



# Military Sexual Trauma



Independent Study Course Released: January 2004

Sponsored by  
Department of Veterans Affairs  
Employee Education System

This is a Veterans Health Administration System-Wide Training Program sponsored by the Veterans Affairs Employee Education System and the Office of Public Health and Environmental Hazards, Department of Veterans Affairs. It is produced by the Employee Education System.





DEPARTMENT OF VETERANS AFFAIRS  
UNDER SECRETARY FOR HEALTH  
WASHINGTON DC 20420

**A MESSAGE FROM THE UNDER SECRETARY FOR HEALTH**

Dear Colleagues in Quality Health Care:

I am very pleased to present the enclosed Veterans Health Initiative (VHI) independent study guide on the basics of "Military Sexual Trauma." "Military Sexual Trauma" has been designed and written by VA clinicians and administrators. To ensure that our veterans get the right care, at the right time, in the right place, at the right cost, it is important that all clinicians be aware of the specific conditions and sensitivities associated with a veteran who has experienced sexual trauma. What may appear to be a relatively minor symptom or problem from a health care provider's perspective may in fact herald a grave and even life-threatening problem for the individual who has experienced this non-combat injury. Greater awareness of the specialized health issues facing persons who have been sexually assaulted or raped is needed to assure therapeutically appropriate clinical processes.

The Education Contact at your medical center has the necessary information to enable you to receive continuing medical education credits for studying this book and successfully completing the accompanying test. It is my expectation that every practitioner in the VA system will complete this course. I hope that you will keep this book available for reference when you have the opportunity to provide care for veterans who have experienced the traumas contained in this VHI. This is one way that we can ensure provision of quality health care across the continuum of acute care, rehabilitative care, and extended care. VA sees veterans who have experienced sexual trauma and associated disorders in a variety of health care settings, and they are counting on you to provide the best care possible. We owe them nothing less.

A handwritten signature in blue ink that reads "Robert H. Roswell".

Robert H. Roswell, M.D.

Enclosure

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# Independent Study Outline

TRACE Code: 03.VHI.SH&T.PA

Every day, VA clinicians care for women and men who suffer from physical and mental sequelae of sexual harassment and sexual assault which occurred during military service. However, this problem, which has come to be known as “military sexual trauma”, has only recently reached the consciousness of the nation.

This independent study module is a part of the Veterans Health Initiative (VHI). The VHI is a comprehensive program of continuing education designed to improve recognition and treatment of health problems related to military sexual trauma, to include sexual assault and sexual harassment.

After completing this independent study, participants will be able to:

1. Describe the VA mandate, and prevalence of military sexual trauma (MST);
2. Describe the relevance of MST to VA clinicians;
3. Identify the health correlates of sexual trauma;
4. Explain the effective screening methods for MST;
5. List the steps when responding to MST disclosure;
6. Explain the referral process of a patient who experienced MST to mental health and social services;
7. Describe the mental health treatment for MST;
8. Describe the documentation requirements for MST treatment and compensation;
9. Explain the compensation issues associated with MST;
10. Describe the complex patient-provider relationship issues associated with MST;
11. Identify the risk factors that could cause PTSD flares in MST survivors;
12. Define revictimization;
13. Assess intimate partner violence;
14. Describe treatment of acute sexual trauma victims; and
15. Recognize how clinicians can care for themselves and avoid burnout.

The expected outcomes of this independent study are to improve the quality of health care provided to veterans who have experienced military sexual trauma. Drug treatments and dosages provided in this study guide should be double-checked prior to prescribing therapy.

## Purpose

## Background

## Objectives

## Outcome

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## Independent Study Outline

**Target Audience** This independent study is primarily designed for Department of Veterans Affairs clinicians and interested VA staff. Other health care providers, especially those working in veterans and military health care facilities in the U.S., also are encouraged to complete this study module.

**Format** This program is available in booklet form and on the Web at:  
<http://www.va.gov/vhi>\_\_\_\_\_

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## Program Description

### This Program Includes:

- Independent study written material
- Test for CME credits
- Program evaluation

This activity has been planned and implemented in accordance with the Essentials and Standards of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of VA Employee Education System and Department of Veterans Affairs Office of Public Health and Environmental Hazards. The VA Employee Education System is accredited by the ACCME to provide continuing medical education for physicians.

### *Content Materials*

Definitions, VA Mandate, and Prevalence  
Relevance to VA Clinicians  
Health Correlates of Sexual Trauma  
Screening for MST  
What to Do Next: Responding to MST Disclosure  
Referring the Patient to Mental Health and Social Services  
Treatment of Mental Health Sequelae  
Documentation Issues  
Compensation Issues  
Complex Patient-Provider Relationship Issues  
Medical Procedures for MST Survivors: Avoiding PTSD Flares  
Risk for Revictimization  
Intimate Partner Violence  
Acute Sexual Trauma  
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### *Appendices*

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Appendix B: Advantages of Screening for MST  
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Appendix D: Information about Sexual Trauma & VA Services  
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Appendix F: Supplement: Additional Compensation  
& Pension Claims Issues  
Appendix G: Danger Signals in Staff-Patient Relationships  
Appendix H: Domestic Violence Screening: Special Issues  
Independent Study Questions for CME Credit  
Independent Study Program Registration/Answer Sheet/  
Participation Satisfaction Form

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## Program Implementation and VA Application Procedure

### *To receive credit for this course:*

1. Read the independent study materials.
2. Complete the CME test questions. A passing score of 70% or higher on the CME test is required to receive credit. This test may be retaken.
3. Complete the program evaluation.
4. The estimated study time for this program is 3.5 hours.

If you are using the Independent Study Registration/Answer/Evaluation Form (two sided) at the back of the independent study booklet, please send the completed form within two weeks after reading the material to:

Employee Education Resource Center  
Attn: SDU  
Medical Forum, Suite 500  
950 North 22nd Street  
Birmingham, AL 35203-5300

**NOTE: Scantron forms cannot be photocopied. For additional copies of this independent study, Scantron forms or other VHI independent study modules, please contact your facility education contact person.**

If you have attained a passing score of 70% or higher a certificate will be mailed to you approximately 6-8 weeks after your test has been graded. The test may be retaken.

The CME test and program evaluation can be completed using the VA Internet. The address is: <http://www.ees-learning.net>.

After you take the test, you will receive immediate feedback as to pass or fail. You will be allowed to retake the test. Upon passing the test and completing the program evaluation, you will be able to immediately print your certificate according to instructions.

**NOTE: If you experience difficulty reaching this Web site, please contact the Help Desk via e-mail at [eeslibrihelp@lrn.va.gov](mailto:eeslibrihelp@lrn.va.gov), or call 1-866-496-0463. You may also contact your local computer support staff or librarian for assistance.**

**NOTE: In order to complete the CME test and Evaluation, your computer must have Internet Explorer 4.0 or Netscape 4.0 or higher.**

If you have questions or special needs concerning this independent study, please contact:

Bob Smith, EdD, MCP  
205-731-1812, Ext. 317; E-mail - [bob.smith@lrn.va.gov](mailto:bob.smith@lrn.va.gov)

**This program will no longer be authorized for CME credit after June 2005.**

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## Program Development

### Co-Editors

**Carole Turner, RN, MN, CNAA**  
National Director, Women Veterans  
Health Program.  
Veterans Health Administration  
Department of Veterans Affairs  
Central Office  
Washington, DC

**Susan Frayne, MD, MPH**  
Physician-Researcher  
Center for Health Care Evaluation  
Veterans Health Administration  
Veterans Affairs Medical Center  
Palo Alto, CA

### Authors

**Gloria Boston, MSW, LCSW**  
Clinical Social Worker  
Veterans Health Administration  
VA Northern CA Healthcare System  
Redding, CA

**Arlene Bradley, MD**  
Director, Women's Health Clinic  
Veterans Health Administration  
Veterans Affairs Medical Center  
Roseburg, OR

**Mirian Butterfield, MD, MPH**  
Psychiatrist & Researcher  
Health Services Research and  
Development  
Veterans Health Administration  
Veterans Affairs Medical Center  
Durham, NC

**Maria Crane, PsyD**  
Assistant Chief, Mental Health &  
Behavioral Sciences Services  
Veterans Health Administration  
Veterans Affairs Medical Center  
Bay Pines, FL

**Susan Frayne, MD, MPH**  
Physician-Researcher  
Center for Health Care Evaluation  
Veterans Health Administration  
Veterans Affairs Medical Center  
Palo Alto, CA

**Rachel Kimerling, PhD**  
Research Clinical Psychologist  
Clinical Laboratory and Education  
Division  
National Center for PTSD  
Veterans Health Administration  
Veterans Affairs Medical Center  
Palo Alto, CA

**Harold Kudler, MD**  
Mental Health Coordinator  
VISN 6  
Veterans Health Administration  
Veterans Affairs Medical Center  
Durham, NC

**Susan Mather, MD, MPH**  
Chief Public Health & Environmental  
Hazards Officer  
Veterans Health Administration  
Department of Veterans Affairs  
Central Office  
Washington, DC

**Katherine McKay, PhD**  
Director of Student Development  
University of South Florida  
St. Petersburg, FL

**Maureen Murdoch, MD, MPH**  
Core Investigator,  
Center for Chronic Disease  
Outcomes Research  
Veterans Health Administration  
Veterans Affairs Medical Center  
Minneapolis, MN

**Melissa Polusny, PhD, LP**  
Staff Clinical Psychologist  
Veterans Health Administration  
Veterans Affairs Medical Center  
Minneapolis, MN



---

## Program Development

### **Isabel Rose, PhD, MSW**

Assistant Professor  
School of Social Work  
Wayne State University  
Detroit, MI

### **Nina Sayer, PhD, LP**

Psychologist & Core Investigator  
Center for Chronic Disease  
Outcomes Research  
Veterans Health Administration  
Veterans Affairs Medical Center  
Minneapolis, MN

### **Erica Sharkansky, PhD**

Clinical Psychologist  
Women's Health Sciences Division  
National Center for PTSD  
Veterans Health Administration  
VA Boston Healthcare System  
Boston, MA

### **Amy Street, PhD**

Clinical Research Psychologist  
Women's Health Sciences Division  
National Center for PTSD  
Veterans Health Administration  
VA Boston Healthcare System  
Boston, MA

### **Carole Turner, RN, MN, CNAA**

National Director, Women Veterans  
Health Program  
Veterans Health Administration  
Department of Veterans Affairs  
Central Office  
Washington, DC

### **Linda VanEgeren, PhD**

Staff Clinical Psychologist  
Women's Comprehensive  
Health Center  
Veterans Health Administration  
Veterans Affairs Medical Center  
Minneapolis, MN

### **Ellen F.T. Yee, MD, MPH**

Staff Physician  
Veterans Health Administration  
New Mexico VA Health Care System  
Albuquerque, NM

### **Planning Committee**

#### **Carole Turner, RN, MN, CNAA**

National Director, Women Veterans  
Health Program  
Veterans Health Administration  
Department of Veterans Affairs  
Central Office  
Washington, DC

#### **Susan Mather, MD, MPH**

Chief Public Health &  
Environmental Hazards Officer  
Veterans Health Administration  
Department of Veterans Affairs  
Central Office  
Washington, DC

#### **Linda VanEgeren, PhD**

Staff Clinical Psychologist  
Women's Comprehensive  
Health Center  
Veterans Health Administration  
Veterans Affairs Medical Center  
Minneapolis, MN

#### **Susan Frayne, MD, MPH**

Physician-Researcher  
Center for Health Care Evaluation  
Veterans Health Administration  
Veterans Affairs Medical Center  
Palo Alto, CA

#### **Katherine McKay, PhD**

Director of Student Development  
University of South Florida  
St. Petersburg, FL

#### **Gloria Boston, MSW, LCSW**

Clinical Social Worker  
Veterans Health Administration  
VA Northern CA Healthcare System  
Redding, CA

#### **Robert Smith, EdD, MCP**

Program Manager  
VA Employee Education System  
Birmingham Employee Education  
Resource Center  
Birmingham, AL

---

## Program Development

### **Pamela Hebert, DrPH**

Program Manager  
Nurse Planner  
VA Employee Education System  
Birmingham Employee Education  
Resource Center  
Birmingham, AL

### **Nancy Donovan, MSW**

Program Manager  
VA Employee Education System  
Minneapolis Employee Education  
Resource Center  
Minneapolis, MN

### **Project Support Assistant**

#### **Donna Burnett**

VA Employee Education System  
Birmingham Employee Education  
Resource Center  
Birmingham, AL

### **Learning Technology and Media Development**

#### **Jeffrey Henry**

Media Producer  
VA Employee Education System  
North Chicago VAMC  
North Chicago, IL

### **Graphic Artist**

#### **Joseph Radford**

Graphic Artist  
VA Employee Education System  
Salt Lake City Employee Education  
Resource Center  
Salt Lake City, UT

---

## **AMA and ANCC Continuing Education Credits**

### **Accreditation**

#### **Accreditation Council for Continuing Medical Education (ACCME)**

The VA Employee Education System is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

#### **American Nurses Credentialing Education**

VA Employee Education System is accredited as a provider of continuing education in nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

#### **American Psychological Association (APA)**

The VA Employee Education System is approved by the American Psychological Association to offer continuing professional education for psychologists. The Employee Education System maintains responsibility for the program.

### **Continuing Education Credit**

#### **Accreditation Council for Continuing Medical Education (ACCME)**

The VA Employee Education System designates this educational activity for a maximum of 3.5 hours in Category 1 credit towards the American Medical Association Physician's Recognition Award. Each physician should claim only those hours he/she actually spent in the educational activity.

#### **Association of Social Work Boards (ASWB)**

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#### **American Nurses Credentialing Education**

VA Employee Education System designates this educational activity for 4.2 contact hours in continuing nursing education.

#### **American Psychological Association (APA)**

As an organization approved by the American Psychological Association, the VA Employee Education System is offering this activity for 3.5 hours of continuing professional education credit. The Employee Education System maintains responsibility for the program.

The Employee Education System maintains responsibility for the program. A certificate of attendance will be awarded to participants and accreditation records will be on file at the Employee Education System. In order to receive a certificate from EES, you must read the material, complete and pass the CME test with a 70% or higher, and complete a program evaluation.

### **Report of Training**

It is the program participant's responsibility to ensure that this training is documented in the appropriate location according to his/her locally prescribed process.

## Disclosure Statement

The Employee Education System (EES) must ensure balance, independence, objectivity, and scientific rigor for all EES sponsored educational activities. The intent of this disclosure is not to prevent faculty with a significant financial or other relationship from presenting materials, but rather to provide the participant with information on which they can make their own judgments.

It remains for the participant to determine whether the faculty interests or relationships influence the materials presented with regard to exposition or conclusion. When an unapproved use of a FDA approved drug or medical device, or an investigational product not yet FDA approved for any purpose is mentioned, EES requires disclosure to the participants.

Faculty have provided the following information:

Arlene Bradley  
Susan Frayne  
Rachel Kimerling  
Maureen Murdoch  
Melissa Polusny  
Isabel Rose  
Amy Street  
Carole Turner  
Linda VanEgeren  
Ellen Yee  
Susan Mather  
Erica Sharkansky  
Nina Sayer

**No disclosable relationships or FDA issues**

Faculty Name  
Mirian Butterfield

Sources of Funding for Research/Grants . . . . .	Organon, Eli Lilly and Company, and GlaxoSmithKline
Consultant . . . . .	Bristol-Myers Squibb Company, Eli Lilly and Company
Speaker's Bureau Member . . .	Eli Lilly and Company, Pfizer Inc., and SmithKline Beecham

Maria Crane  
Did not submit disclosures or FDA issues to EES

### Americans with Disabilities Act Policy

The Employee Education System wishes to ensure no individual with a disability is excluded, denied services, segregated, or otherwise treated differently from other individuals participating in this independent study because of the absence of auxiliary aids and services. If you require any special arrangements to fully participate in this independent study, please contact Bob Smith, EdD, MCP, Program Manager, at 205-731-1812 extension 317, or e-mail [bob.smith@lrn.va.gov](mailto:bob.smith@lrn.va.gov).

