Military Sexual Trauma
An Overview: Prevalence, Diagnostic Considerations and Treatment

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Overview of Presentation

- Introduction
- Military Sexual Trauma (MST) Population
  - Perception of Maltreatment
- PTSD: A Conceptual Framework
  - It starts with fear...
- Conceptual Considerations
  - What explains the distress?
  - PTSD symptom expression: Addiction and Control
    - What is the main “addiction”? 
Overview of Presentation

- Control After Trauma
  - Temporal Dimensions of Control
    » “When” are they trying to control?
      - Past, Present, Future
      - Control patterns within PTSD

- Intervention Strategies with MST Populations
  - Using Evidenced-Based Principles:
    - Exposure – Reactions to Triggers
    - Seeking Safety (SS) – Changing Poor Coping Habits
    - Cognitive Processing – Addressing Unhelpful Thoughts
Overview of Presentation

- Demographic Considerations:
  - What makes a good MST treatment candidate?

- Summary and Clinical Recommendations
  - Treatment Recommendations for Providers
Military Sexual Trauma (MST)
Military Sexual Trauma (MST): Distinctions of the Population

VA term:
- Refers to experiencing sexual assault and/or threatening acts of sexual harassment while in the military
  - Against one’s will
  - May or may not involve physical violence
  - Various forms of abuse could be involved (touching, grabbing, oral/vaginal/anal sex, sodomy)
- Could involve coercion or “implied threat”
  - Threats of retaliation, continued maltreatment, or career implications
Military Sexual Trauma (MST): Distinctions of the Population

- Prevalence Rates:
  - Underreported and rates typically only include Veterans that have used VHA services
  - **2007** – American Journal of Public Health (AJPH)
    - Approximately 22% among female Veterans and 1.2% among male Veterans
  - **2010** – AJPH reported among U.S. Veterans returning from recent conflicts (OEF and OIF)
    - 15.1% of female Veterans; 0.7% of male Veterans
  - **Roughly 1 in every 5 women; 1 in every 100 men**
Military Sexual Trauma (MST): Distinctions of the Population

- Prevalence: MST experiences fairly prevalent among veterans
  - More common with women
  - Ratio of men to women in military as a moderator

- High rates of PTSD
  - “Intense fear, helplessness, horror”
Military Sexual Trauma (MST): Distinctions of the Population

- Qualitative differences in MST survivors:
  - Sexual trauma correlated with military service
    - Where victim lives and works
      - Increases actual/perceived chance of revictimization
      - Increases sense of powerlessness/helplessness (i.e., reduces sense of control)
    - Stimulus generalization likely to occur
      - “Total” environment (care vs. threat)
    - Multiple identities impacted
MST as “Maltreatment”

- Similar to victims of familial maltreatment
  - Veteran feels reliant on military for several aspects of identity and care

- Definitions and Dimensions (Barnett et al., 1993)
  - Physical Abuse
  - Sexual Abuse
  - Neglect
  - Emotional Maltreatment
  - Witnessing Familial (i.e. within group) Violence
Conceptual Framework of PTSD
PTSD – A Conceptual Framework: How does PTSD develop?

- **Early Development:**
  - Messages about the way the world “works”
    - Belief in a “just world” – e.g. good things happen to good people; bad things happen to bad people
    - What constitutes fear:
      - “don’t walk down a dark alley by yourself”
      - “look both ways before you cross the street”
  - Then…the traumatic event(s)
    - Confirms what is already believed
    - Shatters what was believed
PTSD – A Conceptual Framework: How does PTSD develop?

- “Stages” of PTSD Development:
  - At the root: FEAR
    - Intense → shock
    - Horror
    - Helplessness
  - Re-experiencing vs. Remembering
    - Flashbacks; Nightmares – Happens “at any time”
  - “On Edge”
    - Looking for the trauma
    - Hypervigilant behaviors – noticeable to others; feedback
    - Time-limited in nature (e.g., need to sleep)
PTSD – A Conceptual Framework: How does PTSD develop?

- **“Stages” of PTSD Development:**
  - **Avoidance:** “PTSD’s Right Hand Man”
    - Don’t go there…
    - Forget it…
    - Cut off from “natural rewards” – e.g., social interaction
  - **Anger:** “this is not fair”
    - “Incredible Hulk Syndrome”
  - **Consequences:** Guilt and Shame
  - **Grief and depression**
    - Long legacies of loss and destruction
PTSD – A Conceptual Framework: How does PTSD develop?

“Stages” of PTSD Development:

- A change in self-image:
  - “I am the bad guy/person”
  - “I am a monster”
  - “You need to fear me”

- Relationship Problems
  - Trust
  - Intimacy

- Health Problems and Poor coping
  - E.g., increased use of ETOH and drugs
Treatment Selection: Conceptual Considerations
Conceptual Considerations to Intervention

- Identify The “Emotional Culprit”
  - Basic “negative” emotions: anger, disgust, shame, sadness, fear
  - Assessment needed at onset to determine which emotion most explains the patient’s presentation

- Understand that the root of PTSD = FEAR
  - The person is afraid
    - PTSD acts as an intensifier (ex: alka seltzer)
Conceptual Considerations to Intervention

- Likely has developed some addiction to cope with fear:
  - Addiction = dysfunctional attempts to regain control post trauma

- SUD Addiction and PTSD – significant correlation
  - “Two Bullies”: PTSD and Substance Abuse
    - If not substance use, then what?
      » Possibly just addicted to isolation/avoidance
Conceptual Considerations to Intervention

