

Female Veterans' Experiences With VHA Treatment for Military Sexual Trauma

Sara Cichowski, MD; Malia Ashley; Orlando Ortiz, MD; and Gena Dunivan, MD

Provider validation and support for females' experiences as well as a range of therapies are essential treatments for female veterans with military sexual trauma.

Females are the fastest growing population to seek care at the Veterans Health Administration (VHA).¹ Based on a 2014 study examining prevalence of military sexual trauma (MST), it is estimated that about one-third of females in the military screen positive for MST, and the rates are higher for younger veterans.² Military sexual trauma includes both rape and any sexual activity that occurred without consent; offensive sexual remarks or advances can also represent MST. The issue of MST, therefore, is an important one to address adequately, especially for female veterans who are screened through the VHA system.

Since 1992, the VHA has been required to provide services for MST, defined as "sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military."³ Despite this mandate, it has taken many years for all VHA hospitals to adopt recommended screening tools to identify survivors of MST and give them proper resources. Only half of VHA hospitals adopted screening 6 years after the policy change.⁴ In addition, the environment in which the survivors receive MST care may trigger posttraumatic stress symptoms as many of the other patients seeking care at the VHA hospital resemble the perpetrators.⁵ Thus, up to half of females who report a history of MST do not receive care for their MST through the VHA.⁶

Having a history of MST significantly increases the risks of developing mental health disorders, including posttraumatic stress disorder (PTSD), major depressive disorder, generalized anxiety disorder, and

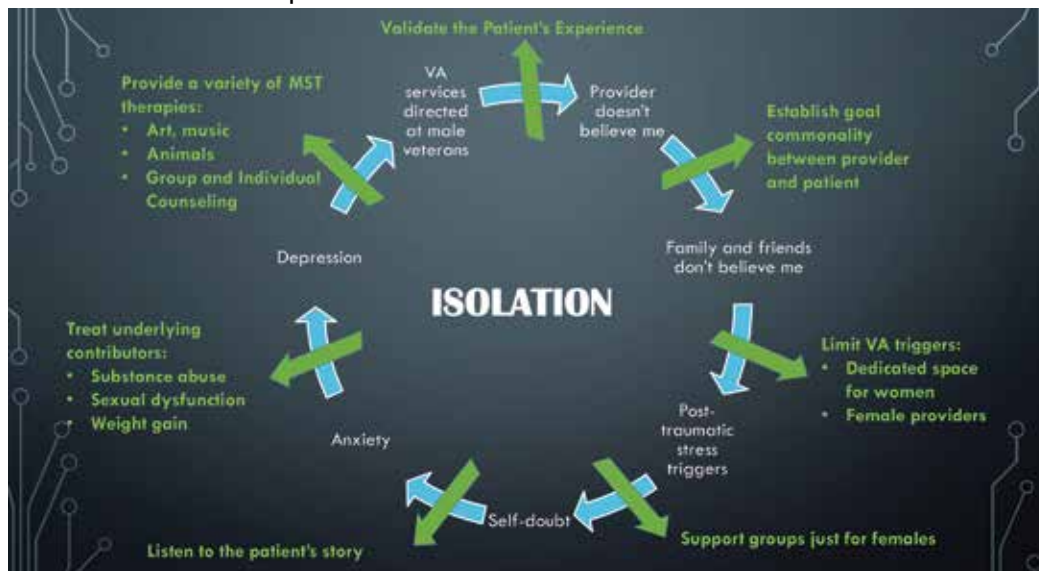
suicidal ideation.² This group also has overall decreased quality of life (QOL). Female veterans have increased sexual dysfunction and dissatisfaction, which is heightened with a history of MST.⁷ Addressing MST requires treatment of all aspects of life affected by MST, such as mental health, sexual function, and QOL. The quality of treatment for MST through VHA hospitals deserves attention and likely still requires improvement with better incorporation of the patient's perspective.