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# Definitions, VA Mandate, and Prevalence

## Learning Objectives

1. Identify the historical events contributing to the development and implementation of the Department of Veterans Affairs (DVA) Military Sexual Trauma (MST) Program.
2. Identify difference between sexual harassment and assault as defined by the DVA.
3. Describe basic MST eligibility requirements.
4. Identify proportions of male and female veterans who screen positive for MST.

## What is Sexual Trauma?

Every day, VA clinicians care for women and men who suffer from physical and mental sequelae of sexual harassment and sexual assault which occurred during military service. However, this problem, which has come to be known as “military sexual trauma”, has only recently reached the consciousness of the nation. **Military sexual trauma (“MST”)** has been defined by the Department of Veterans Affairs as:

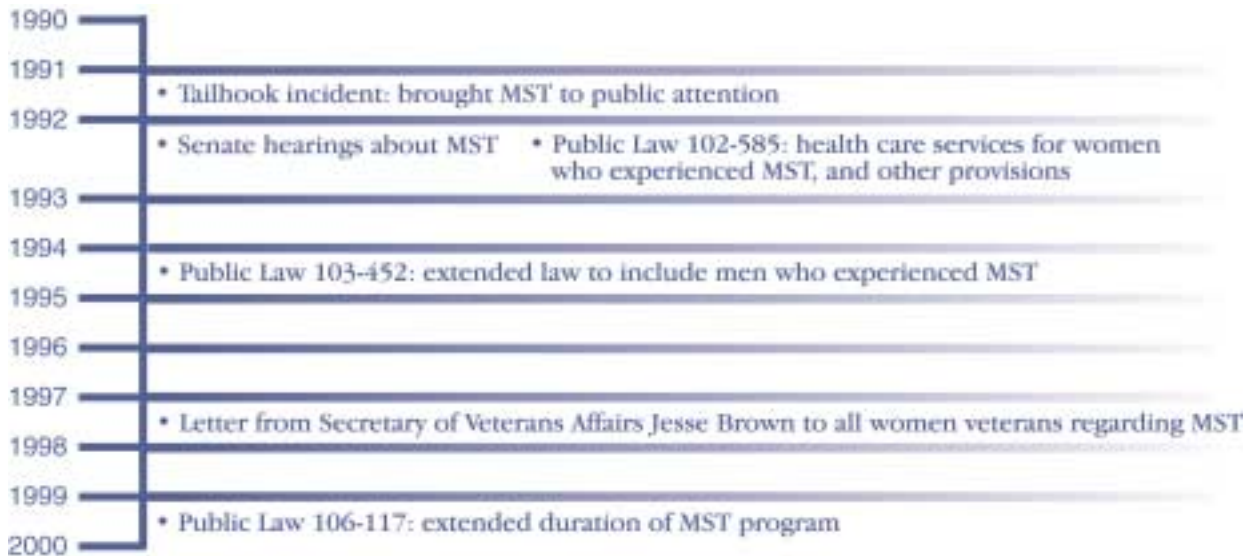
***sexual harassment that is threatening in character or physical assault of a sexual nature that occurred while the victim was in the military, regardless of geographic location of the trauma, gender of victim, or the relationship to the perpetrator.***

VA clinicians are legally obligated to address the substantial physical and mental illness that can follow MST. This Veterans Health Initiative (VHI) will explain how they can help their patients who are suffering from disability related to prior MST.

## What led to this emphasis?

The Navy’s Tailhook Incident in 1991 unleashed a groundswell of concern on the part of traumatized women veterans, their advocates, and their Congressional representatives. Hearings held before the Senate Veterans Affairs Committee on June 30, 1992, where women veterans told their gripping stories of sexual harassment and assault while on active duty, energized the system to provide more comprehensive care to women

veterans and focused attention on the serious health consequences of sexual trauma for women. More recently, when it became evident that many male veterans have also been the victims of military sexual trauma, Congress updated VA's mandate to assure gender-neutral access to care for its sequelae. These events are summarized in the following timeline, and additional information about relevant legislation is included in [Appendix A](#).



Unfortunately, despite efforts on the part of DOD, episodes of sexual harassment and sexual assault do continue to occur in military troops and in elite military academies. Such events receive ongoing attention in the national media, and their prevalence is substantiated by recent research.

### How Common is MST?

Among *active duty* military, about 5-6% of women have experienced military sexual assault, and about 78% military sexual harassment.<sup>1,2</sup> Following discharge from the military, a national cross-sectional, community-based telephone survey found 30% of women who served in the Vietnam era or later had been sexually assaulted.<sup>3</sup> In a group of women serving in the Gulf War, 8% experienced attempted or completed sexual assault during their deployment, even though that conflict was of relatively short duration, and occurred *after* the Tailhook incident had led to system-wide policy changes.

*About 1 in 4 female VA patients have experienced MST*

The prevalence is much higher among women in a VA population, as a number of studies have shown. In a national survey of 3,632 women veterans using VA, 23% reported a history of military sexual assault and 55% reported a history of sexual harassment while on active duty.<sup>4</sup> Among female patients at the Baltimore VA, 41% had a history of rape, and 60% of those rapes occurred while on active duty.<sup>5</sup> These rates of sexual assault *while in the military* are higher than *lifetime* rates among women in the general population.



*Half of veterans who screen positive for MST are men.*

This situation is not unique to women; in VA health care settings, MST is a mainstream health care issue for men as well. Based on VA's 2002 national MST surveillance data from approximately 1.7 million VA patients, about 22% of women and 1% of men have experienced MST. Thus, among VA patients, women are 20 times more likely to be victimized during their military tour than men are. However, there are 20 times more men than women in the VA system. Therefore, the actual numbers of men and women who screen positive for MST in VA are about equal. *Even though MST is far more common in women, 54% of all VA patients who screen positive for MST are men.* Military sexual harassment is also common: about 38% of men receiving VA care have experienced sexual harassment while in the military.<sup>1</sup>

While the focus of this VHI is upon MST, it is important to remember that military service represents a small slice of most VA patients' lives. Many veterans have also been exposed to other types of violence, such as child abuse and domestic violence. Later sections touch on these issues.

## How has VA responded?

The Department of Veterans Affairs (VA) is concerned about MST because it is known that any type of trauma can have enduring effects on a person's physical and mental health ([Section 3](#)). Enabling legislation authorizes VA to provide confidential, priority counseling and treatment to eligible veterans for MST-related physical and psychological problems.

## Who is eligible and how do they access care?

Any veteran who believes he/she experienced MST can apply at any VA medical facility (VAMC), Readjustment Counseling Service (Vet Center) or Veterans Benefits Office (VBA) for counseling and treatment of any MST-related injury, illness, or psychological condition, without obligation for co-payment. Veterans do not need to have a service-connected (SC) rating to receive these services. Even veterans with less than 24 months of active duty service (who otherwise would not be eligible for VA services) are eligible to receive this particular benefit. Reservists and members of National Guard units who were activated to full-time status in the Armed Forces are also eligible, unless the Reservist/National Guard member's service was on "active duty for training" (ADT). A Reservist/National Guard member who has received a service-connected rating for MST is eligible to receive MST counseling and treatment as well. It is important to know that sexual trauma counseling can be provided *even if a veteran did not report the incident when it occurred*. (See VHA Under Secretary for Health Information Letter (IL) 10-97-037 of November 27, 1997 for specifics of eligibility details, e.g., if veteran was not dishonorably discharged.)

The VA clinician does *not* need to determine whether the self-reported MST occurred; the patient's statement that it did suffices. Instead, the VA licensed health care provider must decide whether any of the patient's

presenting physical or mental health problems resulted from the trauma, which occurred while the veteran was serving on active duty. If so, the patient can receive VA care for those problems without obligation for co-payment. Counseling services may be contracted to community providers if, in the opinion of a VA mental health professional, receipt of these services in VA facilities is not feasible (e.g., because of geographic inaccessibility) or is not clinically advisable.

## **Do veterans have to be “service-connected” to get this benefit?**

MST counseling is provided independent of the Veterans Benefits Administration (VBA) claims process. When veterans are screened for MST, they are informed that they are not required to have a service-connected rating from the MST incident in order to begin or continue treatment. Indeed, MST counseling can be helpful for veterans who are considering filing a claim, because:

1. The claims process can be very traumatic for some veterans; counseling can help veterans as they think through whether or not to apply. If they decide to apply, ongoing counseling can help to support them through the process.
2. If a mental health diagnosis (e.g., PTSD) is identified and documented in the mental health setting, this can help to substantiate a future claim.

Several VHA Directives have been published that establish policy and provide guidance to VA facilities on the delivery, documentation, and tracking of MST counseling and services. Key documents include:

### **VHA Directives related to MST**

**Military Sexual Trauma Software** - VHA Directive 99-039 dated August 27, 1999. <http://www.va.gov/wvhp/docs/199039.pdf>

**Military Sexual Trauma Software Mandate** - VHA Directive 2000-008 (expires December 31, 2004)

[http://www.va.gov/wvhp/docs/VHA\\_DIRECTIVE\\_2000-008.doc](http://www.va.gov/wvhp/docs/VHA_DIRECTIVE_2000-008.doc)

**Eligibility Criteria for VA Health care to Veterans Seeking Counseling or Treatment for Sexual Trauma** - USH Information Letter 10-97-037, November 1997

<http://www.va.gov/publ/direc/health/infolet/109737.htm>

Table 1 below shows in a simplified way how the VA MST counseling and treatment benefit differs from the VBA MST compensation & pension benefit.

<b>VA MST Counseling &amp; Treatment Benefit vs. VBA MST Compensation &amp; Pension Benefit</b>		
	<b>MST Counseling &amp; Treatment Benefit (Based on Public Laws 102-585, 103-452, 106-117)</b>	<b>VBA MST Compensation &amp; Pension Benefit ("Service-connected disability" claims)</b>
How is MST determined?	Veteran states that he/she experienced MST	Veteran successfully proves to the Compensation & Pension Board that he/she experienced MST.
How is eligibility determined?	VA clinician determines that veteran's current symptoms are related to or consequences of MST.	Compensation & Pension Board determines that the veteran is currently disabled by a medical or mental health condition causally related to the MST.
What is the benefit?	MST counseling, and/or medical care for problems, which the clinician believes are related to the MST without co-payment obligation.	Medical care for the condition for which they received the service-connected status, without co-payment obligation (and possibly other benefits).

Table 1





## Relevance to VA Clinicians

### Learning Objectives

1. Describe at least two (2) clinical reasons *why* a health care provider should ask about MST and other experiences of violence.
2. Describe at least two (2) reasons, from a patient's perspective, why a health care provider should ask about MST and other experiences of violence.

### Why should I ask?

Primary care clinicians and other VA medical providers may be familiar with the high prevalence of MST in their female and male patients, but skeptical about its relevance to their practices. Why should medical providers concern themselves with their patients' MST histories? Consider these facts:

- **Exposure to violence can affect *physical* health.**
  - Sexual trauma is associated with high rates of *physical* symptoms and *medical* conditions clearly in the domain of medical providers ([Section 3](#)).
- **Sexual trauma is also associated with increased rates of *psychological* distress, such as post-traumatic stress disorder (PTSD), depression, and substance use disorders.**
  - Patients with mental illness typically present to the *medical* setting, rather than the mental health setting. Therefore, for patients suffering from ongoing psychological distress, medical providers are in a strong position to connect patients with definitive treatment ([Section 6](#)).
- **Sexual trauma can have complex effects upon *patient-provider interactions*.**
  - For example, routine medical procedures like colonoscopy or dental examinations might terrify a sexual trauma survivor. Likewise, boundary issues and interpersonal struggles can arise in the care of patients with trauma histories. Frustrating behaviors like heavy health care utilization or poor adherence to lifestyle modifications may become less perplexing and more amenable to intervention when understood in the context of a trauma history. For routine medical care to proceed smoothly, the clinician should consider such life experiences when using the strategies described in [Sections 10 and 11](#).

- **Acknowledging the sexual trauma history can be validating for the patient.**
  - This can communicate acceptance and can strengthen the patient-provider relationship. Patients are typically open to discussing this issue. However, they rarely raise the topic unless asked explicitly. It is up to the clinician to ask (**Section 4**).

(See **Appendix B** for additional information about the relevance of this issue to medical providers.)



# Health Correlates of Sexual Trauma

## Learning Objectives

1. Identify medical and psychological sequelae of sexual trauma.
2. Identify the effects of MST on utilization of and access to health care.

Considerable research has demonstrated that sexual trauma is associated with increased medical and mental health problems and health care utilization, described next. Various mechanisms for these associations have been explored.

## Is physical health really worse in patients with a MST history?

Numerous studies, mostly of women, have found a relationship between physical health and a history of sexual trauma. Compared to those without a sexual trauma history, women reporting sexual harassment or sexual assault histories are more likely to perceive their health as poor. They experience higher levels of physical symptoms during the first year following sexual assault, and these symptoms can persist for years following MST. In women who use VA services, those who report military sexual assault report more frequent health problems and are more likely to be unemployed due to physical limitations.<sup>4, 6-10</sup>

Specific physical symptoms have consistently been seen with higher frequency among sexual trauma survivors. Table 1 below lists the specific categories of physical symptoms, and other symptoms associated with sexual trauma survivors.

Physical symptoms seen with increased frequency in sexual trauma survivors	
Category	Examples
<i>Chronic pain</i>	Low back pain, headaches, pelvic pain
<i>Gynecologic</i>	Sexual dysfunction, menstrual abnormalities, menopausal symptoms, reproductive difficulties
<i>Gastrointestinal</i>	Diarrhea, indigestion, nausea, swallowing difficulties
<i>Other</i>	Chronic fatigue, sudden weight changes, palpitations

Table 1

In addition to physical symptoms, **medical conditions** have also been identified with increased frequency in patients with sexual trauma histories. Disease inventories (using self-report methodologies) indicate that medical conditions more common in sexual trauma survivors include:

- arthritis;
- obesity;
- diabetes;
- hypertension;
- hyperlipidemia;
- myocardial infarction;
- chronic lung disease;
- endometriosis;
- miscarriage; and
- infertility.<sup>6, 7, 10</sup>

One study that included both men and women and used objective measures of disease found that older women who reported a history of sexual assault had increased risk of breast cancer and arthritis, while older men who reported sexual assault history had increased risk of thyroid disease.<sup>11</sup>

Given the association between history of sexual trauma and increased medical and mental health problems, it is not surprising that there is also increased utilization of medical services among women with sexual trauma histories compared with nonvictimized women and women who have experienced other crimes, despite the fact that their pre-assault health care utilization was *not* elevated.<sup>4, 12</sup> Typically patients with a sexual trauma history present to *medical* (not mental health) providers.<sup>9</sup>

### Why do sexual trauma survivors have more physical illness?

A number of mechanisms for the association between sexual assault and physical illness have been proposed.

