NORTHERN ILLINOIS UNIVERSITY

Gender Similarities and Differences in Military Sexual Trauma

A Capstone Submitted to the

University Honors Program

In Partial Fulfillment of the

Requirements of the Baccalaureate Degree

With Honors

Department Of

Psychology

By

Megan Boehning

DeKalb, Illinois

5/11/19
University Honors Program
Capstone Approval Page

Capstone Title (print or type)
Gender Similarities and Differences in Military Sexual Trauma

Student Name (print or type) ___Megan Boehning

Faculty Supervisor (print or type) __michelle m. lilly

Faculty Approval Signature __[Signature]

Department of (print or type) ___Psychology

Date of Approval (print or type) ___11/9/18

Completed Honors Capstone projects may be used for student reference purposes, both electronically and in the Honors Capstone Library (CLB 110).

If you would like to opt out and not have this student's completed capstone used for reference purposes, please initial here: ______ (Faculty Supervisor)
GENDER SIMILARITIES AND DIFFERENCES IN MST

Abstract

While treatment and knowledge of military sexual trauma has improved, there are still issues in understanding MST and how well victims adjust. There are various consequences that affect MST survivor’s lives, including health, psychological, and lifetime implications. Though men and women both face many of the same outcomes of MST, they also endure gender-specific sequelae. This manuscript will examine the similarities and differences in barriers, symptoms, and treatment for men and women service members. Much of the research that is presented in this paper includes meta-analyses as well as singular studies. The main demographics in the studies tend to be Caucasian men and women who served in the army, were between the ages of thirty and fifty, and were either married or separated/divorced. The major findings suggest that men and women appear to experience mostly the same sequelae but at different magnitudes. To be specific, men are prone to more sexual problems, homelessness, and issues of masculinity and sexuality while women are prone to more chronic pain conditions, higher association of PTSD, and issues with their role as a woman. This information can help people better understand and treat men and women who have experienced military sexual trauma.
Gender Similarities and Differences in Military Sexual Trauma

Military sexual trauma (MST) is a prevalent and debilitating experience that both men and women service members endure at dramatic rates. According to a secondary source in Katz (2015), military sexual trauma is defined as a psychological trauma that results from a physical sexual assault, sexual battery, or sexual harassment, which can be either verbal or physical, and either occurs while on duty or in training. While MST still comes with stigma and secrecy, the occurrence of military sexual trauma was not brought into the public view until 1991 during the Tailhook Association symposium where eighty-three women and seven men were sexually assaulted by more than one hundred Navy and Marine Corps officers (Katz, 2015). This event resulted in the exposure of MST and the emergence of multiple laws. In 1992, Public Law 102-585 was created to help women who experienced sexual trauma while serving on duty by providing counseling and assistance to them for one year (Katz, 2015). This same law was not extended to include men until 1994 when Public Law 103-452 was developed (Katz, 2015).

Several other laws have been introduced in the more recent years including the mandating of universal screening of MST and a designated coordinator for MST at Veteran Administration centers, as well as the ability to either use restricted or unrestricted reporting (Katz, 2015). One of the more recent laws, Title 38 US. Code, was developed in 2014, which allows the inclusion of inactive service members in receiving treatment (Katz, 2015). Since then many more bills have been proposed and put into place (Katz, 2015). From all of this, it may seem like military sexual trauma is an issue that is being minimized and solved; however, there are still many issues that revolve around MST, such as underreporting, prevalence rates, treatment effectiveness, and understanding the difference in experience and adjustment after MST for males and females.
Military sexual trauma remains a very important issue for several reasons. First, victims tend to not report their assault and instead keep quiet for many years. In a secondary source mentioned from Conrad, Young, Hogan, and Armstrong (2013), they reported that 80-90% of MST experiences go unreported. Another study found that 67% of women and 81% of men do not report their experiences of MST (O’Brien, Keith, & Shoemaker, 2015). Given that the majority of men and women do not report, this leads to a barrier in improving knowledge of MST since the statistics may not reflect the true prevalence of cases (Monteith, Gerber, Brownstone, Soberay, & Bahraini, 2018). Similar problems related to prevalence include the definitions that are used to define MST as well as the method of assessment and sample used in research studies (Katz, 2015). Many studies provide different ways of defining military sexual trauma, such as including actual assault or threatened assault along with instances of unwanted sexual behavior or instances of unwanted sexual attention (O’Brien & Sher, 2013). Another major reason for underreporting is due to the rules and guidelines of reporting military sexual trauma. According to a secondary source in Williams and Bernstein (2011), if a victim wants to seek punishment for their perpetrator, they have to make an unrestricted report in which they cannot remain anonymous. On the contrary, if a victim just wants to seek treatment without punishing their attacker, they can make a restricted report and remain anonymous (Williams & Bernstein, 2011). Not having the option to remain anonymous can lead to service members not reporting the MST, and hence a lack of punishment for their perpetrator. Due to underreporting, increased exposure may result in revictimization, and the possibility of higher prevalence than is known (Williams & Bernstein, 2011).

