

Military Sexual Trauma Services Offered in the VHA

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Since the early 1990s, VA medical centers have expanded their services for sexual trauma, but offerings continue to vary widely across different facilities.

Military sexual trauma (MST)—which includes sexual assault and harassment—is a serious problem, with prevalence rates reported to be as high as 41% for female veterans and 4.2% for male veterans.¹⁻³ According to 2002 VA national MST surveillance data, 22% of female and 1% of male VA patients report experiencing MST.⁴ But because veterans overwhelmingly are male, more than half (54%) of all veterans who screen positive for MST within the VHA are male.⁴

The effects of sexual trauma on men and women are profound. Survivors of such trauma tend to struggle with marital and family problems, feelings of shame and anger, issues with trust and safety, and sexual difficulties.⁵ Other common problems include substance abuse and dependence, depression, anxiety disorders, and suicidal ideation.⁶⁻¹² Male victims also often report concern over their sexuality or masculinity.¹³

Both men and women who experience sexual trauma are likely to experience psychiatric symptoms after the trauma (41.2% of men and 11.3% of women) and a general history of psychiatric hospitalizations (51.7% of men and 17.9% of women).¹¹ In particular, a diagnosis of posttraumatic stress disorder (PTSD) is quite common. Estimates

from community samples of women who were victims of rape found that between 32% and 57.1% experienced symptoms of PTSD at some time following the rape.^{14,15} PTSD symptoms include nightmares; exaggerated startle; irritability; avoidance of reminders of the traumatic experience; flashbacks or intrusive memories; sleep disturbances; feeling numb, detached, or disconnected; and trouble concentrating.

Since the early 1990s, VA medical centers (VAMCs) have been responding to congressional mandates to provide screening and services to men and women who have experienced sexual trauma while in the military. In 1995, a survey revealed that while all VAMCs have responded to the mandates, the level of response has varied widely.¹⁶ The goals of the current study, therefore, are (1) to determine whether VA services have adapted or expanded since the 1995 survey, (2) to investigate the types of services currently provided to veterans who have experienced MST, (3) to identify any existing barriers to providing such services, and (4) to evaluate if there are any disparities in treatments offered to men and women.

BACKGROUND

During the last decade, Congress, the DoD, and the VA increasingly have recognized the problem of sexual trauma experienced by many veterans while in the service. The Veterans Health Care Act of 1992, P.L. 102-585, provided the authority for treating MST in female veterans, and the

Veterans Health Programs Extension Act of 1994, P.L. 103-452, extended this authority to all veterans. However, these acts “do not outline specific guidelines for clinical protocols, team make-up, administration, or treatment procedures.”¹⁶ Therefore, treatment may vary widely across different VAMCs.

The initial 1995 survey of MST treatment in female veterans at VAMCs showed that approximately 5 patients were seen per week and newly referred patients were seen, on average, within a week.¹⁶ The number of facilities that offered treatment of MST in male veterans is unknown because the survey did not ask this question.¹⁷ About half of the VAMCs had established a sexual trauma treatment team. VAMCs without such a team tended to provide nonspecialized services to female veterans or provide community referrals. The survey did not examine the types of treatments offered.¹⁷

Treatments for MST

Cognitive behavioral treatments—which address problematic thinking patterns—are the most studied interventions to address the psychological sequelae of sexual trauma. Several empirically supported, manualized treatments (treatments with a protocol of specific steps for clinicians to follow) have been developed, such as cognitive processing therapy (CPT). Other treatments include stress inoculation training and imaginal and in vivo exposure.¹⁷⁻¹⁹ Treatments focus on improving anxiety manage-

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ment and coping skills, changing fear networks, decreasing avoidance, and modifying maladaptive or problematic beliefs.

Stress inoculation training, for example, consists of a 3-phase program focused on helping patients change how they react to stress and “inoculate” them against future stressors. In the conceptualization phase, therapists working within this treatment model educate patients about the nature of the stress response and teach them how to evaluate situations in order to determine the appropriate coping strategy. In the skills acquisition and rehearsal phase, patients are taught coping skills. Finally, in the application and follow-through phase, therapists encourage patients to apply the newly learned skills to a variety of stressful situations.¹⁸

Treatments using imaginal and in vivo exposure rely on the process of habituation by presenting patients with an anxiety-producing stimulus with the goal of reducing the emotional impact of that stimulus.¹⁹ When the exposure procedure is carried out in a real life situation, it is called in vivo exposure. When in vivo exposure is not possible, therapists instruct patients to imagine the stress-producing situation using imaginal exposure techniques.