Qualitative research allows for incorporation of the patient's perspective and is useful for exploring new ideas and themes.⁸ Current qualitative research using individual interviews of MST survivors focuses more on mental health treatment modalities through the VHA system and how resources are used within the system.^{9,10} While it is important to understand the quantity of these resources, their quality also should be explored. Research has identified unique gender-specific concerns such as female-only mental health groups.¹⁰ However, there has been less focus on how to improve current therapies and the treatment modalities (regardless of whether it is a community service or at the VHA system) females find most helpful. There is a gap in understanding the patient's perspective and assessment of current MST treatments as well as the unmet needs both within and outside of the VHA system. Therefore, the purpose of this study is 2-fold: (1) examine the utilization of VHA services for MST, as well as outside services, through focus-group sessions; and (2) to offer specific recommendations for improving MST treatment for female veterans from the patient's perspective.

Sara Cichowski is a Female Pelvic Medicine and Reconstructive Surgeon at New Mexico VA Health Care System and University of New Mexico. **Malia Ashley** is a Medical Student, **Orlando Ortiz** is a Resident Physician in psychiatry, and **Gena Dunivan** is a Female Pelvic Medicine and Reconstructive Surgeon, all at the University of New Mexico in Albuquerque.

Correspondence:
Sara Cichowski (sara.cichowski@va.gov)

FIGURE. MST Conceptual Framework



Abbreviation: MST, military sexual trauma.

METHODS

After obtaining institutional review board approval (16-H192), females who screened positive for a history of MST, using the validated MST screening questionnaire, were recruited from the Women’s Continuity Clinic, Urology clinic, and via a research flyer placed within key locations at the New Mexico Veterans Affairs (VA) Health Care System (NMVAHCS).¹¹ Inclusion criteria were veterans aged > 18 years who could speak and understand English. Those who agreed to participate attended any 1 of 5 focus groups. Prior to initiation of the focus groups, the investigators generated a focus-group script, including specific questions or probes to explore treatment, unmet needs (such as other health conditions the veteran associated with MST that were not being addressed), and recommendations for care improvement.

Subjects granted consent privately prior to conduction of the focus group. Each participant completed a basic demographic (age, race, ethnicity) and clinical history (including pain conditions and therapy received for MST). These characteristics were evaluated with descriptive statistics, including means and frequencies.

The focus groups took place on the NM VAHCS Raymond G. Murphy VA Medi-

cal Center campus in a private conference room and were moderated by nonmedical research personnel experienced in focus-group moderation. Focus groups were recorded and transcribed. An iterative process was used with revisions to the script and probe questions as needed. Focus groups were planned for 2 hours but were allowed to continue at the participants’ discretion.

The de-identified transcripts were uploaded to the web-based qualitative engine Dedoose 6.2.21 software (Los Angeles, CA) and coded. Using grounded theory, the codes were grouped into themes and subsequently organized into emergent concepts.^{8,12} Following constant comparative methodology, ideas were compared and combined between each focus group.^{8,13} After completion of the focus groups, the generated ideas were organized and refined to create a conceptual framework that represented the collective ideas from the focus groups.

RESULTS

Between January and June 2017, 5 focus groups with 17 participants were conducted; each session lasted about 3 hours. The average age was 52 ± 8.3 years, and were from a diverse racial and ethnic

background. Most reported that > 20 years had passed since the first MST, and care-seeking for the first time was > 11 years after the trauma, although symptoms related to the MST most frequently began within 1 year of the trauma (Table 1). The majority (11/17) had participated in some sort of traditional treatment for MST, such as medications, group therapy and/or private counseling. Many females were using alternative therapies for treating pain conditions associated with MST (Table 2).¹⁴

PRELIMINARY THEMES

The Trauma

Focus-group participants noted improved therapies offered by the VA but challenges obtaining health care:

“...because I’m really trying to deal with it and just be happy and get my joy back and deal with the isolation.”

“Another way that the memories affected me was barricading myself in my own house, starting from the front door.”

