Mental Health Findings for Service Members Who Experienced Sexual Assault and Sexual Harassment

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PROJECT AIM

The Psychological Health Center of Excellence (PHCoE) within the Department of Defense (DoD) sought to better understand the current state of the science of the mental health needs of service members who have experienced sexual assault/sexual harassment through review of recent research.

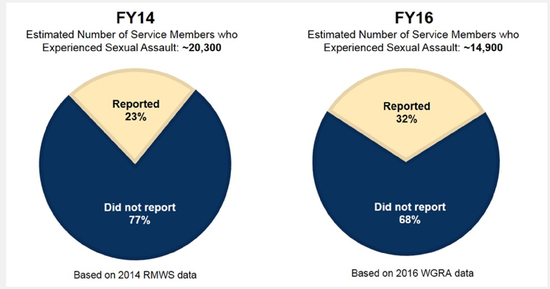
Q: What is known about the unique mental health needs of service members, both male and female, who have experienced sexual assault or sexual harassment, including:

1. ***Prevalence;***
2. ***Mental health and psychosocial consequences;***
3. ***Gender differences; and***
4. ***Disparities in the delivery, effectiveness, barriers, and access to mental health treatment and prevention services?***

SCOPE OF SEXUAL ASSAULT/SEXUAL HARASSMENT IN DOD

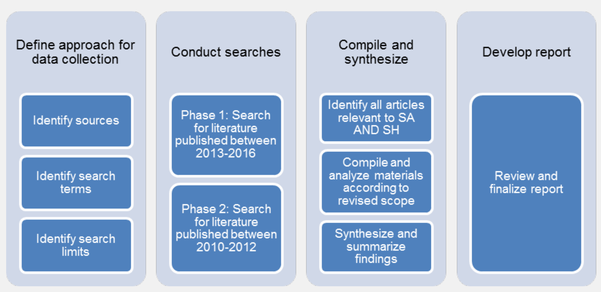
Per the DoD Fiscal Year (FY) 2016 Annual Report on Sexual Assault in the Military:

- ❑ 6,172 reports of sexual assault involving service members; 5,350 of these reports were made by service members
- ❑ Females made 79% of the reports and males made 20% (1% missing data)
- ❑ ~10% of the reports were for incidents that occurred before the service member entered into military service
- ❑ 601 formal complaints of sexual harassment in FY 2016



LITERATURE SEARCH METHODOLOGY

A broad literature search was performed to identify studies that examined the mental health needs of service members who experience sexual assault/sexual harassment published between 2010 and 2016. Based on the search, 152 relevant publications were reviewed. Data was summarized into synthesized findings.



LITERATURE REVIEW FINDINGS

PREVALENCE OF SEXUAL ASSAULT/SEXUAL HARASSMENT

- ❑ Self-reported rates of sexual assault: ~9 to 13% in service women and less than 1 to 2% in service men (Holland, Rabelo, & Cortina, 2014; 2016 DoD Workplace and Gender Relations Survey of Active Duty Members (WGRA); Millennium Cohort Study)
- ❑ Self-reported rates of sexual harassment: ~15 to 36% in service women and 1 to 4% in service men (Klingensmith, Tsai, Mota, Southwick, & Pietrzak, 2014)
- ❑ Both male and female service members in a deployed setting experience higher rates than civilian or non-deployed counterparts (Leardmann et al., 2013)

CORRELATES OF SEXUAL ASSAULT/SEXUAL HARASSMENT IN THE MILITARY

- ❑ Less education and never been married status (Klingensmith, et al., 2014)
- ❑ Mental health conditions, including (Beckie, Duffy, & Groer, 2016; Pavao et al., 2013):
  - Posttraumatic stress disorder (PTSD)
  - Depression
  - Substance use disorder (SUD)
- ❑ Significantly associated with increased risk for suicide and suicide ideation among both men and women (Kimerling, Makin-Byrd, Louzon, Ignacio, & McCarthy, 2016; Monteith, et al., 2016; Monteith, Menefee, Forster, & Bahraini, 2016; Monteith, Menefee, Forster, Wanner, & Bahraini, 2015)

TREATMENT OF MENTAL HEALTH CONDITIONS SECONDARY TO SEXUAL ASSAULT/SEXUAL HARASSMENT

- ❑ Best practices treating psychological symptoms secondary to sexual assault/sexual harassment are similar to treatment strategies for PTSD and other trauma-related conditions (Brancu, Straits-Tröster, & Kudler, 2011; Conard, Young, Hogan, & Armstrong, 2014)
- ❑ ***Note:*** While more than $^1/_2$ of active duty service members who experienced sexual assault sought treatment for their related mental health conditions, more than $^1/_3$ did not complete their treatment (Zinzow et al., 2015)

IMPACT OF MILITARY CULTURE ON SEXUAL ASSAULT/SEXUAL HARASSMENT

- ❑ ***Theoretical*** **factors that may contribute to rates of sexual assault/sexual harassment in the military (Stander & Thomsen, 2016) :**
  - ***Demographics*** (e.g., preponderance of young, single, male and lower-ranking personnel)
  - ***Recruiting and self-selection*** (e.g., high prevalence of premilitary sexual trauma, volunteering for service to escape difficult life circumstances)
  - ***Military lifestyle*** (e.g., combat deployment, high mobility, heavy drinking and coed barracks where sexual activity is common)
  - ***Military culture*** (e.g., hostile attitudes toward women, rape myth acceptance, hypermasculinity and an organizational climate condoning sexual aggression)
  - ***Military structure and policy*** (e.g., prevention and response policies that make reporting and prosecution difficult; gender typing of military occupations; top-down hierarchical structure)