1. A possibility is that this reflects a *lower threshold for reporting symptoms or higher rates of somatization disorders*. However, this would not explain higher rates of diagnosed disease in patients with a sexual trauma history.
2. There could be *direct health effects* of the assault; for example:
  - 4-30% of sexual assault victims contract a sexually transmitted disease during the assault;
  - 4% sustain serious physical injuries; and
  - 5% of women of childbearing age become pregnant.
3. *Indirect mechanisms*. Individuals with histories of sexual trauma are more likely to engage in *behaviors* that can lead to future health problems, such as:
  - tobacco use;
  - substance use disorders; or
  - high-risk sexual behaviors (e.g., multiple partners, unprotected sex, prostitution).



4. ***Physiologic mechanisms.*** A substantial body of scientific evidence has documented sustained neuroendocrine derangements in people with sexual trauma histories. For example, dysregulation of the hypothalamic-pituitary-adrenal axis and adrenergic dysfunction after sexual trauma are well established, and can persist for years after the trauma.<sup>13-16</sup> These physiologic abnormalities may explain in part why patients with a sexual trauma history have a greater burden of physical illness.

## How does MST influence psychological health?

A history of sexual assault in women has been associated with increased risk of:

- *depression;*
- *post-traumatic stress disorder (PTSD);*
- *suicidal ideation and attempts* (especially among patients with PTSD);
- *panic disorder;*
- *generalized anxiety disorder;*
- *obsessive-compulsive disorder;* and
- *substance abuse and dependence.*<sup>17-19</sup>

The psychological effects of sexual trauma in men have not received adequate attention. Like women, the majority of men who are sexually assaulted go on to develop PTSD symptoms.<sup>20, 21</sup> Men are at higher risk for completed suicide than women; poor social supports, older age, and co-morbid addiction or depression all convey added risk of suicide.<sup>22</sup>

In addition to these psychiatric diagnoses, sexual trauma is also associated with ***psychological symptoms*** and ***social issues***, although such reactions to trauma are certainly not universal. Sexual trauma can be associated with:

- self-blame and shame;
- difficulties with trust;
- problems in psychological defense mechanisms (repression, denial or normalization of the trauma);
- poor self-esteem and body image;
- gender identity fragility (especially in men, who are more likely than women to have experienced same-sex assaults);
- sexual problems;
- impulsivity;
- anger;
- perpetration of violence;
- problems with readjustment after military service; and
- work difficulties.<sup>4, 7-9, 23</sup>

There is some evidence that sexual trauma experienced during the military may have a more deleterious impact on mental health than sexual trauma

occurring outside the military context.<sup>24</sup> Further, veterans whose war-zone experiences (e.g., combat) are complicated by MST may have an amplification of the effects of war zone trauma.<sup>25</sup> Thus, VA clinicians care for patients who have a high prevalence of exposure to traumas that can have particularly severe effects.

For patients reporting multiple victimization experiences, the severity of mental health sequelae tends to be even more pronounced.<sup>26</sup> For example, sexually revictimized women are more likely to have a lifetime diagnosis of PTSD, report problems with shame, experience difficulties in interpersonal functioning and engage in high risk sexual behavior.<sup>27, 28</sup> While less

research has addressed the consequences of multiple victimization among males, one study found that rates of revictimization were comparable among male and female sexual assault victims.<sup>29</sup> Given their increased risk of more severe mental health sequelae, women and men who have had repeated victimization experiences may be particularly likely to benefit from a mental health referral.

*MST survivors who have had repeated victimization experiences are likely to present with more complex and severe problems that may benefit from mental health referral.*

## Does everyone develop chronic problems after sexual assault?

In spite of the research showing consistently high rates of medical and psychological sequelae, which can persist for years after the trauma, it is important to remember that some patients with sexual trauma histories continue to function quite well. Primary care providers see three classes of patient:

1. Patients who have processed the trauma and are currently doing well
2. Patients who *seem* to be doing well, but who actually have undetected current distress related to the prior MST (their silent suffering may not be clinically evident)
3. Patients who have obvious current psychological distress (e.g., anxiety, interpersonal difficulties) or diagnosed psychiatric conditions (e.g., PTSD)

To reach patients with ongoing distress, clinicians need to first identify the trauma history and then determine how the patient is currently coping. Since many medical providers have not been trained how to identify a sexual trauma history, the next section addresses this issue.

# 4

## Screening for MST

### Learning Objectives

1. Develop the skills to effectively screen patients for history of MST.
2. Identify two sexual trauma-screening tools.
3. Recognize gender-specific differences in the experiences of sexual assault victims.
4. Recognize provider responses that might offend patients with MST history.

### Why screen all patients for MST?

All VA patients should be screened for MST because:

1. VA mandates universal screening (Public Law 103-45); and
2. screening of VA patients has positive clinical effects.

MST is common and is often associated with physical and mental health sequelae amenable to intervention. However, many patients do not spontaneously disclose a trauma history. Therefore, the first step in helping patients is to identify the MST history.

### But won't I upset the patient if I ask? How do I avoid being offensive?

Many caring clinicians worry that asking about an MST history may offend or upset the patient. However, studies conducted in the private sector provide reassurance that, although most patients have never been asked

*The majority of patients would like providers to ask*

about a history of sexual trauma, *the majority of men and women would like their physicians to ask routinely.*<sup>30, 31</sup> In surveys, patients say that if asked, they would answer truthfully, and they believe providers can help.

All the same, there are barriers to disclosure, some unique to veterans. Veterans who reported MST while still in the military often state that subsequent to the report they were transferred to less desirable positions or experienced other negative consequences, such as escalation of the trauma or being court-martialed for fraternization. Some who pursued the complaint or pressed charges report that this process was worse than the

MST itself. Regardless of the veteran's sexual orientation, veterans may be especially reticent about revealing same-sex assaults or harassment because of policies in the military about homosexuality. In light of such concerns, veterans may be hesitant to spontaneously reveal this information to government employees. Affected veterans may also be concerned about how they will be viewed by their family, friends, and others in the community. Male veterans may have particular concerns about disclosure due to the gender-related stigmas.<sup>32, 33</sup> Therefore, clinicians need to develop skills that allow them to ask in the least threatening way possible.

## How do I screen?

The next sections dissect the screening process. Important elements include:

- ***Establishing a comfortable climate for disclosure.***  
For example:
  - assuring a lack of interruptions and a private setting,
  - assuming a nonjudgmental stance, using unhurried speech and making good eye contact.
- ***Deciding on screening modality.*** Three major options are:
  - a written, self-administered intake form;
  - screening by the clinic nurse in a private room, or
  - screening by the clinician (e.g., when taking the social history).
- ***Introducing the line of questioning.*** For example:
  - "Violence is common in our society, so I ask all my patients about this."
- ***Asking the question.*** For example:
  - "While you were in the military:
    - Did you receive uninvited and unwanted sexual attention, such as touching or cornering, pressure for sexual favors, or verbal remarks? [Sexual harassment]
    - Did someone ever use force or the threat of force to have sexual contact with you against your will? [Sexual assault]"

Once a clinician has established a routine for asking, these steps can proceed smoothly.

## How do I establish a comfortable climate for disclosure?

While most patients are willing to disclose a trauma history to their medical providers, patients may feel threatened by the prospect. Survivors of sexual assault often feel that others blame them for what happened.<sup>34</sup> While clinicians may perceive the health care environment as safe, to a patient it may feel perilous. For example, the patient may dread the prospect of being touched during the

*The screening steps are illustrated in three (3) Case examples, Grace-1 (part 1) (page 117), Kevin-2 (part 1) (page 121), and Carlotta-3 (part 1) (page 125) for review. You may also view a short video related to these steps by going to <https://www.ees-learning.net>.*

physical exam (**Section 11**). It is, therefore, essential to create a warm, safe and non-judgmental environment in which the veteran may disclose an MST history, and to assure his or her confidentiality in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations (see <http://www.aspe.hhs.gov/admsimp>) and VA policy.

The physical setting and clinical approach influence the patient’s perception of how receptive and empathic the clinician will be. How does the clinician set the tone? Table 1 gives some examples of how the environment can shape the patient’s experience and influence his/her comfort with disclosure.

<b>MST Environment and Patient Perception</b>	
<b>Environment that may feel threatening to patient</b>	<b>Environment that may feel secure to patient</b>
<ol style="list-style-type: none"> <li>1. A stark, cold exam room with the patient waiting, shivering, in a johnny</li> <li>2. Clinician frequently leaves the room or accepts multiple telephone interruptions</li> <li>3. Clinician leaves the exam room door open</li> </ol>	<ol style="list-style-type: none"> <li>1. Tranquil pictures are hanging on the walls, and ambient temperature is comfortable</li> <li>2. Clinician attends to the patient without interruption</li> <li>3. Clinician sits at the same level and makes good eye contact</li> <li>4. Clinician’s speech is unhurried (despite the tremendous time pressures of the current health care environment)</li> <li>5. Questioning is non-judgmental; if the patient declines to respond to the inquiry, his/her wish is respected</li> <li>6. Inquiry occurs in a private setting, where confidentiality can be assured</li> </ol>

Table 1

### **Who should screen, and where?**

VA facilities handle MST screening logistics in a variety of ways. Table 2 presents common acceptable approaches for screening patients with MST.

MST Screening Logistics		
Approach	Advantages	Special considerations
<p><b>Intake forms:</b> patient completes a self-administered form, which includes questions about MST, while at home or in the waiting room</p>	<p><b>Efficient:</b> decreases the chance that these questions will be overlooked in the course of a busy encounter</p> <p><b>Normalizing:</b> every patient receives the form, so they know they are not being singled out</p> <p><b>Sets the tone:</b> communicates to the patient that the clinician is open to discussing these issues, and, if one of many questions on the form, conveys the concept that the MST history is one aspect of overall health</p>	<p><b>Privacy:</b> the patient should complete the form in a spot where others will not be looking over his/her shoulder, and return it to the clinician, or to the clerk in a closed folder</p> <p><b>Assistance:</b> patients who are illiterate or vision-impaired can have the form administered verbally in a private room</p> <p><b>Follow-up:</b> clinicians can run through the form in the patient's presence, inviting the patient to expand on positive or negative responses; e.g., "I see you marked 'no'. The reason we ask is that many patients have had such experiences, and they may not be aware that they are entitled to receive counseling."</p>
<p><b>Intake by nurse:</b> the nurse screens for an MST history in a private room during routine clinical intake</p>	<p><b>Efficient:</b> divides responsibilities between care providers; assures systematic screening</p>	<p><b>Repeated disclosure:</b> some patients find it intrusive to have to reveal this history to multiple providers</p>

Table 2

Table 2 (cont.)

Approach	Advantages	Special considerations
	<p><i>Private:</i> conducted behind closed doors</p> <p><i>Team:</i> conveys to patient that nurses and other clinicians function as a team; some perceive nurses as less threatening than primary care providers</p>	
<p><i>Screening by primary care provider:</i> the clinician includes questions in the course of the clinical interview (e.g., as part of the Social History)</p>	<p><i>Clinical assessment:</i> the clinician is able not only to screen for MST, but also to conduct additional assessment regarding its current clinical impact and need for further intervention</p> <p><i>Patient-provider relationship:</i> the clinician can express empathy and convey the idea that addressing sequelae of MST is just one aspect of overall care</p>	<p><i>Logistics:</i> clinicians need to find a comfortable approach that allows them to remember to screen every patient</p>

Table 2

Since screening for MST is a clinical procedure, it is not advisable for administrative staff (e.g., clerks) to perform the screening.

### How do I introduce this line of questioning?

Clinicians find different ways to incorporate questions about sexual trauma into the medical interview. Many incorporate it into the social history, when they are asking about home life, sexual behaviors, depressive symptoms, etc. Normalizing statements can help introduce the questioning, e.g.,

*“Violence is common in our society, so I ask all my patients about this.”*

*“Many of my patients have had upsetting experiences in their lives which may still bother them today.”*

*“In response to increased awareness that many men and women have experienced sexual harassment or sexual assault*

*during their military service, VA has launched a national effort to identify those veterans who may be in need of services, so all veterans are now being asked about certain experiences.”*

Linking the question to a patient’s complaint or echoing his/her concerns may be useful, e.g.,

*“I see many patients who have problems like yours, and some have had distressing experiences in their lives, such as being hurt by a partner or being forced to have sex against their will. Has anything like that ever happened to you?”*

However, this type of approach must be used judiciously, lest the patient misinterpret it as suggesting that the clinician is dismissing his/her symptoms as “all in my head”.

These types of introductory statements can be followed with more specific questions, presented in the next section.

*To see an example of an approach discussed above, review Video Clip #1. You may review the video at: <https://www.ees-learning.net>.*

### Are there specific questions I can Use?

The Trauma Questionnaire (TQ) (Table 3) was developed by VA clinicians and validated in a VA setting.<sup>35</sup> Item 5 asks about military sexual harassment, and Item 6 asks about military sexual assault; it also includes questions about other lifetime traumas such as domestic violence.

Trauma Questionnaire			
Some people experience traumatic events during their military service. We are trying to find out about these events and how they affect veterans’ lives. We also want to find out if veterans want mental health help addressing these or other concerns. To answer a question, please check <u>yes</u> , <u>no</u> , or <u>don’t know</u> . Thank you for your time.			
	Yes	No	Don’t know
1. Have you ever been involved in a major accident or disaster?			
2. Have you ever been physically assaulted or been a victim of a violent crime?			
3. At any time, has a spouse or partner (significant other) ever threatened to physically hurt you in any way?			
4. At any time, has a spouse or partner (significant other) ever hit you, kicked you, or physically hurt you in any way?			
Did this happen to you while you were in the military?			
5. Have you ever received uninvited and unwanted sexual attention (e.g., touching or cornering, pressure for sexual favors, verbal remarks?)			

Table 3



Table 3 (cont.)

	Yes	No	Don't know
Did this happen to you while you were in the military?			
6. Has anyone ever used force or the threat of force to have sex with you against your will?			
Did this happen to you while you were in the military?			
7. Were you ever sexually assaulted or touched in a sexual way, by a person 5 or more years older than you, when you were younger than 13?			
8. Would you like to talk to a mental health worker about any of the above problems?			
9. Do you have any mental health questions or concerns that are not on this questionnaire?			
10. Would you like to talk to a mental health worker about these other problems?			

Table 3

Besides Items 5 and 6 of this questionnaire (which can be administered in written or verbal format), other specific questions can be used such as:

*“Has anyone ever touched you in a sexual way or had you touch them in a sexual way that made you uncomfortable?”*

*“Have you had a sexual experience that you did not want?”*

Table 4 highlights some key considerations when choosing questions:

Do	Don't
Use questions that describe the <i>specific behavior</i> in simple terms (e.g., “someone forced you to have sex against your will”)	Use <i>jargon</i> or emotionally loaded terms (e.g., “rape”, “sexual assault”, “domestic violence”, “sexual abuse”, “incest”) that the patient may not recognize as applying to him/her (e.g., a woman may not realize that a husband can rape a wife, or may think that if she was intoxicated it could not have been a sexual assault)
Take a <i>non-judgmental</i> stance (e.g., “many of my patients have had disturbing experiences which can influence their health and well-being”)	Use <i>negative questioning</i> (e.g., “you were never sexually assaulted, were you?”)

Table 4

**Section 5** discusses how to respond if the patient discloses that he/she has indeed experienced MST, but first we turn to some concrete concerns many clinicians have about the screening process.

## **What should I expect the patient will tell me?**

Patients who report an MST history may or may not disclose details about the trauma to their health care providers. However, it is helpful for clinicians to have some understanding of the range of experiences commonly seen in MST.

