Guest Editorial

Providing Care to Survivors of Military Sexual Trauma

Ashton M. Lofgreen, PhD

In recent decades, several high-profile scandals have brought to light the problem of sexual harassment and sexual assault in the US Armed Forces. Such scandals are unfortunately not rare exceptions, but rather a manifestation of more pervasive patterns of sexual misconduct within the military that have affected numerous service personnel. In fact, women serving in the “post-9/11” era are more likely to face sexual violence or harassment at the hands of a fellow service member than to be injured by an enemy combatant.1 Furthermore, it is not just a “women’s issue.” Approximately 4% of men have experienced military sexual trauma (MST)—as many men as women in raw numbers when considering the preponderance of men in the military.2 Additionally, people who are non-gender conforming and members of the LGBTQ+ (lesbian, gay, bisexual, transgender, queer) community are at disproportionate risk of these experiences.3,4

People who have experienced MST often share that although they prepared to make the ultimate sacrifice for their country and comrades, they never prepared to be harmed by a “brother or sister in arms,” whom they were trained to trust with their life. Some survivors report that an insufficient or even detrimental institutional response when reporting MST was as distressing as the initial trauma. These betrayals are particularly painful to service members who often consider their military service a core part of their identity. The effect of MST has been extensively examined and found to lead to long-term deleterious physical health outcomes as well as psychological wounds including post-traumatic stress disorder (PTSD) and depression.5 Perceptions of military institutional betrayal in this population are predictive of suicide attempt.6

Efforts have been made by the military and Congress to address the problem of MST. For example, in 1999 the Veterans Health Administration (VHA) implemented universal screening for MST and was mandated by Congress to provide free services to any service member or veteran for MST-related conditions. In 2004, the military’s Sexual Assault Prevention and Response Office was established to provide support and advocacy for those reporting MST. More recently, in 2017, Congress specifically included language in the Military Code of Justice to include online behavior, such as the nonconsensual posting of nude photos, for inclusion as a crime subject to court-martial. Efforts have also been made to move the handling of prosecution of alleged perpetrators outside the Military Chain of Command to improve objectivity in the pursuit of justice. Although this legislation has not yet been passed, these efforts have been renewed in the form of the “I Am Vanessa Guillen Act,” and was introduced to Congress in September 2020.7 Specialist Vanessa Guillen was murdered by a fellow service member at Fort Hood this year; her family has reported that she was experiencing sexual harassment prior to her murder.

Despite these efforts and clear improvements in the availability of resources for survivors, the problem of MST continues. Providers in the Department of Defense (DoD), VHA, and civilian sector must be aware of the problem and prepared to treat the health concerns and psychological wounds left behind. To that end, this issue of Psychiatric Annals focuses on the problem of MST to help providers assist survivors in the healing process. Specifically, we invited experts to discuss: (1) legal, advocacy, and
mental health resources available within the DoD for MST survivors still serving; (2) special considerations for treating PTSD secondary to MST; (3) best practices for suicide assessment and intervention with MST survivors; and (4) MST and risk of sexual revictimization post-service. Each article provides an overview of the topic, highlights the state of current knowledge, and discusses ideas for future directions in research, practice, or policy. It is our hope that this issue will not only increase awareness of MST, but also help providers feel prepared to deliver best-practice clinical care to veterans.

REFERENCES