Male-Dominated VA

Participants also noted that, along with screening improving the system, dedicated female staff and service connection are important:

“The Womens Clinic is nice, and it’s nice to know that I can go there and I’m not having to discuss everything with men all over the place.”

“The other thing... that would be really good for survivors of MST, is help with disability.”

While the focus-group participants found dedicated women’s clinics helpful and providing improved care, the overall VA environment remains male-dominated:

“Because it’s really hard to relax and be vulnerable and be in your body and in your emotions if there’s a bunch of penises around. When I saw these guys on the floor I’m like, I ain’t going in there.”

This male-dominated sense also incorporated a feeling of being misunderstood by a system that has traditionally cared for male veterans:

“People don’t understand. They think, oh, you’re overreacting, but they don’t know what it feels like to be inside.”

TABLE 1 Patient Demographics

Demographics	Study Participants
Age, mean, (SD)	52 (8.3)
Race/ethnicity, No. (%)	
Non-Hispanic white	7 (41)
Hispanic	5 (29)
American Indian	4 (24)
Black	1 (6)
Language, No. (%)	
English primary language	15 (88)
Spanish primary language	2 (12)
Relationship status, No. (%)	
Single	13 (76)
In a stable relationship	4 (24)
Currently sexually active, No. (%)	4 (24)
History of hysterectomy, No. (%)	7 (41)
Time since symptoms first started, y (SD)	25.4 (12.7)
First time receiving treatment for MST, y (SD)	11.8 (9.52)
Medical conditions reported, No. (%)	
PTSD	15 (88)
Depression/bipolar disorder	14 (82)
Anxiety	13 (76)
Chronic back pain	12 (71)
Overactive bladder	7 (41)
Chronic abdominal pain	6 (35)
IBS	4 (24)
Migraines	4 (24)
Chronic pelvic pain	4 (24)
Chronic headaches	3 (18)
Fibromyalgia	2 (12)
Neurologic conditions	1 (6)
Interstitial cystitis	1 (6)

Abbreviations: IBS, irritable bowel syndrome; MST, military sexual trauma; PTSD, posttraumatic stress disorder.

“I wouldn’t say they treat you like a second citizen, but it’s like almost every appointment I go to that’s not in the Women’s Clinic, the secretaries or whatever will be like ‘Oh, are you looking for somebody, or..’

Assumption Females Are Not Veterans

“There was an older gentleman behind me, they were like ‘Are you checking him in?’ I said, ‘I’m sure he’ll check himself in, but I’m checking myself in.’”

Participants also reported that there is an assumption that you’re not a veteran when you’re female:

“All of the care should be geared to be the same. And we know we need to recognize that men have their issues, and women will have their issues. But we don’t need to just say ‘all women have this issue, throw them over there.’”

Self-Doubt

“The world doesn’t validate rape, you asked for it, it was what you were wearing, it was what you said.”

Ongoing efforts to have female-only spaces, therapy groups, and support networks were encouraged by all 5 focus groups. These themes, provided the foundation for emergent concepts regarding patients’ perceptions of their treatment for MST: (1) Improvement has been slow but measurable; (2) VA cares more about male veterans; (3) The isolation from MST is pervasive; (4) It’s hard to navigate the VA system or any health care when you’re traumatized; and (5) Sexual assault leaves lasting self-doubt that providers need to address.

Isolation

Because there are barriers to seeking care the overarching method for coping with the effects of MST was isolation.

Overcoming the isolation was essential to seeking any care. Participants reported years of living alone, avoiding social situations and contexts, and difficulty with basic tasks because of the isolation.

“That the coping skills, that the isolation is a coping skill and all these things, and that I had to do that to survive.”

Lack of family and provider support and the VHA’s perceived focus on male veterans perpetuated this sense of isolation. Additionally, feeding the isolation were other maladaptive behaviors, such as alcoholism, weight gain, and anger.