**Perpetrator:** The perpetrator(s) may be male or female, and may be military personnel (a colleague or supervisor) or a civilian. The veteran may or may not have known the perpetrator(s).

**Circumstances of assault:** The assault may occur on or off base, in a combat zone or stateside. Rape (of both men and women) can be a form of torture of prisoners of war. Witnesses may have been present, either participating in the assault, passively observing, or attempting to rescue the victim. A weapon may or may not have been used. The perpetrator and/or the victim may have been under the influence of alcohol or drugs. Besides threatening the patient physically (perhaps leading the victim to fear for his/her life), the perpetrator may have threatened the victim's military career or the victim's family if the victim did not submit. The assault may have been a single incident, or may have occurred repeatedly. The victim may or may not have had a history of prior childhood trauma.

**Nature of assault:** Sexual harassment of both men and women is common, and can include uninvited and unwanted sexual attention, such as touching or cornering, pressure for sexual favors, or verbal remarks. Sexual assault involves the use of force (or threat of force) to have sexual contact against the victim's will. Among the common forms of sexual contact are oral, anal, or (for women) vaginal penetration. Associated with the assault may be other forms of injury, including fractures, lacerations, and head trauma, as well as sexually transmitted diseases and pregnancy.

**Response to assault:** The victim may or may not have sought medical attention following the assault to treat injuries, sexually transmitted diseases, or psychological distress. If he/she did seek medical attention for injuries, he/she may or may not have revealed their cause to the treating clinician. The victim may or may not have told a friend or supervisor about the assault. If so, the victim may have had positive experiences (e.g., being believed and comforted, seeing successful personnel or legal actions against the perpetrator) or negative experiences (e.g., being ridiculed or discredited, being demoted or transferred, or being court-martialed for fraternization).

**Gender effects:** While there are many similarities between the experiences of women and men who are sexually assaulted, there are also differences by gender.

### *Women*

Women are often a numeric minority, not only in the military (where there may be limited numbers of other women in whom they can confide), but also in the VA health care setting. Since women are most often attacked by men, they may feel threatened in a VA setting (with its preponderance of male patients), where women, by virtue of their minority status, can stand out as different. (Of note, men are also most often attacked by men, so they can likewise feel threatened by a VA setting.) Women's acculturation tends to emphasize the primacy of relationships, with a sexual assault representing a severe violation of trust. Women veterans are less likely than male veterans to be married, and may have lower social supports. Finally, military service generally involves a gender-nonstereotypic role for women; this could be either a resilience factor (e.g., if the woman perceived herself as a maverick) or a vulnerability factor (e.g., if the woman perceived herself as an outsider). VA primary care providers should be prepared for the possibility that their female patients will raise such issues. Some may just want to articulate such experiences in a validating clinical setting. For others, there may be management implications. For example, some women veterans will specifically request to have a female primary care provider, and some will be more comfortable receiving care in a setting where there are other women in the waiting room (such as in a designated women's clinic). For both women and men, the trustworthiness of the clinician can have great importance.

### *Men*

Men also have distinct experiences with MST. A common theme among men who have been raped is a perception that the trauma significantly reflects on and/or affects the survivor's own masculinity or sexual orientation.<sup>36, 37</sup> While most women are raped by members of the opposite sex, most men experience rape by other men. Heterosexual men may fear that they betrayed some feminine or homosexual quality that provoked the attack. Homosexual men may come to relate to their sexual orientation with an overwhelming sense of vulnerability.<sup>38</sup> Men who have been raped tend to feel personally responsible for the attack, and ashamed for not having been powerful enough to repel or escape their attackers. (Women trained as soldiers may feel similar shame.) They may hide their victimization from others and may hesitate to share this history with a health care provider, especially male providers (lest they be thought of as "less manly" than the provider). When men do seek help, they may feel revictimized in the process. Some of their sense of revictimization may be entirely subjective (secondary to the patient's personal fears and beliefs) but some providers have unconscious negative reactions to male survivors related to traditional gender role stereotypes. All these factors may prevent male MST survivors from getting the help they need.<sup>39</sup> Therefore, even though MST is less prevalent in men, it is extremely important that men receive routine MST screening. When men disclose a history of MST, they should be reassured that many other men have had similar experiences, and that no one deserves to be treated in that way. Both men and women need to understand that sexual assault is a crime of power and control, not sexual

passion. Clinicians need to respond to both men and women in a non-judgmental, affirming manner.

## How do I avoid opening Pandora's Box?

Many providers fear that screening for sexual trauma will open a floodgate: the patient will need to reveal details about the trauma, and will express strong emotions of pain and anger. Clinicians may face a dilemma, feeling unprepared to cope with detailed disclosure and worried about derailing a busy clinic, yet recognizing that information about a patient's sexual trauma history is relevant to medical care.

The reality is that patients show a range of disclosure styles. For example, some patients disclose with a flat or even cheerful affect, showing no overt signs of distress. Others may be visibly anxious, express a need to leave the room or become tearful or angry. An occasional patient will start to go into great detail about the trauma, perhaps even dissociating from the clinic context and begin to re-experience the trauma as if it were happening in the present tense.

Clinicians can usually manage the disclosure process in a way that conveys empathy while at the same time placing limits on time and depth of disclosure. Usually it is enough to listen empathically.

While some patients will only be comfortable stating that the MST occurred (without providing any details), most patients will provide limited details, such as:

- when the trauma happened;
- who attacked them;
- what type of assault it was (e.g., sexual assault, use of a weapon);
- what injuries they sustained;
- whether they received treatment afterward; and
- whether they have felt comfortable enough to disclose this information to anyone else previously.

*To see an example of Dissociation, review Video Clip #5. You may review the video at: <https://www.ees-learning.net>.*

These types of details may be relevant to a medical provider.

However, if a patient begins to disclose in greater detail (e.g., a moment-by-moment account of what happened during the assault) or if the patient appears profoundly distressed by even minor disclosure, it is helpful for the clinician to gently limit the disclosure process. In doing so, the clinician needs to avoid implying that the information provided was disgusting or shameful, or that the patient, who likely feels very vulnerable at this point, was wrong to have shared this information. The clinician also must avoid giving the impression that he/she does not believe the patient. Instead, it should be clear that this limit-setting is an act of caring. For example, the clinician might say:

*"I'm sorry that this happened to you. No one deserves to be hurt like that. I am very glad that you were willing to share*

*this information with me, as it will help me to do a better job as I provide your medical care. I am going to ask that we not discuss the details of this trauma today, because that is best done with a counselor who has special training in knowing how to help you work through a very upsetting past experience. Many of my patients who have had experiences like yours have found it very helpful to talk with one of our counselors. Would you be interested in that?"*

After disclosing sensitive information, patients sometimes have feelings of shame and regret about having “exposed” themselves. To address such reactions, at the end of the visit it may be helpful to reassure the patient that if any concerns arise before the next visit, he/she is welcome to call.

## Does clinician gender matter?

### Should male clinicians ask females about MST?

Both male and female providers can successfully screen for MST. However, since most perpetrators of MST are men, male clinicians may have concerns that patients (both women and men) who have experienced MST will have generalized negative feelings about men. This is sometimes true, and an occasional patient will specifically request to see a clinician of a particular gender; if this request can be honored, it is generally advisable to do so. However, for most patients, a clinician of either gender will be acceptable. That being said, clinicians need to remember that the clinician’s characteristics (e.g., gender, race, age, manner of speech) can potentially remind any MST survivor of his/her assailant. Efforts to minimize the patient’s level of fear during the clinical encounter ([Section 11](#)) can help to decrease the intensity of such “transference” reactions. Some patients find it helpful to discuss these issues directly with their mental health providers. By exploring maladaptive Post-traumatic beliefs (e.g., “all men are dangerous”) in the setting of mental health therapy, patients can learn to develop beliefs that are more helpful. In fact, for patients who were assaulted by men, it can potentially be helpful to experience a positive, safe professional relationship with a male medical provider.

*Both male and female providers can effectively screen for MST*

### What if I have my own Trauma history?

Many clinicians have their own trauma histories. For them, asking the patient about sexual trauma can potentially trigger painful memories. Occasionally this imposes an excessive burden on the clinician. In this case, the patient still needs to be screened, so arrangements should be made for a colleague to conduct the screening. More commonly, clinicians who have a trauma history are able to maintain enough emotional distance to allow them to ask these questions effectively. If they do, it is essential that they remain vigilant about maintaining appropriate boundaries (e.g., not disclosing their own trauma history to the patient or becoming overly involved in the patient’s

story); see [Section 10](#) for more information about boundaries. They also need to monitor themselves for symptoms of vicarious traumatization or burnout ([Section 15](#)). Discussing difficult clinical situations with a trusted colleague can help to lessen the impact of an emotionally charged encounter and offer a different perspective.



## What to do Next: Responding to MST Disclosure

### Learning Objectives

1. Describe logical steps the provider should take once the patient discloses an MST history.
2. Identify effective key elements in responding effectively to patients who disclose a history of MST.
3. List principles guiding provider responses to patient's MST disclosure.

### My patient just disclosed an MST history. What do I do next?

Primary care providers may worry about how to respond to a patient's MST disclosure. Fortunately, there are concrete steps the clinician can follow which will help the process to go much more smoothly. This is always a sensitive topic, but with practice, medical providers can become comfortable discussing it, and gratified by the fact that they help their patients in doing so.

The first steps after the patient discloses an MST history include:

- **Validation/empathy** - e.g., "I'm sorry that you experienced sexual trauma during the military."
- **Educating** - e.g., "Many veterans have experienced sexual trauma during the military."
- **Assessing current status, including health sequelae of trauma, and current safety** - e.g., "Do you feel that you are currently having physical or emotional effects from the trauma?"
- **Assessing level of support** - e.g., "Have you been able to discuss this with anyone previously?"

Key elements of the initial response to disclosure of MST are represented by the mnemonic "**RESPECT**", as depicted in Table 1 (next page).<sup>40</sup> These concepts help primary care providers to avoid some common pitfalls, such as:<sup>41, 42</sup>

- **negative questioning** (e.g., "you were never sexually assaulted, were you?")

- **labeling** (e.g., when speaking with the patient, referring to “people like you”; or when speaking with colleagues, referring to “that crazy patient”)
- **implicit assumptions about the patient** (e.g., “She probably brought it on by going out drinking with the guys”)
- **trust issues** (e.g., patient not trusting the provider may minimize disclosure of trauma)
- **control issues** (e.g., provider controlling the interview with an authoritative stance or a loud voice, or allowing little time for patient to talk)
- **denial** (e.g., provider believes that patient would not have had such an experience(s))
- **boundary crossings** (e.g., around professional boundaries, duration of clinical encounter, etc.) (**Section 10**)

*To see an example of RESPECT go to page 123 and view the Case example Kevin-2. You may also view a short video related to RESPECT by viewing Video Clip #2 at: <https://www.ees-learning.net>.*

Guiding Principles of Provider Response to MST disclosure		
Principle	Concept	Concrete Steps/Examples
<b>R - respect</b>	Be respectful and validating of the veteran’s MST experience. Convey a non-judgmental, non-shaming stance. The role of the medical provider is to provide health care, not to determine the truthfulness of the disclosure. In one study of rape survivors, those who felt that they were believed had fewer subsequent emotional and physical health problems. <sup>43</sup>	<ul style="list-style-type: none"> <li>• Listen attentively to the patient’s story in a private setting.</li> <li>• Validate: convey to the patient that he/she did not invite the MST and did nothing to deserve it, and that the consequences he/she attributes to the abuse are valid, e.g., “no one deserves to be hurt in that way”.</li> <li>• Maintain appropriate boundaries around the disclosure process, e.g., not pressing the patient to disclose more than he/she is ready to (<b>Section 4</b>).</li> </ul>
<b>E - empathy</b>	Empathy is the ability to understand or experience the emotional state of another. This can be as simple as acknowledging the patient’s current feelings before moving on	<ul style="list-style-type: none"> <li>• Convey an authentic and empathic stance, e.g., “I can see that talking about this MST issue makes you very sad.”</li> </ul>

Table 1



Table 1 (cont.)

Principle	Concept	Concrete Steps/Examples
	<p>to another topic. Providers may find it challenging to maintain an empathic stance with patients whose MST has caused them to become hostile, emotionally distant, distrustful, or needy (<b>Section 10</b>).</p>	<ul style="list-style-type: none"> <li>Express regret about the patient’s experience: “I am sorry that you experienced sexual trauma during the military.”</li> </ul>
<p><b>S - support</b></p>	<p>People who experience sexual trauma may have difficulty with interpersonal relationships. Furthermore, there are societal taboos around sexual trauma that can penalize and isolate the victim. Therefore, veterans with an MST history often have a limited social support network.</p>	<ul style="list-style-type: none"> <li>Determine what kind of social support the patient is currently experiencing, e.g., “Who is supportive of you in your life now? Do you currently have anyone you can confide in about your feelings around the MST?”</li> <li>Remember that primary care providers and other VA clinicians are often an important part of a veteran’s support network.</li> </ul>
<p><b>P - patient perceptions and preferences</b></p>	<p>Patients vary in their perceptions of whether or not the MST history is affecting their lives currently in terms of physical or emotional health and what type of help, if any, is needed. Attention to a patient’s preferences and perceptions communicates respect.</p>	<ul style="list-style-type: none"> <li>Seek to understand the patient’s perceptions, e.g., “How has the MST experience affected your life and health?”</li> <li>Ask the patient about his/her preferences regarding help with MST (<b>Section 6</b>).</li> </ul>
<p><b>E - educate</b></p>	<p>Sharing information about MST communicates to the patient that the clinician cares about this topic, and takes this issue seriously.</p>	<ul style="list-style-type: none"> <li>Teach patients about MST prevalence and sequelae, e.g., “Many veterans have experienced MST. Some may have health problems related to MST such as chronic pain, PTSD, depression or problems with drugs and alcohol.” <b>(See Appendices C and D for Resources &amp; MST patient information)</b></li> </ul>

Table 1

Table 1 (cont.)

Principle	Concept	Concrete Steps/Examples
<p><b>C - clinician beliefs about MST</b></p>	<p>Hearing the patient’s history of MST can be burdensome to clinicians, potentially contributing to clinician burnout. This may be particularly true for clinicians who have themselves experienced past trauma.</p>	<ul style="list-style-type: none"> <li>• Be aware of your own beliefs about MST and mindful of professional boundaries.</li> <li>• Seek support when needed (<b>Section 15</b>).</li> <li>• Learn more through continuing education, e.g., in annual meetings of the Society for General Internal Medicine (<a href="http://www.sgim.org">http://www.sgim.org</a>) or the American College of Physicians (<a href="http://www.acponline.org">http://www.acponline.org</a>) or the International Society for Traumatic Stress Studies (<a href="http://www.istss.org">http://www.istss.org</a>). Many state medical societies also have ongoing educational programs.</li> </ul>
<p><b>T - Triage</b></p>	<p>While many survivors of MST are stable and will not require immediate assistance, a few may require expedited referral for mental health or crisis services.</p>	<ul style="list-style-type: none"> <li>• Safety: Assess for current suicidal or homicidal behaviors or ideation, and screen for ongoing family violence (<b>Section 13</b>).</li> <li>• Psychosis: Determine whether the patient has experienced anything unusual or frightening, or fears that people are out to get him/her.</li> <li>• Substance use: Screen for problematic use of alcohol and other substances.</li> <li>• Stabilization: For patients in acute crisis (medical or psychological), address the acute issues, and defer intervention for the MST history until the patient is stabilized.</li> </ul>

Table 1



## Referring the Patient to Mental Health and Social Services

### Learning Objectives

1. Identify barriers to patient's willingness to accept a mental health referral and provider strategies to overcome them.
2. Describe steps providers should take if a patient refuses a mental health referral for MST counseling.
3. Identify VA resources and array of health care experts specializing in the treatment of trauma patients.