CPT was designed specifically for the treatment of rape victims.¹⁷ This treatment draws on cognitive information processing theory, which describes how trauma can create conflicts between pre-existing schemas and the rape experience, causing patients to either (1) assimilate new information into their current schemas: “Good things happen to good people and bad things happen to bad people. I was raped, thus, I must have deserved it;” or (2) to accommodate the trauma information in a maladaptive way: “I thought the world was a

safe place, but this horrible thing happened to me. Therefore, the world is a completely dangerous place.” In this type of treatment, therapists educate patients about the effects of trauma and the information processing theory. They then instruct patients to write about the traumatic event and to read their accounts out loud during the treatment session, exposing them to the traumatic material.

METHODS

Each VAMC has an identified MST coordinator who is in charge of coordinating screening for MST. Many MST coordinators also organize treatment programs for MST-related conditions (for example, PTSD, depressive disorders, anxiety problems, or sexual dysfunctions), offer treatment for these conditions, and/or refer patients to appropriate providers. Using a national list, we contacted each VAMC’s MST coordinator through e-mail and invited him or her to participate in an online survey about the MST services available at his or her facility during the last 12 months.

Our survey was based on the survey conducted in 1995, but we added questions to obtain additional information.¹⁶ Specifically, we asked participants about the sources of referrals for MST services, the number of patients referred to the program, the organization of their MST program, the types of mental health and medical services offered to MST patients, the barriers to providing services, the average waiting time for first appointment, the assessment used, and future plans for additional treatments. Most of the questions allowed participants to select 1 or several provided choices and to supply additional information not covered by the choices available.

We conducted the survey using a Web-based survey service (www.surveymonkey.com). The site instructed

participants to follow a link and complete the online questionnaire. (The survey was accessible only to study participants.) We initially contacted the MST coordinators in December 2005 to invite them to complete the survey. We sent a reminder e-mail after 1 month and concluded the study at the end of February 2006. The Salem VA Medical Center’s research and development committee approved the study under exempt protocol because we did not collect any personal information about the participants. No compensation was provided to participants.

RESULTS

We sent the survey to 145 MST coordinators at VAMCs across the country; of these, 89 participants (61%) completed the survey. Six coordinators indicated that they did not wish to participate for a variety of reasons, such as being too busy. The remainder of those we contacted did not respond to the requests to participate in the study.

About half (49%) of respondents indicated that they work as part of an “organized treatment team” (n = 44). Approximately one-quarter of all respondents (n = 21) reported having a specific MST treatment team at their facility. Others who are part of an organized team work with a mental health outpatient team, a women’s stress disorder treatment program, a women’s health team, or a PTSD clinical team (PCT).

The purpose and function of each organized team varied. Of those with a treatment team, roughly 70% (n = 29) hold staff meetings, which are used for administrative and interdisciplinary case management (86.2%), team support and education (86.2%), staffing of new patients (82.8%), and peer supervision (55.2%). In addition, a small pro-

Table 1. Service differences between VAMCs^a with and without a treatment team

	VAMCs with treatment team	VAMCs without treatment team	<i>t</i> test
Male clients per week, mean (SD), no.	13.0 (13.6)	4.5 (4.6)	<i>t</i> (51) = 3.073, <i>p</i> < .01
Female clients per week, mean (SD), no.	31.5 (32.2)	9.7 (8.1)	<i>t</i> (54) = 3.482, <i>p</i> < .01
New male referrals per year, mean (SD), no.	22.3 (23.1)	8.9 (11.3)	<i>t</i> (53) = 2.743, <i>p</i> < .01
New female referrals per year, mean (SD), no.	50.7 (49.2)	21.9 (24.0)	<i>t</i> (55) = 2.765, <i>p</i> < .01
Waiting time for new referrals, mean (SD), days	16.7 (9.2)	15.8 (11.9)	<i>t</i> (61) = 0.334, <i>p</i> = .740

^aVAMCs = VA medical centers.

portion of respondents with teams (10.3%) indicated that they use these meetings for other purposes, including program development, planning, and staffing for patients experiencing problems. On average, the teams hold about 25 meetings per year (SD = 19.77, with 1 outlier of 350 removed). Many teams also meet regularly with various health professionals, including staff of women's health care clinics (38.6%) and psychiatric treatment providers (36.4%).

For most VAMCs, the MST coordinator's position falls under women's services (24%) or general outpatient services (35%). Approximately one-third fall under another program, including a PCT (8%), or within behavioral health, nursing, social work, or psychology (22% total).

We asked respondents how many patients they see each week (male and female), the number of new patient referrals (male and female), and the wait time for new patients (Table 1). Overall, an average of 54 new veterans are referred per year and 30 veterans are seen per week. Responses ranged widely, however, with some facilities reporting no referrals or seeing only 1 patient per week, while others have as many as 317 new cases per year and see 200 patients per week. The average wait time for an initial appointment is 16 days, with a range from 0 to 45 days.