Military Culture
The elevation of sexual assault and harassment in the military can be explained by the culture and the ways soldiers are reinforced and trained. Being a member of the military comes with a lot of regulation and structure, such as strict rules, uniforms, and shared missions, which allows service members to be united while also clarifying who is not a member of the group (Katz, 2015). This intense framework is also tied with violence, as being a soldier requires the ability to commit acts of violence quickly and without thinking, along with the obligated capacity to lose empathy and compassion for enemies (Katz, 2015). Military culture also emphasizes hypermasculinity because men are supposed to be aggressive and tough, which distinguishes what is feminine and unacceptable as a byproduct (Katz, 2015). Violence and hypermasculinity may ultimately foster sexual violence through the acceptance and cultivation of aggression, restricted emotions, rigid ideas of sex roles and norms, and sexual objectification of women (Katz, 2015). Thus, when a soldier assaults a fellow soldier, they are following the military’s fundamental goal of domination through violence especially of those who are weak, which is hard to unlearn (Katz, 2015).

Military culture not only promotes sexual violence, but also creates a grueling environment that puts the victim through even more psychological distress. Regardless of MST, service members go through challenging and unique experiences, such as dealing with extreme stress, seeing and coping with losses of fellow soldiers without proper time to grieve, strict rules, hazing, being outside of normal civilian life, and having no appropriate outlets for ridding frustrations (Katz, 2015). According to a department of defense (DOD) report referenced in Conrad et al. (2013), approximately 97% of MST victims know the perpetrator of their trauma. Directly knowing the perpetrator results in more emotional abuse and can make the victim question whether they were at fault for the MST (Katz, 2015). The victims then have to continue
to live, work, sleep, eat, and even rely on the perpetrator for their safety, which can cause feelings of powerlessness, captivation, isolation, shame, and self-blame (Katz, 2015). MST survivors often experience betrayal trauma because they depend on and are attached to their perpetrator for safety reasons and must continue to do so in order to stay alive (Katz, 2015). This also leads to betrayal from the military as an institution because they receive employment, values, structure, purpose, and even identity from the military (Katz, 2015).

MST and Gender

Based on the civilian world, it may seem like military sexual trauma should only be a relevant issue for women; however, it is imperative that men are also studied when looking at MST. The majority of studies provide very large prevalence rates for women with much lower prevalence rates for men, yet the prevalence of MST among men may actually be around 53% (Katz, 2015). Since the majority of service members in the military are male, the rates of military sexual trauma might be around the same for both men and women (Romainuk & Sana, 2017). Another possible reason that their rates are not as high may be due to the idea that men underreport their MST at a greater rate than women do (O’Brien et al., 2015). However, these rates may be subsequent to change because there is an increasing amount of women joining the forces. By year 2035, it is estimated that women will make up 15% of the total living veterans according to a secondary statistics report (Conrad et al., 2015). While prevalence rates might be similar, it is important to distinguish that men and women experience MST differently (O’Brien & Sher, 2013). In the sections that follow, demographics, risk factors, gender specific problems, barriers, health implications, psychological disorders, life outcomes, and suggested treatments will be discussed in regards to both men and women victims of military sexual trauma.