“I was always an athlete until my MST, and I still find myself drinking whisky and wanting to smoke pot. It’s not that I want to, I guess it gives me a sense of relief, because my MST made me an alcoholic.”

Participants reported that successful treatment of MST must include treatment of other maladaptive behaviors and specific provider-behavior changes.

At times, providers contribute to female MST survivors’ feeling undervalued:

“I had an hour session and she kept looking at her watch and blowing me off, and I finally said, okay, I’m done, good-bye, after 45 minutes.”

Validation

Participants’ suggestions to improve MST treatment, including goal sharing, validation, knowledge, and support:

*“They should have staff awareness groups, or focus groups to teach them the same thing that the patients are receiving as far as how to handle yourself, how to interact with others. Don’t bring your sh** from home into your job. You’re an employee, don’t take it personal.”* (eAppendix, available at mdedge.com/fedprac)

The need for provider-level support and validation likely stems from the sense that many females expressed that MST was their fault. As one participant said,

“It wasn’t violent for me. I froze. So that’s another reason that I feel guilty because it’s like I didn’t fight. I just froze and put up with it, so I feel like jeez it was my fault. I didn’t... Somehow I am responsible for this.”

Thus, the groups concluded that the most powerful support was provider validation:

“The most important for me was that I was told it was not my fault. Over and over and over. That is the most important thing that us females need to know. Because that is such a relief and that opened up so much more.”

At all of the focus groups, female veterans reported that physician validation of the assault was essential to healing. When providers communicated validation, the women experienced the most improvement in symptoms.

Therapies for MST

A variety of modalities was recommended as helpful in coping with symptoms associated with MST. One female noted her therapy dog allowed her to get her first Papanicolaou (Pap) smear in years:

“Pelvic exams are like the seventh circle of hell. Like, God, you’d think I was being abducted by aliens or something. Last time, up here, they let me bring my little dog, which was extraordinarily helpful for me.”

For others, more traditional therapy such as prolonged exposure therapy or cognitive behavioral therapy, was helpful.

“After my prolonged exposure therapy; it

saved my life. I'm not suicidal, and the only thing that's really, really affected is sometimes I still have to sleep with a night light. Over 80% of the symptoms that I had and the problems that I had were alleviated with the therapy."

Other veterans noted alternative therapies as beneficial for overcoming trauma:

"Yoga has really helped me with dealing with chronic pain and letting go of things that no longer serve me, and remembering about the inhale, the exhale, there's a pause between the exhale and an inhale, where that's where I make my choices, my thoughts, catch it, check it, change it, challenge my thoughts, that's really, really helped me."

From these concepts, and the specific suggestions female veterans provided for improvement in care, we developed a pictorial conceptual framework of the results. In this framework, isolation is perpetuated by mental health, lack of support (both from society and the VA), and self-doubt. Patient recommendations to break this cycle based on focus-group coding could disrupt the cycle of isolation (Figure).

DISCUSSION

This qualitative study of the quality of MST treatment with specific suggestions for improvement shows that the underlying force impacting health care in female survivors of MST is isolation. In turn, that isolation is perpetuated by personal beliefs, mental health, lack of support, and the VHA culture. While there was improvement in VHA care noted, female veterans offered many specific suggestions—simple ones that could be rapidly implemented—to enhance care. Many of these suggestions were targeted at provider-level behaviors such as validation, goal setting, knowledge (both about the military and about MST), and support.