RESEARCH USES INCONSISTENT TERMS TO EXAMINE SEXUAL ASSAULT

sexual assault (SA)
Intentional sexual contact characterized by use of force, threats, intimidation, or abuse of authority or when the victim does not or cannot consent (DoDD 6495.01)

sexual harassment (SH)
A form of sex discrimination that involves unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature (DoDD 1350.2)

military sexual trauma (MST)
Psychological trauma, which in the judgment of a VA 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 (VA, Title 38 U.S. Code 1720D)

intimate partner violence (IPV)
Physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner (CDC)

sexual violence
Sexual act committed against someone without that person's freely given consent (CDC)

sexual abuse
Unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent (APA)

BARRIERS TO CARE

- ❑ Stigma (Burns, Grindlay, Holt, Manski, & Grossman, 2014; Carlson, Stromwall, & Lietz, 2013; O'Brien, Keith, & Shoemaker, 2015; Sadler et al., 2013; Turchik et al., 2013; Zinzow et al., 2015)
- ❑ Concerns about privacy and confidentiality (Burns et al., 2014; Turchik et al., 2013)
- ❑ Lack of available gender-specific or gender-appropriate interventions (e.g., same-gender group or residential treatments) (Hamilton, Poza, Hines, & Washington, 2012; Sadler et al., 2013)
- ❑ Lack of knowledge of available services (Burns et al., 2014; Hamilton et al., 2012; Turchik et al., 2013; Washington et al., 2011)
- ❑ Limited access to services (e.g., geographic barriers and limited long-term housing options) (Hamilton et al., 2012)
- ❑ Barriers to implementation of treatment programs (Gallegos, Cross, & Pigeon, 2015) :
  - Patient level (e.g., need a specific number of patients available to attend)
  - Provider level (e.g., need to train providers on new interventions)
  - Organizational level (e.g., need for physical space and leadership support)
  - Policy level (e.g. need mandates to promote implementation)

MALE SEXUAL ASSAULT

- ❑ Underreported at higher rates than for females; more than 80% of men did not report their sexual assault per DoD estimates by the U.S. Department of Justice in 2013 (O'Brien et al., 2015) and the 2016 DoD WGRA
- ❑ Male service members who experience sexual assault/sexual harassment have increased rates of mental health conditions (Kimerling et al., 2010; B. S. O'Brien & Sher, 2013)
- ❑ Men who reported a recent experience of sexual assault/sexual harassment are 60% more likely to separate from military service (Millegan, Wang, LeardMann, Miletich, & Street, 2016)
- ❑ Fear of being perceived as homosexual may be a factor in reporting (Bell, Turchik, & Karpenko, 2014; Hoyt, Klosterman Rielage, & Williams, 2011)
- ❑ Men less likely to seek sexual assault/sexual harassment-related treatment than women (Turchik, Pavao, Hyun, Mark, & Kimerling, 2012)
- ❑ Barriers to seeking care include stereotypes about masculinity, military culture, and not wanting to appear vulnerable (Hoyt et al., 2011)

FUTURE RESEARCH NEEDS

Category	Future Research Areas Identified as Related to Sexual Assault and Sexual Harassment
Prevalence and Incidence	☐ Standard definition of terms to more accurately identify and compare rates
Prevention	☐ Effectiveness of service-specific, and other prevention programs ☐ Risk factors, which largely have been gleaned from civilian literature
Mental Health Correlates	☐ Relationships between sexual assault and mental health conditions ☐ Long-term effects
Screening	☐ Efficacy of current screening practices in DoD ☐ Effectiveness of screening tools and procedures
Treatment	☐ Treatment outcomes in active duty populations, especially for mental health conditions other than PTSD ☐ Care utilization, including during deployment ☐ Gender-specific (and race and ethnicity) mental health care utilization ☐ Use of civilian mental health care services, particularly for those in rural locations
Barriers	☐ Unique barriers to care that active duty personnel may face, particularly in deployed environments ☐ Gender-specific challenges for male service members when seeking mental health treatment
Military Culture	☐ Impact of hypermasculinity ☐ Identification of military-specific risk factors ☐ Interplay between sexual assault, sexual harassment, and combat-related stressors
Male Sexual Assault	☐ Factors that encourage men to seek treatment ☐ Demographic correlates and psychological ramifications for men

There are several challenges to research on sexual assault/sexual harassment, to include:
1.Small sample sizes
2.Heterogeneous populations
3.Lack of consistent terminology

Poster presented at the AMSUS Annual Meeting in November 2017. For more information, please contact alia.h.creason.ctr@mail.mil. The views expressed in this presentation are those of the authors and do not necessarily represent the official policy or position of the Psychological Health Center of Excellence, Department of Defense, Department of Veterans Affairs, or any U.S. government agency. (PUID# 4710)