Demographics & Gender-specific Issues
Before looking at the implications of military sexual trauma, it is important to first understand the demographics and characteristics of victims. According to Kimerling, Gima, Smith, Street, and Frayne (2007), men with positive screen results for MST were younger, white, separated, divorced, never married, and were more likely to have a service connected disability compared to men with negative screen results. As for women with positive screen results, they too were more likely to be younger, white, never married, and had a service connected disability compared to women with negative screen results for MST (Kimerling et al., 2007). There are also certain risk factors that are correlated with experiencing military sexual trauma, such as alcohol use, histories of abuse and assault, and negative home life (Katz, 2015; Williams & Bernstein, 2011). While these demographics and characteristics are associated with MST, it is important to recognize that military sexual trauma can happen to any service member under any condition.

It may seem like sequela of military sexual trauma should be the same for men and women; however, there are unique gender factors that may affect or exacerbate the way both parties experience adjustment after MST. In a DOD report referenced in Monteith et al. (2018b), 97% of perpetrators of sexual assault are male, which may explain why men have sexuality concerns after MST. When men are victimized, their physical reactions to the assault causes confusion on whether they enjoyed it while also causing sexuality concerns (O’Brien et al., 2015). This then leads to not reporting or disclosing their MST for fear of homophobic reactions and negative views of homosexuality in the military due to the previous “Don’t Ask, Don’t Tell” law (O’Brien et al., 2015; Romaniuk & Sana, 2017). Being assaulted by another man comes with long-term consequences. According to Monteith et al. (2018b), men become hyperaware of how they appear to ensure that they do not come off as “gay” or “feminine”, and they also avoid and
develop negative attitudes towards homosexual men. Even though female perpetration is less common, being assaulted by a women is equivalent to being assaulted by someone who is considered “weak” as viewed by the military, which leads to increased identity and masculinity concerns for men (O’Brien et al., 2015). This can cause them to avoid, fear, and view women more negatively while also disconnecting from men (Monteith et al., 2018b; O’Brien et al., 2015).

Similar to questioning their sexuality, men also worry about their masculinity and their ability to fend for themselves after MST (Katz, 2015). Strength is highly rewarded and celebrated in the military, and showing weakness or passivity is frowned upon and devalued, which reinforces the idea that men should be able to fight off perpetrators (O’Brien et al., 2015). This can lead to men believing that their manhood was stolen, and that they do not deserve to have such a strong military identity (O’Brien et al., 2015). As mentioned previously, men tend to be younger when they experience assault in the military, so they deal with their MST in order to keep their social status within the military group (Elder, Domino, Rentz, & Mata-Galan, 2017). Many try to prove their masculinity by sleeping with numerous women, excessively working out, and getting into violent confrontations (O’Brien et al., 2015). They also have more insufficient justification guilt than women, which is the belief that their actions (i.e. not fighting back) during the trauma were not justified (O’Brien et al., 2015). For instance, men often have fantasies about getting redemption against their perpetrator, and they also contemplate whether they could have fought back during the assault even if there were no way to do so (O’Brien et al., 2015).

The societal belief that men always want to have sex results in the idea that men cannot be traumatized or have unwanted sex and attention (Katz, 2015). Due to these common held beliefs, even male soldiers think that male rape is a rare occurrence, so many victims think that
they won’t be believed if they disclose to others and instead keep the MST secret (O’Brien et al., 2015). Disclosure is an important step in dealing with military sexual trauma. For instance, negative disclosure may lead to institutional, perpetrator, or other betrayal while positive disclosure can lessen the severity of trauma symptoms (Monteith et al., 2018b).