Previous work showed that tangible (ie, words, being present) support rather than broad social support only generally helps reduce posttraumatic stress symptoms.¹⁵ These researchers found that tangible support moderated the relationship between number of lifetime traumas and PTSD. Schumm and colleagues also found that high social support predicted lower PTSD severity for inner-city women who exper-

TABLE 2 Patient-Reported Treatments for Chronic Pain Conditions Associated With MST

Therapy	Presently Using, No. (%)
Medications	11 (65)
Physical therapy	9 (53)
Tai chi	6 (35)
Yoga	5 (29)
Acupuncture	5 (29)
Chiropractic	4 (24)
Nerve blocks	3 (18)
Elimination diet	2 (12)

Abbreviation: MST, military sexual trauma; VA, US Department of Veterans Affairs.

rienced both child abuse and adult rape.¹⁶ A prior meta-analysis found social support was the strongest correlate of PTSD (effect size = 0.4).¹⁷

Our finding that female MST survivors desire verbal support from physicians may point to the inherent sense that validation helps healing, demonstrated by this meta-analysis. Importantly, the focus group participants did not specify the type of physician (psychiatrist, primary care provider, gynecologist, surgeon, etc) who needed to provide this support. Thus, we believe this suggestion is applicable to all physician interactions when the history of MST comes up. Physicians may be unaware of their profound impact in helping women recover from MST. This validation may also apply to survivors of other types of sexual trauma.

A second simple suggestion that arose from the focus groups was the need for broader options for MST therapy. Current data on the locations female veterans are treated for MST include specialty MST clinics, specialty PTSD clinics, psychosocial rehabilitation, and substance use disorder clinics, showing a wide range of settings.¹⁸ But female veterans are also asking for more services, including animal therapy, art therapy, yoga, and tai chi. While it may not be possible to offer every resource at every VHA facility, partnering with community services may help fulfill this veteran need.

The advent of telehealth may also help address female veterans' concerns about being surrounded by male patients and should be further explored.

The focus groups' third suggestion for improvement in MST was better treatment for the health problems associated with sexual trauma, such as chronic pelvic pain, sexual dysfunction, and weight gain. It is important to note that the female veterans provided this list of associated health conditions from the broader facilitator question "What health problems do you think you have because of MST?" Females correctly identified common sequelae of sexual abuse, including pelvic pain and sexual dysfunction.^{14,19} Weight gain and obesity have been associated with childhood sexual trauma and abuse, but they are not well studied in MST and may be worth further exploration.^{20,21}

Limitations

There are several inherent weaknesses in this study. The female veterans who agreed to participate in the focus group may not be representative of the entire population, particularly as survivors may be reluctant to talk about their MST experience. The participants in our focus groups were most commonly 2 decades past the MST and their experience with therapy may differ from that of women more recently traumatized and engaged in therapy. However, the fact that many of these females were still receiving some form of therapy 20 years after the traumatic event deserves attention.

Recall bias may have affected how female veterans described their experiences with MST treatment. We did not inquire about the timing of therapy and whether they sought VA care first, followed by community care, or vice versa. Finally, although the data were analyzed separately by 3 investigators, biases in data analysis may arise with qualitative methods.

Strengths of the study included the inherent patient-centered approach and ability to analyze data not readily extracted from patient records or validated questionnaires. Additionally, this qualitative approach allows for the discovery of patient-driven ideas and concerns. Our focus groups also contained a majority of

minority females (including Hispanic and American Indian) populations that are frequently underrepresented in research.

CONCLUSION

Our data show there is still substantial room for improvement in the therapies and in the physician-level care for MST. While each treatment experience was unique, the collective agreement was that multimodal therapy was beneficial. However, the isolation that often comes from MST makes accessing care and treatment challenging. A crucial component to combating this isolation is provider validation and support for the female's experience with MST. The simple act of hearing "I believe you" from the provider can make a huge impact on continuing to seek care and overcoming the consequences of MST.

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the US Government, or any of its agencies.

