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CME Article

A Reexamination of Military Sexual Trauma and Posttraumatic Stress Disorder

Meredith L. C. Williamson, PhD; Ryan Holliday, MA; Nicholas Holder, BS; Carol S. North, MD, MPE; and Alina Surís, PhD, ABPP

ABSTRACT

Military sexual trauma (MST) is a term that has been formally defined by the United States Congress. However, policymakers, clinicians, and researchers often use different definitions of the term, which hampers efforts to provide accurate MST prevalence estimates, document its medical and psychological consequences, project need for resources to address the problem, identify cases, and provide appropriate treatment. MST covers unwelcome sexual advances, including sexual harassment and/or sexual assault, experienced by military personnel during military duty. Unfortunately, the term MST can easily be misapplied as a diagnosis, and is sometimes even incorrectly used interchangeably with posttraumatic stress disorder (PTSD). This article clarifies the importance of accurate definitions of MST and PTSD in assessing and managing the mental health consequences of these stressful life events. It also outlines the kinds of problems that may arise from unclear definitions and incorrect application of these constructs. **[*Psychiatr Ann*. 2017;47(3):134-138.]**

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Military sexual trauma (MST) has garnered increased attention in recent years, resulting in efforts to improve assessment and treatment for survivors of MST. However, the existing literature contains gaps in knowledge that have delayed complete understanding of MST, which in turn impairs proper assessment, choice of the most appropriate treatment, and meaningful policymaking. For example, the variability in definitions of MST used by clinicians, researchers, and policymakers has produced large discrepancies in published prevalence rates and practices. Additionally, a common misconception is that all MST qualifies as "Criterion A" trauma as part of established diagnostic criteria for posttraumatic stress disorder (PTSD) in *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*).[1] This error alone has the potential to inflate reported prevalence statistics for PTSD in association with MST, generating inappropriate treatment referrals. This article reviews the available knowledge of MST, identifies important gaps in this knowledge, and provides recommendations to address the many problems emerging in practice and research from these knowledge gaps.

HISTORY OF MST

In 1992, US Senate hearings in the wake of the Navy's "Tailhook" scandal prompted passage of the Veterans Health Care Act of 1992[2] to provide health care funding for female veterans who experienced sexual assault and/or sexual harassment during military service. This federal law was subsequently expanded to include male veterans by the Veterans Health Care Extension Act of 1994.[3] In 2004, the US Congress passed the Veterans Health Program Improvement Act,[4] permanently authorizing the Veterans Health Administration (VHA) to provide MST counseling programs. Federal law defines MST as[5]:

> …psychological trauma, which in the judgment of a VHA 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 was redefined in this law as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."[5]

Despite Congress' explicit definition of MST in the federal laws,[2-5] policymakers, clinicians, and researchers continue to use the term differently. Several systematic reviews have noted considerable inconsistency in the definitions of MST used in different studies.[6-8] Although the conceptualization of MST in some studies is limited to sexual assault or rape, others include any form of sexual harassment (even if not repeated or threatening as defined by Congress in 2004).[6-8] As Surís and Lind[7] have observed, these inconsistent definitions of MST have generated a wide range of prevalence statistics among women from as low as 0.4% to as high as 71% in previous research.

Agreement on prevalence rates of sexual assault and harassment among active duty military and veteran populations has been further compromised by incongruence between the VHA and Department of Defense (DoD) classification systems. The DoD separates sexual harassment and sexual assault, thus providing separate prevalence statistics for the two entities, but the VHA's classification of MST incorporates both entities in a single category, reporting only one combined prevalence figure. In 2002, the VHA instituted universal mandatory screening for MST with the following questions asked of all veterans[9,10]:

> (1) Did you receive uninvited and unwanted sexual attention, such as touching or cornering, pressure for sexual favors, or verbal remarks? (2) Did someone ever use force or the threat of force to have sexual contact with you against your will?