### Which patients need a mental health referral?

All patients with a sexual trauma history should be offered the option of a mental health referral. However, it should be noted that not every person who has experienced trauma wants or needs the help of a mental health specialist. Some patients have already processed the trauma, either on their own or with assistance. Furthermore, trauma does not inevitably result in symptoms or impairment. It would seem logical then to only offer a mental health referral to patients who report current symptoms or difficulties related to past trauma. However, patients may have coped by making it appear to others that they are doing well when in fact they are experiencing

*Clinicians should offer mental health referral to all MST survivors, even if they are not reporting current symptoms*

considerable emotional distress and are struggling to function. Therefore, mental health consultation should be offered to all patients with a history of MST and not solely based on whether they are reporting symptoms or not.

Referral to mental health is even more important if active psychological symptoms are identified. As discussed in [Section 3](#), a number of psychiatric conditions are common in patients with MST histories, such as PTSD, major depression, and substance use disorders. Since primary care clinicians may be less familiar with how to screen for PTSD, a brief screening instrument is included in Table 1 (next page).

Primary Care PTSD Screen <sup>44</sup>		
In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, <b>in the past month</b> , you...		
YES	NO	1. have had nightmares about it or thought about it when you did not want to?
YES	NO	2. tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
YES	NO	3. were constantly on guard, watchful, or easily startled?
YES	NO	4. felt numb or detached from others, activities, or your surroundings?

Table 1

While this cannot be used to make a definitive diagnosis of PTSD, current research suggests that a positive response to two items should suggest the patient may have PTSD and should undergo additional evaluation. These items could be included on a primary care intake form, along with the sexual trauma screening questions and domestic violence screening questions. Screens for depression and substance abuse are routine in most VA primary care clinics, and are not included here.

### How do I offer a mental health referral?

An important factor in determining how to approach making a mental health referral is the nature of the relationship between the primary care provider and the patient. Obviously, if the relationship is well established, the provider probably has some ideas about how to present this issue in a way that would maximize the patient’s receptivity. If the patient is new or has infrequent visits, it will likely be more challenging to discuss what may be a sensitive issue for the patient, that is, the patient’s need for mental health care. Although this may be a touchy subject, it should be noted that many patients are not only receptive to a referral but are very appreciative. However, in some cases, patients who need or would benefit from a mental health referral may not be ready to consider a referral when it is initially presented. In such cases, making a referral may require a process of re-visiting the issue by “checking in” with the patient in subsequent visits. Barriers to accepting a referral can diminish with discussion and time, especially in the context of a supportive relationship. In Table 2, there are helpful strategies with examples for discussing a mental health referral with patients.<sup>45</sup>

Mental Health Referral Strategies	
Strategies	Examples
<b>Normalize:</b> Normalize mental health services for trauma-related problems.	“Many of my patients who had similar experiences have found it helpful to speak with a counselor.”

Table 2

Table 2 (cont.)

Strategies	Examples
<p><b><u>Consider the patient's agenda:</u></b> Focus on what is most personally meaningful to the patient.</p>	<p>"You said fatigue is your biggest concern. Many people who have had traumatic experiences find the strain of disturbing memories can be a factor in their fatigue, and that learning some simple stress reduction and coping techniques can help."</p>
<p><b><u>Offer a choice:</u></b> Present the offer of a referral in such a way that the patient knows it is his/her choice. The principle of "informed consent" applies here as it does with any medical treatment. Patients have the right to refuse treatment. This is especially important for trauma survivors because the trauma involved forcing the patient to do something against his or her will. The provider certainly does not want to re-traumatize the patient by forcing a referral.</p>	<p>"You have noticed that ever since the military, you have struggled with depression and at times, you have had trouble functioning. I would urge you to consider getting some help and I recommend that you meet with a mental health professional to discuss treatment options, but it is YOUR decision and I will support you in whatever you decide."</p>
<p><b><u>Explain the decision can be reversed:</u></b> It can help to present the purpose of the initial meeting with a mental health professional as an opportunity to learn more about the possible effects of trauma on the patient's life, to ask questions, and to learn about services. Stress that by agreeing to an initial assessment, the patient is not committing to treatment.</p>	<p>"It can be helpful to meet with a psychiatrist to learn more about medication options and to discuss your concerns about taking a medication. You may decide that medications are not for you or that you are not interested at this time. On the other hand, you might decide that a particular medication might be worth a try."</p>
<p><b><u>Assure the patient you are not abandoning him/her:</u></b> Somatically-focused patients should be reassured that pursuing mental health treatment will not diminish the provider's commitment to pursue a medical evaluation of their somatic symptoms.</p>	<p>"I would like to evaluate you for several of the conditions that can cause diarrhea. In addition to stool and blood tests, I would suggest that we also connect you with a counselor who can explore with you whether stress could be a factor as well."</p>
<p><b><u>Refer to a colleague you know:</u></b> A referral to a specific mental health professional that the primary care provider knows and recommends can increase acceptance of the referral. If feasible, it can be helpful for the primary care provider and the mental health clinician to hold a brief joint introductory meeting with a patient who is reticent about the referral.</p>	<p>"I know you are hesitant about seeing a psychologist. I wonder if it would help to meet Dr. Smith here in the clinic. You and I could have a short meeting with him. We could discuss some of your concerns with him and then you can decide whether you want to pursue getting help at this time."</p>

Table 2

## Are specific resources available to patients who have experienced military sexual trauma?

The extent and type of mental health services varies across VAMCs. Since this is such a common issue, clinicians need to learn about the mental health services available and the procedures for accessing services at their own VA facilities. For example, clinicians need to know:

1. where to send the consult;
2. which mental health providers have expertise in this area; and
3. how a mental health provider could be reached on an emergency basis.

The VA is mandated to provide treatment for military sexual trauma, and every VA has a staff person who has been designated as the “**military sexual trauma coordinator.**”

Military sexual trauma coordinators and Women Veterans Program Managers provide treatment and/or can help patients access treatment for MST. To identify the name of the MST coordinator at a particular facility, the clinician can contact the Mental Health or Behavioral Science department. Another potential resource is the local **Vet Center**. Vet Centers are Veterans Health Administration mental health programs located in the community. Many have a military sexual trauma counselor on staff. This option is particularly helpful for veterans who prefer a community setting rather than a VAMC setting for their mental health care.

Some patients with private insurance or other resources may prefer to seek help with a **private practitioner** or at a community clinic. Typically, the VA will not provide these services through fee basis unless VA services for treatment of military sexual trauma are unavailable or inaccessible (e.g., veteran lives a long distance from the VA).

While this discussion has focused on treatment of patients with a remote trauma history, clinicians occasionally encounter patients with acute trauma (e.g., acute rape or domestic violence).

Managing acute trauma is discussed more fully in **Section 14**. VA facilities need to have a protocol for addressing acute trauma, which are typically treated in hospital-based violence programs; because they see a low volume of acute trauma cases (especially acute rape), many VA facilities refer them to a community-based hospital. Such programs have staff who are familiar with taking forensic evidence and can help victims access supportive services such as shelters/safe homes, legal advocacy, and crisis counseling. VA social workers can also help identify community resources. A list of 800 numbers and national Web sites is provided in **Appendix C**. Agencies that provide assistance with locating local community resources are noted.

*To see an example of Referral to Mental Health Strategies, there are three (3) Case examples, Grace-1 (parts 2 & 3) (page 118), and Kevin-2 (part 3) (page 123). You may also view a short video related to these examples by going to <https://www.ees-learning.net>.*

*Every VA has a “military sexual trauma coordinator.”*

*VA facilities need a protocol for acute trauma (rape, domestic violence)*

## What if a patient declines mental health referral?

The patient of course has the right to refuse a referral. When the patient declines a mental health referral or does not follow through with the referral, it is important to understand the reason for the patient's decision, and to keep the door open to a future referral. The provider should emphasize that, should the patient decide at a later date that they want or need help, the

*The provider should establish an atmosphere conducive to open discussion of treatment options*

provider is always willing to revisit the issue. It is probably more important that the provider establish an atmosphere that is conducive to open discussion of treatment options than to persuade the patient to accept a referral. This is because:

- such an atmosphere allows the patient to work through any ambivalence; once a referral is accepted, the patient is truly ready, increasing the likelihood of a positive outcome; and
- although well intended, overzealous urging can result in the patient feeling intimidated into accepting the referral; this may remind the patient of coercion used during the assault, and could lead the patient to avoid the primary care provider.

Table 3 illustrates some common barriers to referral, and strategies for addressing them.

Common Barriers to Referral and Strategies		
Barrier to Referral	Strategies to Address Barrier	Examples
<p><b><u>Stigmatization/Shame:</u></b></p> <ul style="list-style-type: none"> <li>• About psychiatric diagnoses and about not being in control of one's emotions.</li> </ul>	<p>Educate patient. Emphasize that emotional distress and symptoms are due to the trauma and not due to personal failings.</p>	<p>"Feeling like crying and having nightmares are common after trauma—even when the trauma occurred years ago. This is NOT because you are doing something wrong or are not strong enough. It is not your fault that you are having these problems. You have been struggling alone with this for a long time. Treatment can improve symptoms and help you cope."</p>

Table 3

Table 3 (cont.)

Barrier to Referral	Strategies to Address Barrier	Examples
<ul style="list-style-type: none"> <li>About seeing a psychiatrist or psychologist, or visiting a mental health unit.</li> </ul>	<p>Problem solve with the patient. Seeing a social worker or seeing a mental health provider in the primary care setting may be perceived as less stigmatizing.</p>	<p>“I understand your concerns. We have a social worker that works with the patients in our clinic. She provides counseling and can also discuss with you other services that might be helpful to you. Would you like to meet with her?”</p>
<p><b><u>Documentation concerns:</u></b></p> <ul style="list-style-type: none"> <li>Patient may have concerns about confidentiality and the inclusion of sensitive and personal information in his or her medical record.</li> </ul>	<p>Validate concerns. Inform patient about VA policies regarding privacy and confidentiality. Vet Center, which maintains separate records, may be more acceptable to the patient.</p>	<p>“That is an understandable concern. VA policy stipulates that only those staff that need to access your records in order to provide your care should be accessing your records. Violations of patient privacy are taken very seriously.”</p> <p>“As another option, would you be more comfortable seeking help at a Vet Center, which keeps separate records?”</p>
<p><b><u>Personal meaning or inaccurate beliefs:</u></b></p> <ul style="list-style-type: none"> <li>About the mental health referral. “Being seen in mental health means I am crazy.”</li> </ul>	<p>Provide reassurance and alternative perspective.</p>	<p>“I know some people think that seeking help means you are crazy, but I look at it differently. It seems to me that people seek help because they want to feel better. Wanting to feel better is not crazy at all.”</p>

Table 3





Table 3 (cont.)

Barrier to Referral	Strategies to Address Barrier	Examples
<ul style="list-style-type: none"> <li>Fears related to negative past experiences with mental health care.</li> </ul>	<p>Identify likely differences between past care and current care.</p>	<p>“It sounds like in the military you were seen in mental health to evaluate your fitness for duty. Your current situation is quite different. The focus of the MST coordinator is to discuss treatment options with you and her concern is to help you cope with what happened to you. She has special training in the problems people can face after MST.”</p>
<p><b><u>Medication concerns:</u></b></p> <ul style="list-style-type: none"> <li>Talking about the fear of becoming addicted to psychotropic medications.</li> <li>Fear of being controlled by the medication or of becoming a different person.</li> </ul>	<p>Explain the difference between medications and street drugs.</p> <p>Emphasize that the goal of treatment is to increase control over one’s self and one’s life.</p>	<p>“Antidepressant medications do not make a person high. They correct a biological imbalance. This is very different from the addictive effects of street drugs.”</p> <p>“The medications do not control you. If anything, medications help you to be more in control of yourself. Medications help you to feel more like your old self.”</p>
<p><b><u>Others’ reactions:</u></b></p> <ul style="list-style-type: none"> <li>Concern about the reactions or disapproval of family or friends.</li> </ul>	<p>Assess source of patient’s concern. Emphasize that patient can discuss with his or her therapist whether and how to discuss their care with family or friends.</p>	<p>“I know that you are concerned that your partner may be upset about you seeing a therapist. It is up to you to decide whether and when to disclose this information to anyone else. How would you feel about waiting to decide what you want to do about that and discuss your concerns with your therapist?”</p>

Table 3

Table 3 (cont.)

Barrier to Referral	Strategies to Address Barrier	Examples
<ul style="list-style-type: none"> <li>• Fear that partner will be angry.</li> </ul>	Assess for acute domestic abuse. Emotional abuse involves controlling, intrusive behavior. Reassure patient about confidentiality. Problem solve with patient about keeping the nature of the appointment private.	“From what you told me, it sounds like your partner intimidates you and tries to control you. Let’s talk about how you can get the help you need. How can you see a therapist without your partner knowing?”

Table 3

### What if I am concerned about the safety of a patient who is declining a mental health referral?

The primary care provider is faced with a difficult problem when a patient who refuses mental health care appears to be in acute danger. Some situations may require psychiatric evaluation for involuntary hospitalization. For example:

- suicidal ideation
- homicidal ideation

For the safety of the patient and others, clinicians must follow legal mandates and facility procedures involving involuntary admission under these circumstances.

Other situations may place clinicians in the role of mandated reporter. Depending on the jurisdiction, clinicians may be mandated reporters for situations including:

- domestic violence
- child abuse
- elder abuse
- abuse of adults with disabilities

Clinicians need to be aware of state laws regarding mandated reporting. Local VA legal counsel can be a helpful resource in these situations. Bear in mind that local and state domestic violence (DV) reporting requirements are highly variable. Local and state DV reporting requirements can be accessed at <http://www.fvpf.org> and <http://www.endabuse.org>.

Involuntary commitment and mandated reporting can strain the provider-patient relationship. It can be helpful to consult with a mental health expert regarding the clinical ramifications of reporting and strategies for addressing any relationship problems that may result. For very complex clinical dilemmas, it can also sometimes be helpful to consult with the hospital’s ethics committee.





# Treatment of Mental Health Sequelae

## Learning Objectives

1. Identify options likely to be offered to a veteran who has been referred to mental health for the treatment of MST.
2. Describe the evidence-based psychosocial treatments available for survivors of sexual trauma, including treatment of PTSD, depression, substance abuse/dependence, and borderline personality disorder.
3. Describe efficaciousness of evidence-based pharmacotherapeutic agents in the treatment of the range of symptoms associated with PTSD.

## Are effective treatments available to survivors of sexual trauma?

As reviewed earlier in this module ([Section 3](#)), men and women with a history of MST are at risk for a range of negative psychological outcomes. PTSD is the disorder most closely associated with a history of sexual trauma, but survivors of sexual trauma are also at increased risk for depression, substance use disorders, panic disorder, generalized anxiety disorder, and obsessive-compulsive disorder. Survivors of sexual trauma may also struggle with a range of psychological symptoms, even in the absence of a specific psychiatric diagnosis, including low self-esteem, poor self-care, difficulties with interpersonal relationships, and sexual dysfunction. Effective mental health treatments are available to address a range of psychological conditions associated with exposure to MST.