On average, VAMCs see fewer males (mean, 8.8) than females (mean, 20.6) per week. Similarly, more women are referred for MST services per year than men (mean, 36.3 vs 15.6, respectively). Independent samples *t* tests indicate that VAMCs with a treatment team see significantly more male and female patients each week (mean, 44.6) than VAMCs without a treatment team (mean, 14.2). Further, the number of both men and women referred for MST services is significantly higher at VAMCs with a treatment team than those without a treatment team (mean, 73 vs 30.8, respectively). Waiting times for newly referred patients did not differ significantly between VAMCs with or without a treatment team.

According to independent samples *t* tests, fewer total patients (male and female) are seen at VAMCs where the MST coordinator is located in women's services than in other VAMCs. More specifically, women's services VAMCs, on average, see 2.4 male patients and 10.9 female patients per week compared with an average of 10 men and 23 women per week at other VAMCs. In addition, significantly fewer male referrals are made at these women's services VAMCs (mean, 7.7) compared with other VAMCs (mean, 17.7). Interestingly, we found no significant difference be-

tween the average number of patients referred for MST services at these 2 types of VAMCs.

We also asked participants about specific services that are offered to MST patients at their facilities (Table 2). The treatments offered most often are psychoeducation (82.4%), anxiety management or relaxation skills training (86.5%), cognitive behavioral therapy (CBT) (83.8%), and supportive therapy (91.9%). In addition, many facilities offer specialized treatments, such as CPT (66.2%), dialectical behavior therapy (DBT) (43.2%), eye movement desensitization and reprocessing (EMDR) therapy (32.4%), and exposure therapy (40.5%). About half of VAMCs use psychodynamic (44.6%) or interpersonal therapy (52.7%) approaches. Finally, many facilities have added treatments targeting specific symptoms and issues, such as a focus on nightmares and sleep (37.8%) or intimacy issues (52.7%). VAMCs with a treatment team offer significantly more services than those without a treatment team.

Participants in the study also indicated the kinds of services they plan to offer in the future. Most often reported were group treatments for men, including groups for CBT (9%), psychoeducation (6.7%), psychodynamic therapy (6.7%), and interpersonal therapy (6.7%). No

Table 2. MST^a services offered at VAMCs^b

Treatments	All VAMCs, % (n = 74) ^c	VAMCs with treatment team, % (n = 36)	VAMCs without treatment team, % (n = 38)
EMDR ^d	32.4	38.9	26.3
DBT ^e	43.2	52.8	34.2
Exposure therapy	40.5	55.6	26.3
CPT ^f	66.2	72.2	70.5
CBT ^g	83.8	88.9	78.9
Psychoeducation	82.4	88.9	76.3
Relaxation	86.5	86.1	86.8
Supportive therapy	91.9	97.2	86.8
Psychodynamic therapy	44.6	55.6	34.2
Interpersonal therapy	52.7	52.8	52.6
Sleep/nightmare reduction	37.8	47.2	28.9
Intimacy issues treatment	52.7	52.8	52.6
Other	14.9	16.7	13.2

^aMST = military sexual trauma. ^bVAMCs = VA medical centers. ^c15 participants of the total 89 did not respond to the question about services offered. ^dEMDR = eye movement desensitization and reprocessing. ^eDBT = dialectical behavior therapy. ^fCPT = cognitive processing therapy. ^gCBT = cognitive behavioral therapy.

participants plan to offer either individual or group DBT or exposure therapy to men, and only a few plan to add these services for women (1% to 2%).

We also investigated how many empirically supported treatments VAMCs offer for MST patients. For the purposes of this study, empirically supported treatments include EMDR therapy, DBT, exposure therapy, CPT, and CBT, offered either individually or in a group setting. The average number of empirically supported treatments offered was 6.4. An independent samples *t* test indicates that sites with a treatment team offer significantly more empirically supported treatments than those without a team (mean, 7.4 vs 5.4, respectively). The number of services offered to men and women also differ among facilities. Overall, VAMCs offer more services to women (mean, 10.3) than to men (mean, 8.0).

The MST coordinators responding to this study also identified specific barriers to providing MST services at their facilities. About half of the respondents saw lack of time to design a program and lack of staff as significant barriers (53.9% and 51.7%, respectively). Other barriers included lack of staff training (37.1%), lack of administrative support (33.7%), and lack of screenings and referrals (18%), which result when medical providers do not consistently ask patients about experiencing MST (screening) or do not refer those with positive screens.