In 2014, the VHA MST screening questions were revised[11,12] to more closely align with the congressional definition of harassment (ie, US Code, Title 38 § 1720D).[5]

> (1) When you were in the military, did you ever receive unwanted, threatening, or repeated sexual attention (for example, touching, cornering, pressure for sexual favors, or inappropriate verbal remarks, etc.)? (2) When you were in the military, did you have sexual contact against your will or when you were unable to say no (for example, after being force or threatened or to avoid other consequences)?

A veteran who responds "yes" to either question is determined to have MST (ie, sexual assault and/or sexual harassment) and is thus eligible for referral for MST-related mental and physical health services free of charge in the VHA or the civilian sector if not easily accessible or available at the closest VHA facility.[9]

This universal screening for MST has generated information about the prevalence of MST by the VHA definition of MST, but separating the prevalence of sexual harassment from that of sexual assault is not possible using the data generated by the VHA screening. The available VHA MST prevalence data is representative only of those veterans who interact with VHA services, and thus the prevalence of MST among veterans not using VHA services for MST is unknown.[13]

THE INTERFACE OF MST AND PTSD

The currently established diagnostic criteria for PTSD in *DSM-5* defines a traumatic event in Criterion A as[1]:

> …exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: direct-

> ly witnessing in person, learning of the event happening to a close family member or friend, or experiencing repeated or extreme exposure to aversive details of the traumatic event. (p. 271)

MST involving attempted or completed sexual assault during military service does qualify as a Criterion A traumatic event; however, MST limited to sexual harassment without immediate threat of injury or death does not qualify as trauma. Therefore, although PTSD can be a natural consequence of MST that involves sexual trauma, not all MST as defined by Congress qualifies as trauma, and thus not all types of MST can potentially lead to PTSD.

Even MST involving a traumatic event, however, does not elevate this entity to the level of a psychiatric diagnosis such as PTSD. PTSD requires, in addition to exposure to a traumatic event, a specific constellation of symptoms in four groups (intrusion, avoidance, negative cognitions and mood, and hyperarousal) that begin after the event and are contextually linked to it.[1,14] Therefore, diagnosis of PTSD requires careful assessment of these symptoms and their relationship to a traumatic event, which will not occur if the clinician or researcher simply assumes that a trauma exposure or MST equates to PTSD. The most obvious potential error is to improperly assume that a history of MST fulfills the trauma criterion for PTSD. An even worse error is to conflate MST with the diagnosis of PTSD, using MST and PTSD interchangeably. The unfortunate results of this error may include incorrect diagnosis, inappropriate treatment, and erroneous prevalence estimates.

MST, PTSD, AND OTHER COMORBIDITIES

Although not all MST survivors have been exposed to a traumatic event or developed PTSD, they are at increased risk for other psychiatric and medical illness; therefore, an exclusive focus on MST and potential for PTSD may overlook these other conditions. Psychiatric disorders most frequently associated with MST include depressive, eating, personality, somatoform, and anxiety disorders. as well as substance use.[7-9,15-19] MST is also associated with suicidal ideation and suicide attempts.[3,15,20] Medical conditions that frequently accompany MST include chronic pain, gastrointestinal dysfunction, cardiovascular disease, respiratory conditions, liver disease, obesity, and genitourinary problems.[7-9,15-17] MST is further associated with poor health functioning and quality of life.[7,18] Survivors of MST may also experience distress that is appropriate to the experience of MST and not of diagnostic proportions; regardless, they may experience various psychosocial concerns such as shame, decreased self-esteem, and relationship difficulties.[8,10,15,21] It should not be overlooked that a portion of MST survivors are resilient and do not develop new psychiatric or medical illness after the experience.[16]

Because MST can be easily confused with PTSD, clinicians must carefully conduct diagnostic assessments.

RECOMMENDATIONS FOR CLINICIANS

VHA MST services are widely available for military personnel after their discharge from the military. All veterans reporting experiences consistent with the VHA definition of MST in any VHA setting can receive MST-related treatment, which is specifically noted in the medical record, alerting all providers (psychiatric or medical) treating the veteran of the veteran's MST status. As is common with psychiatric illness, MST carries a negative stigma. This is of particular importance in the VHA system, where all medical providers have full access to all of their patients' psychiatric records. Patients with the MST "label," like many patients with psychiatric disorders, may find their medical complaints discounted by clinicians in medical settings. Because many clinicians have little understanding of MST, they may not differentiate different types of MST, and thus not provide the most appropriate treatment for the individual veteran's history. For example, a veteran who experienced verbal harassment without physical assault may be automatically assumed to be a survivor of rape and inappropriately referred for treatment of PTSD.