Women face much different consequences than men for their military sexual trauma, which may be due to the culture accepting misogyny and allowing violence against women (Williams & Bernstein, 2011). Regardless of MST association, female service members believe that they have to prove themselves to their fellow male service members while also working harder, receiving less opportunities, and feeling less competent than men (Katz, Bloor, Cojucar, & Draper, 2007). They are also always in close proximity to their male counterparts, including for sleep and hygiene purposes, and often feel scrutinized and watched by men (Conrad et al., 2013; Katz et al., 2007). Not only do women experience hostility from men, but they often experience jealousy and have difficulty trusting other female service members (Katz et al., 2007). Since the military values and requires soldiers to be dominant, powerful, and masculine, females have to unlearn everything they were taught about being a woman before they joined the military (Williams & Bernstein, 2011). This role conflict becomes even more pronounced when their fellow male service members reinforce and encourage women to follow the feminine cultural norms (Williams & Bernstein, 2011).

After their service, women may continue to face other hardships that can exacerbate their MST symptoms. One study referenced in O’Brien and Sher (2013) suggests that intimate partner violence may be common among female service members who are married to nonmilitary partners. Women veterans also have increased risks of experiencing postmilitary sexual trauma and further victimization (Creech & Orchowski, 2016). Instead of getting treatment for military
sexual trauma, women tend to seek treatment for their physical symptoms without disclosing their MST, such as headaches, pelvic pain, menstrual problems, gastrointestinal problems, back pain, chronic fatigue, insomnia, anxiety and elevated blood pressure (Conrad et al., 2013). It is reasonable to assume that these gender specific factors cause even more hardship and isolation when they are combined with MST for both men and women.

**Lifetime Traumas and Reporting MST**

It is crucial to examine lifetime prevalence of trauma since many service members are victims of trauma before, during, and after the military (O’Brien & Sher, 2013). According to Katz (2015), the more trauma one experiences then the more consequences they have. If one does not resolve their past and current traumas, they are more likely to have delayed reactions after their traumas and develop more severe symptoms of posttraumatic stress disorder (Williams & Bernstein, 2011). Both men and women soldiers who experience military sexual trauma also experienced childhood sexual abuse but react to the abuses differently. For men, they can grow up to be aggressive and angry, so many of them end up joining the military to become a “man” from experiencing their earlier abuse (O’Brien et al., 2015; Williams & Bernstein, 2011). On the other hand, female survivors of childhood trauma tend to lose their self-protective instincts (Williams & Bernstein, 2011). Women may also have increased risk of revictimization after their MST since Creech and Orchowski (2016) found that females who experienced forced rape during service had high odds of experiencing forced rape after their military service. Additionally, women often experience civilian sexual trauma, but it is important to point out that childhood trauma along with civilian trauma do not account for the strong correlation of PTSD with MST (Kimerling et al., 2007). Having knowledge of the relationship between MST and
lifetime traumas can help with adjustment, as well as understanding the risk for future victimization.

Whether victims report their military sexual trauma also affects their coping with MST. According to a study referenced in Katz (2015), half of the sample that formally reported said that there was no action taken, or that formally reporting elicited more harassment. Contrarily, MST victims who agreed with their reporting outcomes had better well-being and less symptoms compared to those with negative reporting outcomes (Katz, 2015). The majority of victims do not report, so it is important to look at the barriers that influence reporting. For both men and women, reporting their MST could ruin unit cohesion, which is highly valued by the military and needed for service members to stay alive (O’Brien et al., 2015; Katz, 2015). Both parties also do not trust other people and have concerns with confidentiality (Elder et al., 2017; Mengeling, Booth, Torner, & Sadler, 2014).