## What happens when the patient arrives in mental health?

When referring a patient to the mental health setting, it is helpful for the referring clinician to provide the patient with a basic understanding of what to expect when he or she arrives. Patients who understand what to expect

*Patients who know what to expect are more likely to follow through with mental health referrals.*

tend to be less anxious about the referral and more likely to show up for the first mental health appointment. Since many primary care providers have little experience with specific mental health treatments, this section provides

an overview of major accepted psychotherapy and pharmacotherapy approaches. Even though primary care providers will not be administering these treatments (except, perhaps, for teaching simple stress reduction techniques or prescribing basic pharmacotherapy), they need to understand what happens in the mental health setting so as to be supportive and credible to their patients when making the referral.

While the nature of the treatment may vary from site to site, many VA hospitals and Vet Centers have at least one mental health professional with specialized training in the treatment of sexual trauma. Usually, after being referred to mental health for the treatment of sexual trauma, a veteran will be offered **formal assessment** for specific psychiatric diagnoses (e.g., depression, PTSD). The results of this assessment will be used to guide treatment decisions. Depending on the needs of the particular veteran, treatment options may include **individual psychotherapy, group psychotherapy** (supportive or skills-based), and, as appropriate, **psychotropic medications**.

Information about the treatment of specific psychological disorders is reviewed below. From a general perspective, psychotherapy for sexual trauma often involves some or all of the following elements:

1. addressing immediate health and safety concerns;
2. normalizing post-trauma reactions by providing education about trauma and psychological reactions to traumatic events;
3. providing the veteran with validation;
4. supporting existing adaptive coping strategies and facilitating the development of new coping skills, like muscle relaxation or deep breathing; and
5. exploring affective and cognitive reactions including fear, self-blame, anger, and disillusionment.

It is important for veterans to know that some types of psychotherapy focus on talking in detail about the sexual trauma and the veteran's reaction to it, while others do not. Even if patients are reluctant to discuss details of their traumatic experiences, they may still benefit from mental health treatments that focus on improving coping skills.

*Patients reluctant to discuss details of their traumas may still benefit from mental health treatments that focus on improving coping skills.*

## How effective are these treatments?

There is a wealth of information supporting the efficacy of treatment of sexual assault and related disorders among civilian populations, as described next. Since there are unique aspects to sexual trauma that occurred during military service, and since there is little empiric treatment data specific to military sexual trauma, patients ideally should be referred to mental health providers who are familiar with and sensitive to the military context of the trauma.

## What are effective treatments for PTSD?

### Pharmacotherapy

Pharmacotherapy has proven efficacy in reducing a range of symptoms associated with PTSD. General principles of PTSD treatment in primary care are discussed here. Additional details are provided in [Appendix E](#). A detailed discussion of the evolving field of PTSD pharmacotherapy is beyond the scope of this text. However, excellent references include the Veterans Health Initiative on PTSD at <http://www.va.gov/vhi> and <https://www.ees-learning.net/> (in study/PTSD), and the VA/DoD PTSD Treatment Guidelines, at <http://www.guideonline.info>.

Some general principles of PTSD pharmacotherapy are:

- **Patient involvement:** Ensure that the patient is fully informed and engaged in the treatment plan. Patients with PTSD may feel distrustful of health care providers. Unless all their concerns are addressed, they may not start the medication or may discontinue it prematurely.
- **Written instructions:** Give patients written instructions; because of difficulties with attention, concentration and memory, patients with PTSD may not remember verbal instructions.
- **Drug-drug interactions:** Confirm that the medication being started does not interact with the patient's other medications (prescription or non-prescription, and herbal remedies or supplements).
- **Follow-up:** Monitor the patient closely, especially during the initial period after starting the medication. In general, a good rule of thumb is to see the patient back within 2 weeks of starting a new medication for PTSD. The patient also needs to know how to get help and who to contact if he/she has difficulties with the medication.
- **Psychiatric consultation:** Seek psychiatric consultation for more complex conditions (e.g., PTSD with comorbid substance abuse or bipolar disorder, complex PTSD, or patients in severe acute distress), or for patients that have a poor response to first-line medications.
- **Frequency of medication changes:** In general, make only one medication change per visit, so that the effect of any particular intervention can be tracked.

**First-line medications for PTSD are SSRI's** (Selective Serotonin Re-uptake Inhibitors). The U.S. Food and Drug Administration has approved Sertaline (Zoloft) and Paroxetine (Paxil) for the treatment of PTSD, although women may have a more robust response to SSRIs than men.<sup>46</sup> The effective daily dose for treatment of PTSD is similar to dosing for depression. Both medications proven efficacy for all three PTSD symptom clusters (re-experiencing, avoidance/numbing, and hyper-arousal) in major randomized controlled trials.<sup>47-49, 50</sup> Fluoxetine (Prozac), although not FDA approved for PTSD treatment, has also demonstrated efficacy in placebo controlled

trials.<sup>51</sup> In addition, when prescribing these medications, primary care providers need to be aware that there are significant drug-drug interactions between SSRI's and certain other medications, such as Monoamine Oxidase Inhibitors, tricyclic antidepressants, and other medications that share the same cytochrome P450 hepatic metabolic pathway i.e., 2D6 cimetidine, methadone, and 3A4 sildenafil, HIV protease inhibitors, and HMG-CoA inhibitors. A thorough listing of drugs metabolized by the P450 system and important drug interactions can be accessed at <http://www.medicine.iupui.edu/flockhart/clinlist.html>. Sertraline has fewer drug interactions.

When starting SSRI's, primary care providers should advise their patients:

- **Benefits:** Psychopharmacologic therapy is effective for PTSD across core symptom clusters. Treatment is essential to reduce symptoms, increase the patient's functioning and well-being, and reduce psychiatric comorbidity (most often depression).
- **Onset:** While it may take 8-10 weeks for these medications to have their full effect, some patients may experience symptom relief sooner. For example, one study of sertraline in PTSD treatment reported a strong beneficial effect was found on anger symptoms by week 1, and by week 6 emotional upset at reminders, anhedonia, detachment, numbness, hypervigilance were improved. By week 10, improvements in numbing and avoidance of activities and foreshortened sense of future were seen.<sup>52</sup> Improvement should be monitored by following target symptoms (i.e., re-experiencing, avoidance, and heightened arousal or numbing) at baseline and after initiating treatment.
- **Duration of treatment:** Drug trials should last 8-10 weeks. If a patient responds to such a trial, then continued SSRI treatment in PTSD over at least 12 months may prevent symptom relapse.<sup>48</sup>
- **Side effects:** While most patients tolerate SSRI's well, some experience side effects (reviewed below). These often improve within a few weeks of starting the medication. Mania may be induced by the SSRIs in patients with co-morbid bipolar disorder, so patients should be screened for a history of bipolar symptoms before starting these medications.
- **Access:** If the patient develops side effects, he/she should contact the primary care provider (rather than just stopping the medication and waiting for the next scheduled visit).
- **Discontinuing medications:** If a patient or provider elects to stop an SSRI, it should be tapered, because SSRI withdrawal symptoms have been reported.

Some common side effects include:

- **Insomnia** (which may distress patients with PTSD who are already having sleep difficulties; low-dose **trazodone** at bedtime can be helpful adjunct)



- **Agitation** (clinicians need to monitor carefully for suicidal ideation during the initial weeks after starting an SSRI)
- **Sedation** during the daytime
- **Sexual dysfunction** (which may be especially disturbing to patients with an MST history)
- **Anorexia, nausea**
- **Other gastrointestinal** side effects

*Agitation can be a side effect of SSRI's; clinicians need to monitor for this, as it may resemble PTSD symptom exacerbation*

For the hyper-arousal and re-experiencing symptoms of PTSD, **antiadrenergic agents** (clonidine, guanfacine, or propranolol) can be helpful, and will have a more rapid onset of action (1-2 weeks) than the SSRIs.

Table 1 provides a listing of the pharmacotherapy that can typically be prescribed in a primary care setting.

Pharmacotherapy for PTSD Commonly Prescribed in Primary Care Setting		
Medication		Comment
Sertraline	150 mg qd - 200 mg qd	SSRI's are first-line treatment for PTSD. Overall symptoms of numbing, flashbacks, nightmares, and insomnia may improve. Reduces symptoms of impulsivity, rage, and suicidal ideation. When selecting an agent consider which symptoms are most prominent. For example, a more sedating SSRI (paroxetine) in a patient who is more activated may be helpful.
Paroxetine	10 mg qd - 40 mg qd	
Fluoxetine	20 - 80 mg qd	
Trazodone	25 mg qhs - 300 mg qhs	For insomnia: treating in the low dosage range is generally appropriate in the primary care setting; with higher doses, watch for orthostatic hypotension and priapism, and also potential for serotonergic toxicity if used in combination with SSRI's.
Clonidine	0.1 mg bid – 0.2 mg tid, <u>or</u>	Anti-adrenergic agents can reduce hyper-arousal, numbing, and avoidance. May improve sleep, decrease nightmares.
Guanfacine	1 mg bid – 1 mg tid, <u>or</u>	
Propranolol	10 mg qid – 40 mg qid	

Table 1

A number of other medications are also used to treat PTSD. The varying levels of evidence supporting these medications are detailed in [Appendix E](#). Often patients who need these medications are followed by a psychiatrist, because they are usually started in more refractory cases. These additional medications include Tricyclic antidepressants and Monoamine oxidase inhibitors (these older medications have proven efficacy in randomized controlled trials), other SSRI's (besides sertraline and paroxetine which are FDA-approved for PTSD), other antidepressants (e.g., nefazodone, mirtazapine, venlafaxine), atypical antipsychotics (e.g., olanzapine, risperidone, quetiapine), and mood stabilizers (e.g., valproic acid, carbamazepine). A special comment about benzodiazepines (e.g., clonazepam, alprazolam): while these are often used for patients with PTSD, they have no proven benefit for the treatment of re-experiencing and avoidance/numbing symptoms. They can be effective for general anxiety, but their risks (e.g., of sedation and potential abuse in some patients) must be weighed against their benefits, particularly since there are other treatments that **do** have proven effectiveness for PTSD symptoms.

*Benzodiazepines do not have proven efficacy for the re-experiencing and avoidance/numbing symptoms of PTSD*

Even if the patient's PTSD symptoms are being treated in the primary care setting with pharmacotherapy, it is generally advisable to also refer the patient to mental health for psychotherapy. Pharmacotherapy is uncommonly used as a stand-alone treatment for PTSD in VA. However, pharmacotherapy can help to decrease symptoms of PTSD such as heightened anxiety and poor concentration, which, untreated, may interfere with psychotherapy. Thus, pharmacotherapy and psychotherapy may have synergistic benefits in PTSD, as has been demonstrated for depression.

**Section 6** discussed how to refer a patient to mental health for psychotherapy. It can be very helpful if the primary care provider explains to the patient what to expect once he/she arrives in the mental health setting. Therefore, common psychotherapy approaches are presented next, to familiarize primary care providers with effective psychotherapy interventions.

## Psychotherapy

**Cognitive-behavioral therapy (CBT)** is the psychotherapeutic approach to the treatment of PTSD with the strongest level of empirical support. There are over 30 published, well-controlled studies on CBT for PTSD, many of which focus on rape survivors. CBT includes a number of different models, but all CBT treatment approaches use both cognitive and behavioral interventions in the context of a collaborative therapeutic relationship.

- **Cognitive interventions** for PTSD focus on altering trauma-related debilitating and dysfunctional beliefs (e.g., overestimation of danger, self-blame for assault), re-processing the memory of the trauma, and increasing beliefs that promote coping with symptoms and better functioning (e.g., intense emotions are tolerable).

- **Behavioral interventions** include learning skills for coping with intense emotions such as deep breathing or muscle relaxation, managing anger outbursts, and communicating effectively with other people.

In general, CBT has proven very effective in producing significant reductions in PTSD symptoms.

Specific models of CBT that are effective with PTSD are:

- **Stress Inoculation Training (SIT)** - SIT is an anxiety management treatment that has been modified to treat survivors of sexual assault. This treatment combines several anxiety management strategies including psychoeducation about stress and anxiety, and training in a variety of coping skills including muscle relaxation training, breathing retraining, guided self-dialogue, and thought stopping. SIT has been shown to be effective at reducing PTSD and related symptoms among sexual assault survivors.<sup>53, 54</sup>
- **Exposure Therapy** - This form of treatment involves exposing the patient to their memories of the traumatic event by repeatedly describing the traumatic event in detail. This allows the trauma survivor to re-experience the event in a safe, controlled environment in order to reduce the arousal and distress associated with their memories. This also allows the trauma survivor to examine their emotional reactions and beliefs about the traumatic event. For many trauma survivors this form of therapy can be emotionally painful, and it is not used for every patient, but there is compelling evidence for its efficacy, particularly among survivors of sexual assault.<sup>53, 54</sup>
  - *Note: Mental health providers looking for detailed information on the use of exposure therapy with survivors of sexual trauma are referred to Foa and Rothbaum's "Treating the Trauma of Rape: Cognitive Behavioral Therapy for PTSD."*
- **Cognitive Processing Therapy (CPT)** - CPT is a cognitive-behavioral treatment developed specifically for the treatment of sexual assault survivors. It combines elements of standard cognitive therapy (with a particular focus on challenging self-blame and other specific trauma-related cognitions) with elements of exposure therapy. CPT has been shown to be more effective than a wait list control group, producing results similar to those obtained with standard exposure therapy.<sup>55, 56</sup>
  - *Note: Mental health providers looking for detailed information on the use of cognitive processing therapy with survivors of sexual trauma are referred to Resick's "Cognitive processing therapy for rape victims: A treatment manual."*

- ***Eye Movement Desensitization and Reprocessing (EMDR)*** - EMDR is a treatment for traumatic memories that involves elements of exposure therapy and cognitive behavioral therapy, combined with techniques like eye movements or hand taps that cause the patient's attention to alternate back and forth across the midline. EMDR has been shown to be more effective than placebo wait list, psychodynamic, relaxation, or supportive therapies.<sup>57, 58</sup> Research comparing EMDR to more standard CBT therapies shows that significantly better results have been maintained with CBT than EMDR, particularly over time.<sup>59</sup>

Other therapeutic approaches, including *brief psychodynamic therapy and marital/family therapies*, may also prove efficacious for the treatment of PTSD. Currently these approaches do not have the level of empirical support necessary to make a definitive determination.

## What are effective treatments for “Complex PTSD”?

### Psychotherapy

If a victim of military sexual trauma was also exposed to prolonged, repeated traumatic experiences, like sexual or physical abuse during childhood, they may report symptoms of “Complex PTSD,” sometimes referred to as “Disorder of Extreme Stress.” While this disorder is not currently an official diagnostic category, these individuals often present with symptoms of emotion regulation difficulties, including persistent depression, explosive anger, and self-injury, cognitive difficulties, including dissociation and amnesia, and disruptions in a range of interpersonal relationships. These individuals are often diagnosed with personality disorders, particularly Borderline Personality Disorder, depressive disorders, or dissociative disorders. When compared with treatment of PTSD, treatment for these disorders often takes much longer, may progress at a much slower rate, and requires a sensitive and structured treatment program delivered by a trauma specialist. One treatment approach aimed at individuals who suffer with this type of symptomatology that has promising empirical support is *Dialectical Behavior Therapy (DBT)*. DBT was originally designed to address suicidal and self-injurious behaviors.<sup>60, 61</sup> DBT is a comprehensive cognitive-behavioral treatment that combines skills-based group therapy with a structured individual therapy. DBT blends validation/acceptance with change-focused interventions. Since Complex PTSD symptoms can be disruptive and disturbing for patients and clinicians alike, it is important for primary care providers to be aware that effective interventions are available.