- PTSD “shifts” values:
  - Importance placed on:
    - Personal Safety vs. Intimacy
    - Secrecy vs. Genuineness
    - Control over others vs. Trust in others

- Control is extremely important:
  - Trauma damages:
    - Accurate perception of control
    - Perception of control over future events
      - Outside of one’s control
      - Completely under their control (i.e., conditioning history)
      - Reality in “real time” – e.g. “This is happening all over again”
Temporal Dimensions of Control

- Important event-specific dimension of control:
  - Temporal orientation

- Frazier, Steward, Berman (2001) suggest three important questions after a traumatic event:
  - Could I have prevented this? (past)
  - What can I do about this now? (present)
  - Can I prevent this from happening again? (future)
Temporal Dimensions of Control

- Temporal orientation of control:
  - In treatment: Often a lack of explicit focus in explaining how control relates to distress

- Important to consider:
  - Is each type of control (past, present, future) equally adaptive?
  - Are any maladaptive?
  - Do EBPs differ in their focus on control?
  - Do sexual trauma survivors w/ PTSD tend to have patterns in their temporal orientations?
Temporal Dimensions of Control: Summary

- Past control – unrelated or associated with more distress = **NOT HELPFUL**
- Present control – associated with less distress = **HELPFUL**
- Future control – inconsistent relationships with distress = **DEPENDS**
  - Dependent on: specific behaviors identified vs. objective controllability of the event itself
    - Can the event actually be controlled by the person?
Temporal Dimensions of Control: Summary

- If you had to guess...
- Which of the three types of control do PTSD most engage in?

**Answer:**
- PTSD survivors more inclined to orient to past and future
- Not helpful for MST (past = bad; future = not helpful because MST not under patient’s direct control)
Empirically–Based Practices with Military Sexual Trauma (MST) Populations
Evidence – Based Principles for PTSD Populations

- For Providers working with PTSD populations:
  - Intervention consists of addressing 3 main areas:
    - Exposure: Managing reactions to the “trigger”
    - Seeking Safety: Changing poor coping habits
    - Cognitive Processing: Identifying unhelpful thoughts
Empirically– Based Practices (EBPs) for Military Sexual Trauma Populations: An Example

- Cognitive Processing Therapy (CPT): emphasis on restructuring “dysfunctional” thoughts
  - How to highlight Present Control:
    - Conceptualize A–B–C model in terms of control
      » Deemphasize trauma, emphasize current belief on outcome

Example: Activating Event – Trauma
Belief: “Don’t trust anybody, because they’ll hurt you.”
Empirically–Based Practices (EBPs) for Military Sexual Trauma Populations

Belief: “Don’t trust anybody, because they’ll hurt you.”

Consequences/Costs: ???

Questions:
- What does this belief suggest about your control now vs. others control over you?
- Any relationships where this is incorrect?
- Any important differences between what you felt you could control then vs. now?
Empirically–Based Practices (EBPs) for Military Sexual Trauma Populations

- Cognitive Processing Therapy (CPT):
  - How to highlight Present Control:
    - Teach important problematic patterns in control beliefs
      - Dichotomous
      - Out of context or outdated
      - Overly simple
    - Drive “current cost” model of control (“Cost of Inflation”)
    - Make slight reframes of beliefs temporally: “Don’t trust anybody” vs. “I couldn’t trust anybody then, but I might be able to now.”
Demographic Considerations: A “Good” MST Treatment Candidate
Demographic Considerations:

- **Presence of an “Index Trauma”**
  - A specific trauma which promotes symptomology
  - Harder with repeat victimization history
    - Could ask:
      - Which one haunts you the most?
      - If you could redo what has happened to you or take an eraser to certain events in your life, what event would you get rid of or change first?
      - Which comes up most frequently in your nightmares/flashbacks?

- **Clear “fear–based” vs. depressive symptomology:**
  - Exaggerated startle
  - Hypervigilant behaviors
  - Avoidance behaviors due to safety beliefs
Demographic Considerations:

- Person with PTSD and interested in “Trauma Focused” therapy:
  - Talk about trauma in great detail

- Cognitive Ability
  - VCI /PSI Issues?

- Active management of co-morbid disorders:
  - Substance Use – “Numbing of fear structure” – i.e., blunts intensity limiting therapeutic efficacy
  - Active Psychosis

- Cultural Style
  - E.g., Oral vs. Written Expression
Summary and Clinical Implications
Summary and Clinical Implications

- MST population is distinct:
  - Unique event and environmental factors associated with their traumatic experiences
  - Tend to present as more globally “maltreated” than just “victim of sexual assault”

Significant evidence that traumatic event creates a cognitive vulnerability due to control
- Influences later problem-solving
Summary and Clinical Implications

- Impact on control is multi-faceted
  - Temporal control is more important to consider in treatment

- Past and Future control associated with more distress

- Present control associated with less distress
Summary and Clinical Implications

- Encourage patients to develop control beliefs that are present-centered
  - Expect resistance – PTSD populations tend to orient to either past or future

- Conceptualize and integrate interventions that increase present control
  - Regardless of treatment modality
Summary and Clinical Implications

- **Suggestions across treatments:**
  - Use language to emphasize current control over recovery process
  - Deemphasize “uniqueness” of trauma and focus on common “current costs” of beliefs and coping mechanisms
  - Teach simple biofeedback based techniques (e.g., grounding, muscle relaxation, deep breathing) to control “in moment” experience of symptoms
  - Assess and incorporate meaning, strengths, and social supports
  - Monitor alliance and allow person to identify aspects in where he/she would like to have increased control
Questions