When looking at each gender separately, men tend to keep quiet about their MST because of shame, self-blame, fear of not being believed, masculinity concerns, and worry of loved ones viewing them as weak or reprehensible, which reinforces their shame and isolation (Elder et al., 2017; Monteith, Brownstone, Gerber, Soberay, & Bahnaini, 2018). For women, some of their major concerns include career consequences, embarrassment, fear that no action would be done, and not knowing how to report their assault (Mengeling et al., 2014). In one study, women were more likely to use unrestricted reporting even though restricted reporting is rated more positively, which may be a result of the DOD’s preference of unrestricted reporting (Mengeling et al., 2014). Women that used unrestricted reporting experienced loss of confidentiality, career consequences, peer hostility, knowledge of perpetrators harassing other servicewomen, and knowledge of whether perpetrators were punished (Mengeling et al., 2014). Due to these
findings, it is not surprising that many men and women regret their decision to report or not report (Katz, 2015).

**Health Implications**

Now that the gender specific factors, barriers, and past traumas have been established, we can look at the various sequelae men and women service members face. It may seem surprising, but military sexual trauma comes with many health implications. Both male and female victims can experience several physical health symptoms, such as genitourinary problems, musculoskeletal problems, neurological problems, gastrointestinal problems, back pain, headaches, GI symptoms, chronic fatigue, obesity, smoking, sedentary lifestyles, liver disease, and pulmonary disease (O’Brien & Sher, 2013). In addition, they have increased risk of pain with women being at risk for more pain, pain conditions, and severe pain (Cichowski et al., 2017; Romaniuk & Sana, 2017).

Other health complications include difficulties with sex for both men and women, but men appear to have more sexual problems and more sexual abuse trauma symptoms than women (Romaniuk & Sana, 2017). For instance, men tend to avoid sexual activities and discussion about sex while also experiencing sexual dysfunction as a result of their MST (Elder et al., 2017). This is possibly a result of having to deal with the stigma that men cannot be assaulted or harassed (O’Brien, Gaher, Pope, & Smiley, 2008). Women also face similar troubles, such as sexual dysfunction, decreased sexual satisfaction, fear and avoidance of sexual intimacy, and desire and arousal issues, but they also experience many physical problems associated with sex (O’Brien & Sher, 2013). These symptoms include pelvic pain, vaginal bleeding/discharge, painful intercourse, rectal bleeding, bladder infections, and painful urination (O’Brien & Sher, 2013). Other health problems that female service members have are weight loss, hypothyroidism,
irritable bowel syndrome, joint pain, fibromyalgia, and dyspareunia (Cichowski et al. 2017; Kimerling et al., 2007). Since health difficulties are not as recognizable as other sequelae of MST, it is important that clinicians are aware of these potential problems because it can help with identifying MST and treating victims.

**Psychological Disorders and Behaviors**

The most known subset of military sexual trauma sequelae is psychological disorders and related behaviors. After their MST, men and women have issues with emotion and thought including feeling sad, anxious, vulnerable, overwhelmed, angry, shamed, self-hating, and disengaged while also partaking in incorrect cognitions such as all-or-none thinking, self-blaming, and having chronic negative thoughts (Katz, 2015). Male and female victims suffer from many of the same psychological implications but at different magnitudes. For example, many develop posttraumatic stress disorder as a result of their MST, but men’s PTSD symptoms may persist longer than women’s symptoms of PTSD even though women’s association of PTSD to MST is three times stronger (Kimerling et al., 2007; Romaniuk & Sana, 2017). It might be reasonable to assume that men’s symptoms persist since they seek treatment less frequently than women (O’Brien et al. 2015).

Men and women also tend to use similar coping behaviors to deal with their assault or harassment, such as substance abuse, suicidality, and impulsive behaviors (O’Brien & Sher, 2013). Engaging in substance and alcohol abuse allows soldiers to feel numb and reduce their shame, but can also lead to intoxication charges for men as well as drug overdose for women post-deployment (Cichowski et al., 2017; Elder et al., 2017). In a study by Monteith et al. (2018a), they found that men who attempted suicide compared to men who just had suicide ideation differed in certain behaviors and experiences. For example, men who attempted suicide
exhibited powerlessness and guardedness, were sexually assaulted rather than harassed, received more unsupportive and negative reactions, experienced betrayal from the military and other systems, had higher rates of alexithymia, and were victims of more lifetime traumatic experiences, while men who had suicide ideation experienced more sadness and anger, were more prone to supportive reactions, and eventually found a purpose after their MST (Monteith et al., 2018a).