## What are effective treatments for depression?

### Pharmacotherapy

It is well established that pharmacotherapy can be extremely effective in the treatment of depression, which is another common mental health problem in patients with an MST history. Most primary care providers are familiar with the treatment of depression, so its pharmacotherapy is not included here. Depression treatment guidelines can be found at <http://www.oqp.med.va.gov/cpg/cpg.htm>.

Since primary care providers may be less familiar with the effective psychotherapies for depression, they are presented briefly here.

### Psychotherapy

*Cognitive-behavioral treatments* are the form of psychotherapy with the strongest record of proven efficacy in the treatment of depression.<sup>62, 63</sup> Cognitive-behavioral therapies focus on changing the negative styles of thinking and behaving often associated with depression. Specifically, cognitive strategies are designed to change the pessimistic ideas, unrealistic expectations, and overly critical self-evaluations that may be maintaining symptoms of depression. Behavioral strategies address symptoms of depression by increasing positive events, improving self-care, and encouraging patients to engage in more adaptive coping strategies.

## What are effective treatments for substance use disorders?

For trauma survivors, alcohol and drug abuse are frequently comorbid with a diagnosis of PTSD. One widely accepted explanation for this level of comorbidity is that traumatized individuals abuse substances in order to self-medicate their PTSD symptoms. Accordingly, the best results may be achieved when both PTSD and substance abuse are treated simultaneously rather than sequentially.<sup>64</sup> One therapy approach designed to address both problems is the *Seeking Safety program*, which has been implemented at a number of VA facilities. *Seeking Safety* incorporates elements of cognitive, behavioral, and interpersonal therapies to simultaneously address symptoms of PTSD and substance abuse. Another type of therapy with empirical support in treating substance abuse is *motivational interviewing*. Motivational interviewing addresses the common problem of treating patients with substance abuse who are reluctant to acknowledge the problem. It involves a non-confrontational approach designed to engage ambivalent or resistant patients in the process of change. VA's substance abuse clinical treatment guidelines can be found at <http://www.oqp.med.va.gov/cpg/cpg.htm>. Additional information about motivational interviewing can be found at <http://www.motivationalinterview.org>.





## Documentation Issues

### Learning Objectives

1. Describe VHA MST documentation policies and requirements.
2. Explain relationship of documentation to disability claims process and patient billing.
3. Describe appropriate amount of detail and content to document, relative to the patient's trauma history and physical findings.

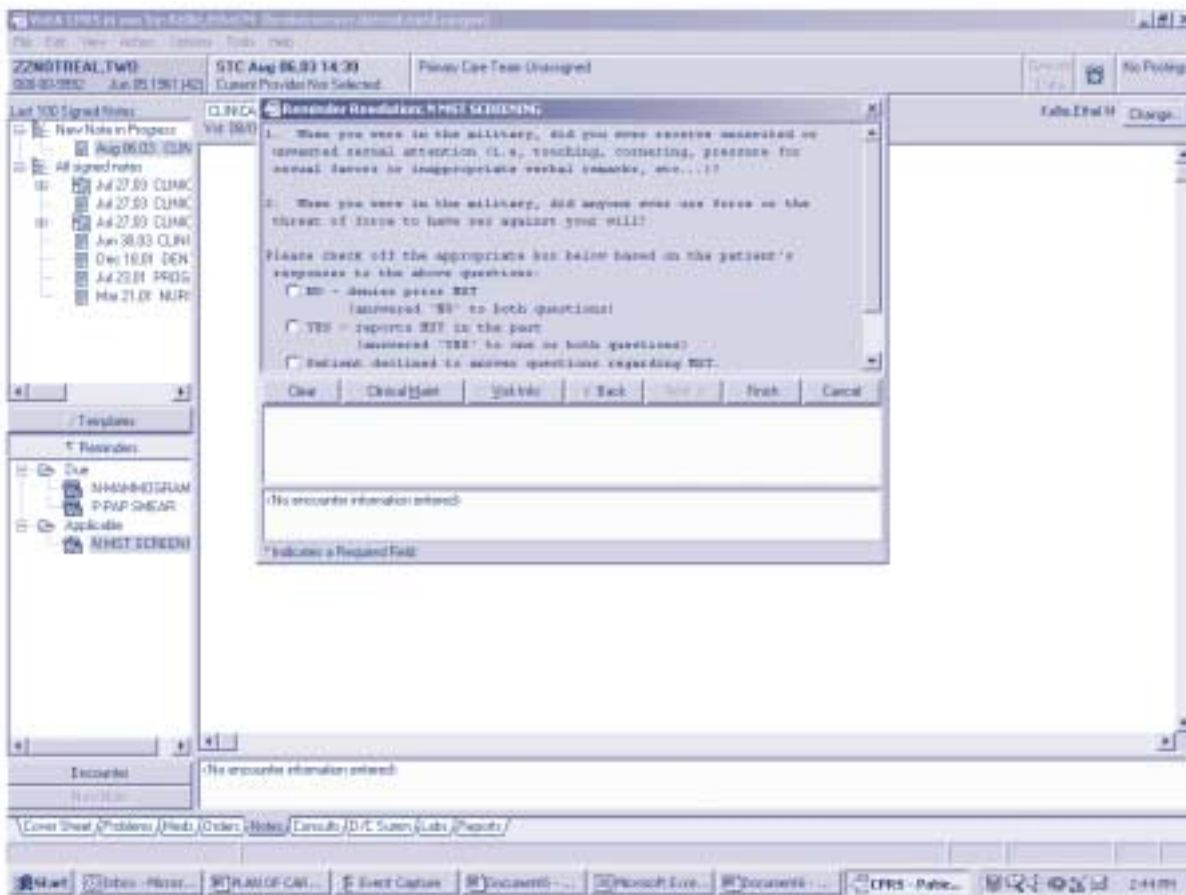
### What are minimal VHA MST documentation requirements?

VA requires that clinicians document whether or not their patients (male and female) have experienced MST. To facilitate documentation, the CPRS (Computerized Patient Record System) at each VA includes a standardized MST screening reminder.

To complete the screening and document it in a progress note, the user would go to the NOTES tab of the chart and start a new note. Once the user opens a new note, the REMINDERS drawer becomes available in the lower LEFT corner of the NOTES tab. If the user clicks on the drawer, it will open with a list of the reminders that are due. Clicking on the reminder will open a dialog as shown on the next page.

*VA clinicians are required to document whether patients experienced MST*

The user would then click on the appropriate option depending on the patient's responses to the questions about MST. When an option is clicked, the text that will go into the progress note appears in a box at the bottom of the dialog and the data that is to be filed in the patient's record, also appears there. Once the user completes the process by clicking the FINISH button, the data is filed in the clinical reminder package of CPRS (so the reminder will not pop up in the future), and the text is inserted into the progress note.



Note: At facilities that have not yet implemented CPRS, it suffices to state, “MST screening completed” in a progress note along with the results of the screening (yes/no/declined to answer). MST status can be also be updated if a patient later discloses the information or changes his or her answer (same procedure outlined above).

## What else should I document?

Is it enough to only document whether the patient has a MST history? In general, primary care providers are discouraged from taking a very detailed accounting of what happened during the MST. The reason is that asking the patient to recount the details of the assault can cause him/her to re-experience the trauma, much as they would during exposure therapy ([Section 7](#)). This should be left to mental health providers with expertise in these techniques, who typically explore details of the trauma only after multiple sessions, which carefully lay the groundwork.



That being said, it can be helpful for primary care providers to document basic information, such as:

- basic elements of what happened, as spontaneously disclosed by the patient
- treatment the patient received immediately following the trauma and subsequently (medical care, mental health care)
- current level of social support
- patient's and clinician's assessment as to whether he/she is currently experiencing any physical or emotional sequelae of the trauma
- documentation that mental health counseling was offered, and whether or not it was accepted

Documentation should include direct quotations from the patient, where possible, making their attribution clear. Clinicians should avoid using judgmental terms, selecting objective terms instead (e.g., saying "patient states/reports" instead of "patient claims/alleges"). A legible, clear, objective medical record will facilitate the patient's subsequent application for compensation, if he/she decides to pursue this in the future ([Section 9](#)).

### **How can I ensure that the patient is not billed for MST-related services?**

VA encounter forms (paper or electronic) now require that the practitioner answer whether the visit was MST-related, based upon the practitioner's clinical judgment. The question is located in the same area of the encounter form that the veteran's service-connected status identifier is located.

A visit is MST-related if the patient was treated for a psychiatric condition or a physical problem that the provider determines is related to the patient's history of MST. Common psychiatric sequelae of MST include PTSD, depression, substance use disorders, and somatoform disorders. Common physical sequelae of MST include chronic pain problems (e.g., headaches, low back pain, fibromyalgia, pelvic pain), gastrointestinal symptoms (including irritable bowel syndrome), etc. (See [Section 3](#) for other common comorbidities). Often these conditions are treated in a primary care or other medical setting.





# Compensation Issues

## Learning Objectives

1. Explain why VA service-connected rating is so important for veterans.
2. State the pros and cons sexually traumatized veterans should consider before applying for VA service-connection.
3. Describe the primary care provider's obligations to sexually traumatized veterans seeking service-connection.
4. Identify technical issues that might help sexually traumatized veterans obtain service-connection for which they are eligible.

## What do primary care providers need to know about compensation?

Primary care providers do not have to be experts in VHA's compensation and pension process, but they *do* need to know:

- **Eligibility:** Veterans who develop health, occupational, or social impairments because of sexual trauma that occurred while they were in the military may be eligible for VA disability benefits.
- **Documentation:** Which medical record elements are important in supporting their patients' future claims.
- **Advocates:** To whom they can refer their patients to guide them through the compensation and pension process.
- **Clinical effects:** How they can prepare their patients for the possibility that PTSD symptoms frequently worsen during the claims process.

More in-depth information for interested readers and for veterans is discussed in [Appendix F](#).

## Which veterans are potentially eligible to file a claim?

Veterans who develop health, occupational, or social impairments because of in-service sexual trauma may be eligible for VA disability benefits. The most common compensative impairment related to MST is PTSD, but other chronic impairments such as infertility (e.g., secondary to a sexually transmitted disease contracted as the result of a sexual assault) or

musculoskeletal injuries (perhaps related to the physical trauma of a sexual assault) are also seen. In general, for veterans to obtain VA disability benefits, there must be competent evidence from a licensed health care provider demonstrating:

- current disability (a medical diagnosis);
- the incurrence of or aggravation of a disease or injury while in the service (lay or medical evidence); and
- a nexus between the in-service injury or disease and the current disability (38 CFR, Section 3.303).

Sexual traumas that occur outside regular tours of duty, off military premises, or during peacetime are all potentially compensative as long as the evidentiary requirements are met. In addition, veterans who suffered illness prior to military service (for example, as a result of childhood trauma) may still file a successful claim for that condition if it can be credibly demonstrated that the illness was aggravated by MST.

*Sexual trauma occurring outside of the military setting may still be eligible for VA compensation if other criteria are met.*

**Note: there is a difference between eligibility for MST counseling, care and services, and eligibility for MST compensation.**

Based upon **Public Law 103-452**, any veteran who self-reports a history of in-service sexual trauma is eligible for health *care* for conditions related to that trauma. In contrast, to receive *compensation* for MST, the standard of evidence is stricter, and a Veterans Benefits Administration (VBA) rating board must determine that the evidentiary requirements outlined above are met.

## How does the VA disability claims process work?

Veterans first submit a disability claim to their regional VBA office, where the claim is reviewed for basic eligibility criteria and additional supporting evidence is sought. Additional evidence might include the veteran's service records and private medical records. The evidence also often includes VA medical records, so clear documentation of MST and its presumed sequelae by VA primary care providers is important (See the section entitled, "What should I document in the patient's medical record?" (page 58)). If the available data are sufficient to support a claim, the veteran may be asked to undergo a medical or psychiatric compensation and pension (C&P) evaluation, which is usually conducted by a Veterans Health Administration (VHA) clinician. The clinician's findings are incorporated into the claims file and then forwarded to a regional office rating board. If the board believes the evidence supports a disability claim, it will provide veteran with a "service-connected" (SC) disability rating ranging from 0%-100%, based on standardized and disease-specific criteria. These rating criteria generally reflect varying levels of occupational, social, and health impairment.<sup>65</sup> Thus, unlike Social Security Disability benefits, veterans do not need to be "totally and completely" disabled to receive VA disability compensation. Veterans with any SC disability rating receive priority enrollment into VHA health care facilities; however, those with a rating of 50% or more receive the highest

priority for enrollment.<sup>66</sup> A 0% SC rating means that the veteran is considered to have an injury or illness that is directly connected to his or her service in the military, but that the injury is currently not disabling. Thus, a 0% SC rating is different from “non-service-connected” status. Monthly compensation begins at a service-connected rating of 10% or more, with greater compensation going to those with higher ratings.

## Why is a service-connected rating for MST important to the veteran?

A service-connected rating may have several important benefits for veterans, including:

- **Improved access to care:** Service-connection is among the most important known predictors of VA health care utilization. For underinsured, impoverished, and disabled veterans, VAMCs frequently represent the health care system of first resort. Service-connected veterans receive the highest priority in the VA health care system. Once enrolled in the VA, regardless of income, service-connected veterans receive free treatment (including pharmacy services) for all their service-connected conditions. Veterans with SC ratings of 50% or more are entitled to free treatment for all medical problems, even those for which they are not service-connected, with a few exceptions.
- **Income:** Disability compensation can make a tremendous difference in disabled veterans’ financial status. Among veteran applicants for Social Security Disability Insurance or Supplemental Security Income, for example, VA disability benefits accounted for about a quarter to a third of their family’s total income, on average.<sup>67</sup> In fiscal year 2003, disabled veterans’ basic compensation ranged from \$104/month for conditions rated at 10 percent to \$2,193/month for conditions rated at 100 percent. Service-connected disability payments are tax-exempt.
- **External validation:** Benefits of service-connection may not be completely monetary. For many veterans, service-connection offers external validation of their disablement, heroism, service to their country, or tribulations while in the service.

## Are there any disadvantages to filing a claim for MST sequelae?

There are also potential downsides to filing a claim. For example, veterans who file claims for service-connection related to military sexual trauma need to understand that they will likely be asked to discuss their trauma in some detail, and that at least some of this discussion will occur in a forensic, as opposed to therapeutic, environment. While this can be stressful for anyone, it is likely to be particularly difficult for veterans with PTSD, where avoidance of trauma reminders is a hallmark of the disorder. Consequently, veterans with PTSD and other disorders may experience

exacerbations of their symptoms while going through the C&P process. Primary care providers and their mental health colleagues need to be prepared for this possibility and should have a treatment plan in place (e.g., medications for symptoms, mental health referral) should it occur.

Veterans who attach symbolic value to receiving service-connection could experience considerable psychological distress if their claim were denied. For example, in the 1995 Armed Forces Sexual Harassment Survey, 59% of women filing rape charges while they were in the service said that they were not taken seriously, were pressured to drop their complaints, saw no action taken in response to their complaints, or experienced retaliatory hostility.<sup>1</sup> As in the civilian sector, few rape charges in the military are found to be prosecutable, and of those, little more than half adjudicate for the plaintiff.<sup>68</sup> For sexually traumatized veterans whose attempts for redress in the military were disbelieved, minimized, or even punished, denial of service-connection may represent a re-enactment of earlier “betrayals.”

