST (e.g., objectification, impact of lost trust and changed military attitudes, and self-blame). Such studies could explore such domains in a more detailed way that draws upon the unfolding information provided in a semi-structured interview. A study on self-blame, for example, could examine the functionality of self-blame mentioned above (i.e., how self-blame might indirectly facilitate unit cohesion and “safety” in a military context; Freyd, 1994; Janoff-Bulman & Frieze, 1983). Such a study could examine whether self-blame may allow survivors to continue to function in their daily tasks in spite of continued contact with perpetrator(s) and/or bystanders who may have not intervened or provided support in response to MST. Through deductive qualitative and quantitative approaches with larger samples, scholars might also ascertain whether themes identified in this study exist within the larger population of women veterans.

We also suggest continued research on the distinct experiences of MST that are influenced by the survivor's gender identity. We analyzed our cisgender male and female samples separately, and the results regarding veteran men are reported elsewhere (Monteith, Gerber, et al., 2018). Our findings from these multiple reports suggest that the experience of MST in women shares some similarities, and some different characteristics and outcomes, compared to those of men. Both men and women reported interpersonal and intimacy difficulties following MST. However, women described objectification as a contextual factor, while men described masculinity- and sexuality-related concerns that arose in response to MST. Future research is also needed to examine distinct experiences of MST with gender nonconforming service members and veterans. In addition, given the role of power differences in MST, future research is needed to examine specific experiences of MST survivors who have multicultural identities and who hold less privilege and/or intersecting identities.

Practice Implications

Our results underscore the importance of multi-level interventions that facilitate validating and supportive responses to MST by institutions, as well as fellow service members and leaders who have the power to prevent and/or minimize the deleterious aftermath of MST. This approach would align with prior research on the helpfulness of interpersonal support in survivors' processing of sexual trauma (Golding, Siegel, Sorenson, Burnam, & Stein, 1989) and with the aims of the Department of Defense (DOD) Sexual Assault Prevention and Response Office (2013) to instill the "values of respect and trust" (p. 14) as part of preventing and responding to MST. Developing a culture in which individuals believe and respect MST survivors' reports could be part of this mission, and part of the department's current Peer to Peer Mentorship program, which already encourages "empathic" response to MST disclosure (DOD, 2014, p. 10).

Women service members could be trained to help one another given the potential that women will experience SH (Burkhart & Hogan, 2015). It is possible that labeling such challenges could help build resilience and community support, and also align with current initiatives for "community involvement" (p. 11) as part of prevention and response (DOD, 2014). Increased awareness regarding potential objectification experienced by women MST survivors may also help facilitate change. As suggested by Campbell and Wasco (2005), building a multi-system and contextualized community response incorporating systemic and cultural changes is an important prevention and intervention strategy.

Our results also suggest that it is not enough to assure a survivor that the perpetrator has been addressed; survivors should be informed about the justice process (e.g., what specifically happened to the perpetrator). This may help mitigate the negative attitudes toward the military institution that many women in our sample described after MST. This would also be in line with prior research on systemic responses that include an emphasis on justice being served to perpetrators (Bell, Street, & Stafford, 2014). Such efforts would align with the current initiative of the DoD, "Enhancing Victim Rights" (p. 17), which provides an opportunity for survivors to provide feedback post-trial (Department of Defense Sexual Assault Prevention and Response Office, 2013).

We also suggest prevention efforts that target service members most likely to perpetrate MST, which in our sample tended to be higher-ranking men in positions of power. Higher ranked leaders could undergo trainings regarding how to hold power and privilege in ways that allow them to uphold the honor and duties of such positions. Trainings could focus on multicultural awareness, and draw upon pedagogy, gender studies, psychology, and other professional training programs (e.g., Case, 2007; Goodman et al., 2004; McIntyre, 2002). This prevention effort could be incorporated into the existing DoD initiative to "Enhance Commander Accountability" (Department of Defense Sexual Assault Prevention and Response Office, 2013, p. 16).

Our findings and implications coincide with broader civilian-based movements toward justice and community support for survivors. The "#MeToo" campaign has empowered millions of survivors of sexual trauma to speak out against a broader culture of sexual violence and silence (Bennett, 2017) that is not specific to the military. Other contemporary movements, such as "Time's Up" and "All Raise," have shed light on and seek to address systemic SH, assault, and inequality in a variety of industries from entertainment to technology (Dickey, 2018; Time's Up, 2018). Thus, while the experiences and sequelae associated with MST may be unique in some aspects, sexual violence certainly is not unique to the military, and community organizing within the military against MST may help to further shift the culture to decrease the occurrence of SA and SH.

Our findings also suggest that the experience of MST is multifaceted and complex, with MST occurring in a specific cultural context and perceived as influencing women's lives in many ways. It is essential for clinicians to understand the context, experience, and aftermath of MST among women veterans. Providers may be better positioned to help women who have experienced MST by understanding that MST sometimes occurs in a context of objectification, loneliness, and isolation. It is also critical that providers and institutions comprehend the extent to which MST may affect women's ability to trust others as well as impart negative attitudes (e.g., disillusionment, resentment) toward military institutions. Considering women's negative attitudes toward the military following MST in the present study (which corroborates Wolff and Mills [2016]), it is essential for community providers to ensure that they have sufficient knowledge and competence to assess for MST and treat its health sequelae, as some survivors may choose to seek treatment outside of VHA. Clinicians should be prepared to recognize trust

violations surrounding and following MST and to address how this may affect the therapeutic relationship and treatment process. In addition, given shifts in women's experience of themselves and their bodies (i.e., self-esteem, self-blame, and body dissatisfaction), clinicians who work with women MST survivors should be prepared to effectively treat these sequelae and recognize their potential influence on treatment.

Conclusions

The experience of MST, as described by veteran women who have experienced SA and/or SH, is complex, multi-faceted, and appears to occur in a context in which power differentials are communicated during and after MST. We encourage policy makers, service members, leaders, and clinicians to continue to pursue knowledge regarding the full contextual experience of MST among women service members and veterans. Such efforts are important for strengthening efforts to address military sexual trauma.

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Note

1. Quantitative measures were administered pertaining to the broader focus of the parent study, which aimed to describe factors that increase risk of suicidal ideation and suicide attempts among MST survivors; however, such measures were not analyzed or included in the current report.

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