References

1. Rossiter AG, Smith S. The invisible wounds of war: caring for women veterans who have experienced military sexual trauma. *J Am Assoc Nurse Pract*. 2014;26(7):364-369.
2. Klingensmith K, Tsai J, Mota N, et al. Military sexual trauma in US veterans: results from the national health and resilience in veterans study. *J Clin Psychiatry*. 2014;75(10):e1133-e1139.
3. US. Department of Veterans Affairs, Veteran Health Administration. Military sexual trauma. https://www.publichealth.va.gov/docs/vhi/military_sexual_trauma.pdf. Published January 2004. Accessed July 16, 2018.
4. Suris AM, Davis LL, Kashner TM, et al. A survey of sexual trauma treatment provided by VA medical centers. *Psychiatr Serv*. 1998;49(3):382-384.
5. Gilmore AK, Davis MT, Grubaugh A, et al. "Do you expect me to receive PTSD care in a setting where most of the other patients remind me of the perpetrator?": home-based telemedicine to address barriers to care unique to military sexual trauma and veterans affairs hospitals. *Contemp Clin Trials*. 2016;48:59-64.
6. Calhoun PS, Schry AR, Dennis PA, et al. The association between military sexual trauma and use of VA and non-VA health care services among female veterans with military service in Iraq or Afghanistan. *J Interpers Violence*. 2018;33(15):2439-2464.
7. Rosebrock L, Carroll R. Sexual function in female veterans: a review. *J Sex Marital Ther*. 2017;43(3):228-245.
8. Glaser BG, Strauss AL. *The Discovery of Grounded Theory. Strategies for Qualitative Research*. http://www.sxf.uevora.pt/wp-content/uploads/2013/03/Glaser_1967.pdf. Published 1999. Accessed July 16, 2018.
9. Kelly MM, Vogt DS, Scheiderer EM, et al. Effects of military trauma exposure on women veterans' use and perceptions of Veterans Health Administration care. *J Gen Intern Med*.

- 2008;23(6):741-747.
10. Kehle-Forbes SM, Harwood EM, Spont MR, et al. Experiences with VHA care: a qualitative study of U.S. women veterans with self-reported trauma histories. *BMC Women Health*. 2017;17(1):38.
 11. McIntyre LM, Butterfield MI, Nanda K. Validation of trauma questionnaire in Veteran women. *J Gen Int Med*;1999;14(3):186-189.
 12. Pope C, Ziebland S, Mays N. Analysing qualitative data. *BMJ*. 2000;320:114-116.
 13. Maykut PMR. *Beginning Qualitative Research. A Philosophical and Practical Guide*. London, England: The Falmer Press; 1994.
 14. Cichowski SB, Rogers RG, Clark EA, et al. Military sexual trauma in female veterans is associated with chronic pain conditions. *Mil Med*. 2017;182(9):e1895-e1899.
 15. Glass N, Perrin N, Campbell JC, Soeken K. The protective role of tangible support on post-traumatic stress disorder symptoms in urban women survivors of violence. *Res Nurs Health*. 2007;30(5):558-568.
 16. Schumm JA, Briggs-Phillips M, Hobfoll SE. Cumulative interpersonal traumas and social support as risk and resiliency factors in predicting PTSD and depression among Inner-city women. *J Trauma Stress*. 2006;19(6):825-836.
 17. Ozer EJ, Best SR, Lipsey TL, Weiss DS. Predictors of post-traumatic stress disorder and symptoms in adults: a meta-analysis. *Psychol Bull*. 2003;129(1):52-73.
 18. Valdez C, Kimerling R, Hyun JK, et al. Veterans Health Administration mental health treatment settings of patients who report military sexual trauma. *J Trauma Dissociation*. 2011;12(3):232-243.
 19. Maseroli E, Scavello I, Cipriani S, et al. Psychobiological correlates of vaginismus: an exploratory analysis. *J Sex Med*. 2017;14(11):1392-1402.
 20. Imperatori C, Innamorati M, Lamis DA, et al. Childhood trauma in obese and overweight women with food addiction and clinical-level of binge eating. *Child Abuse Negl*. 2016;58:180-190.
 21. Williamson DF, Thompson TJ, Anda RF, Dietz WH, Feltz V. Body weight and obesity in adults and self-reported abuse in childhood. *Int J Obes Relat Metab Disord*. 2002;26(8):1075-1082.