Because MST can be easily confused with PTSD, clinicians must carefully conduct diagnostic assessments for PTSD and other psychiatric disorders. There is no method of diagnosing PTSD and other psychiatric disorders without complete assessment of the full diagnostic criteria for these disorders. This can be done by a careful psychiatric clinical interview that assesses all of the criteria, or with structured diagnostic interviews such as the Clinician-Administered PTSD Scale,[22] the Diagnostic Interview Schedule for *DSM-IV*,[23] and the Structured Clinical Interview for *DSM-5*.[24] Diagnostic assessment should not stop with PTSD; however, because PTSD is often comorbid with other disorders, especially mood, anxiety, substance use, sexual dysfunction, and personality disorders,[7,8,9,15-19] and if PTSD is not present, the clinical presentation may be better explained by another diagnosis.

Self-report measures of symptom severity are useful for observing changes in symptom levels over time in patients with psychiatric disorders assessed to meet diagnostic criteria, or for screening patients at risk for psychiatric illness

who will then need a full diagnostic assessment. Symptom screening measures cannot be substituted for psychiatric diagnosis because they do not fully assess diagnostic criteria.[25]

Federal law mandates that all veterans identified as survivors of MST per the VHA's MST Screener be referred for MST-related mental health services.[26] This first requires accurate and full diagnostic assessment, then commencement of treatment appropriate to the disorder(s) diagnosed. Psychotropic medications and psychotherapy for PTSD, major depressive disorder, or other disorders have established efficacy and can be applied for psychiatric disorders accompanying MST. No specialized treatments for psychiatric disorders accompanying MST have been established. Prolonged exposure and cognitive processing therapies are established as useful for civilian sexual assault-related PTSD,[27] and one randomized clinical trial has demonstrated efficacy of cognitive processing therapy for reduction of posttraumatic stress symptoms in veterans with MST-related PTSD.[28]

DISCUSSION

Despite the efforts of government stakeholders (ie, DoD and VHA), policymakers, and researchers to understand MST, inconsistent definitions continue to circulate in the literature and among treatment providers. The result has been an absence of consistent MST prevalence data, misclassification of MST-related conditions, and selection of inappropriate treatment for MST survivors. These errors can be circumvented by use of proper terminology in discussion of clinical material. Precision of language helps keep clinicians and researchers thinking clearly about the different concepts represented by MST and PTSD, reducing the likelihood of confusion about the distinctions in these similar, but different, phenomena.[29] This precision in language, however, is predicated on clear and accurate understanding of the definitions of MST and PTSD, which need to be thoroughly addressed in educational and training programs.

Prolonged exposure and cognitive processing therapies are established as useful for civilian sexual assault-related PTSD.

Precise definitions for MST must differentiate sexual assault from sexual harassment and be applied as part of screening programs instituted in large medical systems, such as the VHA, to provide meaningful and accurate prevalence rates of MST. Additionally, conscientious assessment of psychiatric criteria is required to identify MST-related PTSD and other MST-related disorders and to determine their prevalence rates. These procedures are needed not only for identification of cases and reporting of prevalence that informs the amount of resources needed to address the problem, but also, and more importantly, for providing the best treatment appropriate for MST-related illness.

Future research is needed to examine the generalizability of VHA prevalence rates of MST within the larger veteran population who do not access VHA MST-related services to illuminate the types and amount of MST-related problems among veterans who are as-yet unidentified. With accurate prevalence estimates of MST-related illness, future efforts can focus on more accurate means of identifying cases and on refining evidence-based treatments for MST-related illness. Such efforts can contribute substantially to reducing the physical and mental health burdens on survivors of MST.

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