Both men and women also experience many psychological disorders from their MST, but there is discrepancy about which gender is more prone to these disorders. For instance, O’Brien et al. (2008) reported that men and women victims do not differ significantly on depression, anxiety, dissociation, and sleep disturbances, yet other research has shown that women have stronger associations with alcohol abuse, anxiety disorders, dissociative disorders, eating disorders, depressive disorders, and personality disorders in relation to their MST (Kimerling et al., 2007). On the contrary, men have a significantly stronger relationship to MST for bipolar disorders and schizophrenia or psychoses (Kimerling et al., 2007). Male service members may also exhibit more severe personality pathology specifically on scales that look at relationships, behavioral control, and distorted thinking (O’Brien et al., 2015). They are also prone to displaying adjustment disorders along with difficulties managing their anger (Elder et al., 2017; Kimerling et al., 2007).

Another common psychological disorder male and female victims experience is eating disorders. Service members are exposed to many risk factors of developing eating disorders including strict physical fitness requirements, weigh-ins and weight regulations, change in eating behaviors during service, and extreme repercussions for not meeting weight restrictions (Bartlett & Mitchell, 2015). Women are more likely to have eating disorders; however, it is labeled as a
“women’s issue”, so men may not report or seek help for their eating disorders, which interferes with correct prevalence rates (Bartlett & Mitchell, 2015). Female victims of MST tend to view their bodies negatively and engage in risky eating behaviors such as binging, purging, and over-exercising to cope with their trauma and regulate distress (Bartlett & Mitchell, 2015). According to Williams and Bernstein (2011), women also engage in bulimic behaviors as a search for control and to cope with the demands of being masculine and feminine in the military. All of this shows that men and women experience psychological disorders at different levels, which should be examined when deciding treatment and interventions for victims.

**Life Implications**

The last common group of adjustment outcomes for victims of military sexual trauma is implications for their lives whether that be jobs, relationships, or life choices. To start, many male and female victims end up leaving or transferring from their military careers due to lack of concentration and interpersonal problems as well as difficulty managing anger for men (Elder et al., 2017; O’Brien & Sher, 2013). This then requires them to seek other employment, but they often struggle to keep jobs and experience financial and legal issues (Katz, 2015). Male victims experience further conduct and vocational problems, from not getting along with coworkers and being hypervigilant to abuses of power (Elder et al., 2017). Since service members experience employment issues, it is no surprise that they are likely to become homeless. Brignone et al. (2016) found that having a positive MST screen status is associated with being homeless for men and women soldiers, which can occur immediately or years after returning home. This association with homelessness has a slightly higher risk for men since they receive less help than women and also serves as an early indicator for adverse post-deployment outcomes (Brignone et al., 2016).
Men and women also have difficulties with relationships after their military sexual trauma, which causes further alienation (Katz et al., 2007; Monteith et al., 2018b). For example, one study found that women feel unneeded, underappreciated, and misunderstood because their family wants them to go back to being the woman they were before the military (Katz et al., 2007). Women also have issues with going from being a “soldier” to being a “girl”, which can then result in them leaving their family and working for the military again (Katz et al., 2007). Relationship problems may develop further since many women victims of MST are scared of having their own child after being raped (Katz, 2015). In a secondary study referenced in Katz (2015), a sample of women that were raped in the military and became pregnant showed that 29% gave birth and raised the child, 29% gave birth but gave up the child for adoption, and 43% aborted the child. The women of this study were all raped in their first year or two during service, but the isolation and feeling of being lost lingered for years (Katz, 2015). On a more positive note, some men experience posttraumatic growth as a result of their MST and can feel empathy and advocate for people who have less power, such as children, women, and gay men (Elder et al., 2017). These implications indicate that military sexual trauma affects victim’s lives in more ways than one and preparing for such hardships will help victims readjust after their service.