When we examined responses about perceived barriers based on whether or not a facility has a treatment team, differences emerged between those that do have a team and those that do not (Table 3). Although the biggest barrier for facilities with a treatment team appears to be lack of staff (cited by 45.5% of VAMCs), this deficiency was cited by an even

larger proportion (57.8%) of VAMCs without a treatment team. For VAMCs without a treatment team, the other most significant barriers included lack of time to design a program (68.9%), lack of staff training (46.7%), and lack of administrative support (44.4%). We also analyzed the total number of barriers identified by the participants. Respondents from VAMCs with a treatment team identified fewer barriers than those from VAMCs without a treatment team (mean, 1.7 vs 2.6, respectively).

DISCUSSION

Since the last survey of MST services, awareness of MST has grown, especially among male veterans. Indeed, Congress has extended MST benefits to include all veterans, not just women. The goals of this study were (1) to determine whether VA services have adapted or expanded since the initial survey in 1995, (2)

Table 3. Barriers to providing MST^a services

Barrier	VAMCs ^b with treatment team, %	VAMCs without treatment team, %
Lack of staff	45.5	57.8
Lack of time to design program	38.6	68.9
Lack of staff training	27.3	46.7
Lack of administrative support	22.7	44.4
Lack of screenings and referrals	15.9	20.0
Other	13.6	20.0

^aMST = military sexual trauma. ^bVAMCs = VA medical centers.

to determine what kinds of services are currently being offered to veterans who have experienced MST, (3) to identify barriers that are interfering with the provision of MST services in VAMCs, and (4) to evaluate any disparities in treatments offered to men and women.

Our findings indicate that at about half of the VAMCs represented in the sample, practitioners treating MST patients work as part of a treatment team. These results are comparable to those of the previous survey where 51% of the VAMCs represented worked as part of a treatment team.¹⁶ Overall, we found more MST patients currently are being served than were in the past. With regard to types of services offered to MST patients, VAMCs with a treatment team offer more empirically supported and other treatments. This is understandable because facilities without a treatment team are more likely to have a single provider, who would be unable to handle as large a workload as a team. It is also interesting to note that participants do not plan on much expansion of their treatment offerings in the future. This may be because of the perceived barriers to providing services to this population.

This study's findings suggest that VAMCs with treatment teams are able to see more patients and provide

more services to veterans than those without treatment teams. While still reporting barriers to offering treatments, VAMCs with treatment teams seem better equipped to respond to the needs of the MST patient population, both male and female.

Our results also demonstrate a significant disparity between services VAMCs offer to men and women. While VA surveillance data indicate that more than half of all veterans who screen positive for MST are men, more female patients are referred for services than male patients, according to our study. In fact, our data indicate that 2.4 times more female than male veterans are referred for MST services. The data also suggest that significantly more empirically supported treatments are offered to women than men who report experiencing MST.

The reason for these disparities is unclear, though we can posit several plausible hypotheses. First, practitioners may not be aware of MST services for men, especially in those VAMCs where MST coordinators are housed in women's services. In fact, our data suggest that at VAMCs where the MST coordinator is within women's services, significantly fewer men are referred for services and are seen each week than at facilities where the MST coordinator is housed in another ser-

vice line. Second, the MST movement originated with a need to serve female veterans. Coordinators may need to adapt their services, brochures, and educational materials to ensure that men who have experienced MST are referred for services and that specialized services are made available for these veterans. Third, just as women often do not feel comfortable attending treatments targeting men, men who have experienced MST may not feel comfortable attending treatments targeting primarily women. Facilities may need to offer gender specific treatments for men and women who have experienced MST. Fourth, men may be more likely to refuse referrals for MST-related services. Educating providers on how to speak with male veterans about sexual trauma may increase the likelihood that men will accept referrals.

Study Limitations

Some findings of this study should be interpreted with caution. Our collected data are based on self-report information provided by MST coordinators at different VAMCs and were not verified through any outside sources. The findings may, therefore, be subject to biases. In addition, the information presented represents only the facilities that responded and are not necessarily representative of

all VAMCs. Also, we did not provide respondents with definitions of the various types of treatments, so different participants who indicated that a certain type of service is provided at their facility may not always have been referring to the same treatment. Future research should include clear definitions of treatments to ensure accurate conclusions.

CONCLUSIONS

Our study provides a snapshot of the VA's MST programs for men and women as well as important directions for future funding, training, and research. Although the federal government and the VA now recognize that MST is an important problem that requires attention, our findings show that additional administrative, staffing, and training support are needed.

Of note, the VA has recently begun a national rollout initiative of evidence-based practices to enhance training of VA mental health personnel regarding use of treatments for PTSD. In addition, the VA's Office of Mental Health Services established an MST support team in 2007, which promotes best practices of care for MST.²⁰ The support team offers training for MST coordinators and may help staffs who function without a team to receive some administrative guidance and to develop knowledge and expertise in best practices. The effects of the funding and establishment of this support team on the use of empirically supported treatments, the existing disparities in treat-

ments, and the current barriers to MST treatment will be worthy of investigation. ●

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