**Treatment Suggestions**

Given that all of the sequelae have been discussed, it is easier to look at how these individuals can be helped. Since military sexual trauma victims experience mind-body dysfunctions, treatments including breathing techniques, pain management, sleep improvement methods, mindfulness and yoga, and acupuncture as well as therapy that improves physical functioning may be beneficial (Romaniuk & Sana, 2017). For emotional disorders and issues
(e.g. depression and anxiety), men and women can take different medications to help alleviate symptoms (Conrad et al., 2013). Practices that help identify feelings are important because of the possible relationship between alexithymia and persistence of MST symptoms (O’Brien et al., 2008). Clinicians that treat victims should respond to disclosures of military sexual trauma with empathy and compassion as well as offer help and resources due to the heavy impact that disclosure has on adjustment (Monteith et al., 2018b). It is also important to screen both men and women for eating disorders, promote healthy living attitudes, and reinforce positive body image (Bartlett & Mitchell, 2015).

The treatments mentioned thus far apply to both men and women, but there are also specific treatment suggestions for each gender. Romaniuk and Sana (2017) propose that group therapy of only heterosexual males, anonymous online communication with therapists, education on MST, and building self-efficacy and resilience might help male MST victims especially in reducing isolation. Since men’s symptoms relating to sexuality persist compared to women’s, such specialized interventions should be incorporated into treatment (O’Brien et al., 2008). This may include education on male rape myths, addressing the impact of sexual identity and masculinity issues, decreasing male sexual assault stigma, and devaluing the military’s emphasis of hypermasculinity (O’Brien et al., 2015). Schema therapy can also help male survivors of MST with improving personality dysfunctions as well as avoidance and inappropriate responses (Elder et al., 2017). On the contrary, Williams and Bernstein (2011) suggest that women receive treatments that incorporate violence sensitivity, grounding techniques, spirituality, self-defense, and are transcendence focused instead of recovery focused. It is also important that female victims are screened for past sexual victimization and receive treatment for their chronic pain (Cichowski et al., 2017; Creech & Orchowski, 2016).
Discussion

In conclusion, one can see that men and women victims of military sexual trauma have many difficulties with adjustment, which stem from the event itself as well as the military environment and the roles that each gender are supposed to possess. These factors then affect which sequelae they face, such as barriers of reporting, health problems, psychological disorders, and life implications. From the research provided, it seems as though men struggle more with their MST since they do not report as much, seek less treatment, and have more persistent symptoms than women. Male and female service members experience similar symptomatology along with unique sequelae regardless of which gender struggles more. For instance, they both are prone to have various health problems (i.e. genitourinary, back pain, headaches, fatigue, obesity, etc.), sexual problems, substance abuse, suicide, disordered eating, PTSD, depression, anxiety, homelessness, isolation, relationship problems, and employment issues. On the other end, men have to deal with greater odds of homelessness, more sexual problems, severe personality pathology, and concerns of masculinity. While women have more pain conditions, higher association with PTSD and eating disorders, and concerns with femininity and their role as a woman in and out of the military. These findings are important in assessing and preventing future cases of MST as well as helping victims better adjust to their trauma.

There are future implications for both research and clinical practice from this review. For instance, it may be beneficial to look more at male MST victim’s eating behaviors since eating disorders are labeled as being a “women’s issue”. Compared to men, there needs to be more research on women’s relationship with unit cohesion and with suicidality as well. This review only focused on heterosexual men and women MST victims, so it is important to examine the LGBTQ community and military sexual trauma. Equally important, there are suggested steps for
clinical practice and treatment. This includes incorporating many different features in treatments for MST victims, such as substance abuse, suicidality, relationship problems, emotional issues, disordered eating, and more. All of the issues that result from MST make it difficult for service members to adjust once they go back home, so reintegration techniques should be indicated as well. Lastly, it is imperative that soldiers who experience military sexual trauma receive screening for past, present, and risk for future traumas since they are likely to experience trauma throughout their lifetime.
References