### **Should primary care providers recommend that patients file claims, or not?**

The decision to file a VA disability claim related to military sexual trauma is highly personal and should take into account the veteran’s emotional reserves, eligibility for benefits, and the meanings s/he attaches to service-connection. Clinicians should never push patients to file for VA disability; however, they should be prepared to discuss in at least general terms some of the pros and cons associated with filing such claims (Table 1 next page). Such discussions should be objective and nonjudgmental: *the decision about whether or not to file rests with the patient*. Veterans who require additional information or who wish for a more in-depth discussion of the pros and cons of filing a MST disability claim should be referred to a VBA benefits counselor, their regional VBA Women Veterans Coordinator or VHA Women Veterans Program Manager (these managers are also available to men with MST), a Veterans Service Officer, or a mental health professional.

If the claim is denied, you may consider advising the patient to consult with the service organization or attorney he/she has appointed to assist with the claim. If the patient does not have a representative, you may wish to advise the patient to contact the local regional office to determine which organizations have representation at that office.

Representation by a national service organization or a state department of veterans’ affairs is provided at no cost to veterans. If the veteran wishes to engage an attorney there are specialized rules regarding payment of fees. The veteran should be advised to contact the regional office to gain an understanding of these rules.

Table 1 lists the pros and cons of filing a claim for MST.

Potential Pros and Cons of Filing a VA Military Sexual Trauma Disability Claim	
Pros:	Cons:
<p>Enhanced access to VA health care</p> <p>Potential for compensation and improved economic stability</p> <p>Validation of veterans' sacrifice, service, and tribulations or experiences while in the service</p>	<p>Must disclose details about the sexual trauma in a variety of stressful and non-therapeutic environments</p> <p>Risk exacerbations of existing psychiatric and medical illnesses during claims process</p> <p>Risk feeling betrayed, invalidated, or disbelieved if service-connection is not granted</p> <p>Required to undergo periodic re-evaluations (generally every five years) until rating becomes static and no improvement anticipated</p>

Table 1

### What practical advice can I give to my patient who is thinking about filing a claim?

Providers can offer practical advice to veterans who are considering filing disability claims related to military sexual trauma.<sup>69</sup> For example:

- **Connect the veteran with a mental health provider.** Encourage the veteran to establish a stable, therapeutic relationship with a mental health provider prior to filing a MST claim. This relationship can be extremely valuable during the claims process.
- **Encourage the veteran to take advantage of other resources.** For example:
  - Social support networks (family/friends)
  - VBA Women Veteran Coordinators (who are trained to deal sensitively with both men's and women's MST-related claims) and VBA benefits counselors; these counselors can help patients to obtain accurate information about the steps and time-line involved in the claims process and establish realistic expectations about the claims process.
  - VHA Military Sexual Trauma Coordinators
  - Veterans Service Officers (VSOs) (e.g., county VSOs, or representatives from National Service Organizations); these individuals will also help veterans in the step-by-step process of filing a disability claim, free of charge.
  - Web-based resources such as the Veterans Health Initiative module, "PTSD: Implications for Primary Care", which is

available at <http://www.va.gov/vhi> or <https://www.ees-learning.net/>, and other resources are listed in **Appendix C**.

- **Anticipate PTSD flares.** Offer more frequent follow-up visits to address somatic symptoms that often flare during the C&P process. Veterans who become service-connected are sometimes asked to undergo re-evaluations periodically until their rating is considered permanent. This is to see if their disability has changed with time and hence whether their compensation benefits should be readjusted accordingly. Failure to comply with these re-examinations can result in benefits being reduced or terminated. Thus, veterans should be encouraged to undergo these re-evaluations, but many will need periodic support as they do so.
- **Help the veteran to identify healthy self-care behaviors.** When coping with the stress of the claims process, encourage the veteran to use healthy coping strategies (e.g., meditation, exercise) and avoid unhealthy strategies (e.g., increased alcohol use). Patients should try to avoid feelings of self-denigration, self-doubt and self-blame that often arise when going through the claims process, and instead should take good emotional self-care. Patients should be kind to themselves.
- **Offer MST services independent of C&P claims.** Remind veterans who decide not to file claims that they remain eligible for counseling, care, and services under Public Law 103-452 and that they can always apply for disability benefits at a later time. However, they must be aware of the implications of delay: benefits are generally paid retroactive to the date the veteran's claim was filed.

*To see an example of the above recommendation, there are three (3) Case examples Grace-1 (part 5) (page 119), Kevin-2 (part 4) (page 124), and Carlotta-3 (part 4) (page 127) for review. You may also view a short video related to these recommendations by going to <https://www.ees-learning.net>.*

## What should I document in the patient's medical record?

The average sexually traumatized veteran waits 15 years after leaving the service to file a claim for VA SC status. Thus, even if a patient does not immediately decide to file a claim, s/he may decide to do so at a future date. Taken in conjunction with other evidence, consistent documentation in the medical record, that a veteran attributes certain symptoms or illnesses to MST could help establish a nexus between the claimed in-service sexual trauma and current disability. Attention to the patient's functional performance (e.g., social interactions, employment) in the medical chart can also be useful in establishing his or her level of impairment, which in turn could affect his or her disability rating (and compensation level). Obviously, any historical details about the trauma itself should also be documented. Table 2 (next page) lists what to document and why documentation is beneficial.



Military Sexual Trauma Documentation Recommendations		
What to Document	Why	Examples
Any medical diagnoses plausibly associated with or exacerbated by military sexual trauma	Establishes first component of the claim's evidentiary basis (a medical diagnosis)	Sexually Transmitted Diseases (if chronic residuals are present) Infertility Somatization disorder Sexual dysfunction Low back pain Chronic pelvic pain Migraines
Signs or symptoms concordant with a psychiatric illness	Can be used to support the first component of the claim's evidentiary basis (a psychiatric diagnosis)	Panic Attacks Nightmares Avoidance Behaviors Depression
Medical signs or symptoms consistent with a psychiatric illness	Can be used to support the first component of the claim's evidentiary basis (a psychiatric diagnosis)	Hypertension High Resting Pulse
Signs or symptoms consistent with a past history of MST	Can be used to support the second component of the claim's evidentiary basis (evidence of an in-service stressor)	Refusing intrusive exams (e.g., pelvic exam, flexible sigmoidoscopy) Old Fractures Scars Tearfulness when describing past trauma Difficult patient-physician interactions Substance Abuse

Table 2

Table 2 (cont.)

What to Document	Why	Examples
Attributions licensed health care provider makes between current problems and past MST	Can be used to support the third component of the claim’s evidentiary basis (a nexus between military sexual trauma and current disability)	<p>“Patient with infertility and blocked Fallopian tubes says she developed a serious Chlamydia infection after being assaulted in the service.”</p> <p>“Patient says he has been unable to trust anyone since he was assaulted in the service.”</p>
Veteran’s current functional status	Can be used to determine veteran’s level of disability and hence level of compensation	<p>Current employment</p> <p>Frequent job changes</p> <p>Marital or social difficulties</p>
Veteran’s recollection of the trauma itself	Can be used to support the second component of the claim’s evidentiary basis (evidence of an in-service stressor)	<p>“The patient screened positive for MST today, and described the following details about his trauma. . .”</p>

Table 2

Primary care providers cannot diagnose psychiatric disorders for the purposes of VA compensation, but they can certainly document any symptoms they observe that are concordant with psychiatric illness. Medical signs associated with PTSD, such as hypertension and high resting pulse should be documented, as well as signs of scars, injuries, and fractures that might be consistent with past sexual trauma. Difficult patient-physician interactions, somatization, adherence problems, and the avoidance of certain medical procedures can also be plausibly related to past sexual victimization in some instances and should be documented.

### What about writing letters to specifically support a disability claim?

From time to time, veterans ask their primary care providers to write a letter supporting their VA disability claim. Most often, these letters are simply an opportunity to state in a single place and in a concise manner any medical diagnoses, signs, and symptoms consistent with sexual trauma and disability observed over the course of the clinician’s relationship with the patient. In other words, the letter simply restates and summarizes points previously documented in the medical record. Another option is to write a shorter letter that directs claims processors to the specific areas of the medical chart that address the issues in hand (e.g., “please refer to notes dated 10-11-92

and 2-15-93 for a discussion of the patient's presentation with infertility and her diagnosis of bilateral obstructed Fallopian tubes, and the note dated 4-8-98 where she indicates she developed a severe *Chlamydia* infection after an in-service sexual assault"). As long as there are objective findings consistent with military sexual trauma in the medical chart, we would strongly encourage providers to complete such letters.

Occasionally veterans may ask their clinicians to write a letter stating that their condition is "as likely as not" related to military sexual trauma. Often these letters are requested at the behest of a county or National Veteran Service Officer. Under these circumstances, clinicians need to use their own judgment as to whether they can complete such a letter honestly. If unwilling or unable to do so, the clinician should explain to the patient that he/she does not feel qualified or able to complete such a letter. Offering to complete a more objective letter, such as the one described in the preceding paragraph, may be helpful. It may also be reassuring to remind the patient that, during the C&P examination, he or she will be evaluated by someone the VA has determined to have expertise both in evaluating their difficulties and in relating those difficulties to his or her military history.





# Ongoing Care: Complex Patient Provider Relationship Issues

## Learning Objectives

1. Describe one effective management strategy for the following patient-provider interactions: treatment decisions, boundary violations, dissociative and somatization disorders; and harm to self or others.
2. Identify behaviors that demonstrate patient-provider interpersonal challenges and factors contributing to these patient/provider behaviors.
3. Describe practical techniques for managing challenging provider-patient interpersonal conflicts.
4. Define a patient-provider 'boundary violation'.
5. Explain the importance of boundaries in providing health care to patients with MST history.
6. Describe how health professionals can avoid boundary violations.

Many patients who have experienced sexual trauma are able to continue to maintain healthy relationships. However, for some, trauma can lead to persistent difficulties that can impair interpersonal interactions, including interactions with health care providers. Because these issues can prove quite challenging for clinicians, the next sections address management strategies of common situations:

1. patient-provider struggles around treatment decisions;
2. boundary problems;
3. dissociative disorders;
4. somatization disorders; and
5. harm to self or others.

Often such issues arise in the setting of what has been termed "complex PTSD,"<sup>34, 70</sup> a condition most likely to occur with repeated trauma, especially during childhood. While the focus of this text is upon adult sexual trauma sustained during military service, a substantial number of men and women entering the military have also been abused as children.<sup>5, 71</sup> For individuals with more complex trauma histories, sexual trauma sustained during military service can compound associated relationship difficulties (See [Section 12](#)).

Highly *coordinated care* is essential for patients with such complex biopsychosocial trauma sequelae. Delivery systems which facilitate interaction between all members of the health care team (especially primary

care providers and mental health providers) can help to assure a cohesive program of care. VA has been a leader in the development of innovative interdisciplinary models of health care delivery, including primary care teams and women's health clinics in which medical and mental health providers practice side-by-side.

## **Part 1: Difficult Interpersonal Interactions**

### **What difficult interpersonal interactions can arise when caring for MST survivors?**

Many patients with a sexual trauma history continue to have good interpersonal function following the trauma. However, some develop significant difficulties with subsequent interpersonal interactions, including their interactions with health care providers.<sup>72</sup> Interpersonal difficulties can be disabling and can render relationships chaotic. Conflict around health care issues is common. For example, a patient may avoid care, miss appointments, or refuse needed treatments. Alternatively, a patient may insist on treatments that the clinician believes are not indicated or not within the clinician's scope of practice. This can lead to serious interpersonal struggles, which may distress patient and clinician alike. Seeking to meet perceived needs, the patient may lash out at the clinician in anger, or may engage in "splitting" behaviors, pitting one clinician against another. These presentations may seem familiar to clinicians, as they share characteristics with borderline personality disorder: indeed, some experts conceptualize borderline personality disorder as a manifestation of complex PTSD.<sup>34, 70</sup> This is important to recognize, because these problems are treatable (see [Section 7](#), "Complex PTSD").

Some common interpersonal difficulties that can be seen in trauma survivors, along with management suggestions, are presented in Table 1 (next page).

Trauma related Interpersonal Difficulties	Patient Behaviors	Provider Reaction	Suggested Provider Strategies
Avoidance of interpersonal contact	Missed appointments Problems with treatment adherence Treatment refusal	Helplessness Frustration Shaming the patient Hostile behaviors toward patient	Maintain a supportive stance Instill hope Involve patient in problem solving Try to understand the avoidance dynamics
Unhealthy interpersonal boundaries	Unreasonable demands on provider time Requests for treatments beyond scope of provider's practice Frequent phone calls	Dread of clinic visits with the patient Avoidance of returning calls Accommodating treatment demands that are beyond scope of practice	Gentle limit setting Be clear about availability and after hours care plan Be clear about scope of clinical practice Return phone calls, contracting with the patient around parameters for calling Maintain a professional stance, using surnames Escorted exams
Difficulty regulating emotions	Affective instability Hostility Quick to anger	Frustration Anger Feeling overwhelmed	Maintain a respectful and calm stance Take a deep breath and respond thoughtfully Find "an empathic hook", something likable about patient through which to empathically connect

Table 1

Table 1 (cont.)

Trauma related Interpersonal Difficulties	Patient Behaviors	Provider Reaction	Suggested Provider Strategies
Interpersonal difficulties with trust, and an expectation of betrayal	Suspicious Argumentative Distrustful Splitting behaviors, such as idealization of some providers and devaluing others	Feeling insulted Decreased connection with patient	Reassure patient, Maintain non-confrontational stance, Acknowledge and understand that trust and relationships take time Maintain confidentiality Communicate clearly with patient to assure their understanding of procedures and treatment plan Communicate clearly with other providers Build trust over time with respectful and consistent care

Table 1

### Why are difficult interpersonal interactions seen more often after MST?

While such behaviors may upset clinicians, it is important to see them for what they likely are: coping mechanisms (albeit not very effective coping mechanisms) learned earlier in life as a way to survive sexual violence, including MST. Veterans who were sexually traumatized in the military may have difficulty trusting authority figures (including clinicians); this may lead them to refuse recommended treatments or to insist on interventions they see the provider as withholding. They may be particularly distrustful of VA clinicians; the VA setting is more likely to remind them of the military setting than is a “civilian” doctor’s office. Some patients have difficulty trusting clinicians whose characteristics (e.g., gender) resemble the perpetrator’s characteristics; in general it is reasonable to attempt to honor the request of the occasional patient who requests a clinician of a specified gender.



In addition, MST can impair adult development or reinforce unhealthy interpersonal boundaries. For persons who experienced childhood victimization in addition to MST, these issues can be amplified. Such patients may attach special meaning to the concept of “caring” in the clinical setting. For example, they may see the clinician as in the role of “assailant”, that is, as a caregiver who means the patient harm. In response, the patient might withdraw into a passive “victim” role, or might counter-attack. Alternatively, they may also view the clinician as their “rescuer”, leading to excessive requests (e.g., for prolonged clinic visits), and unrealistic expectations (e.g., that the clinician will never make a mistake).

### **What can be done to minimize difficult interpersonal interactions?**

While interpersonal struggles can be among the most challenging of management issues in the primary care setting, some principles of management may be helpful.

- **Recognize these MST-related dynamics when they occur.** Simply being aware that the patient is reenacting a prior victimization experience (e.g., by unconsciously casting him/herself as victim and the clinician as assailant) can help the clinician to avoid being drawn into the reenactment.
- **Avoid escalating the patient.** Anger is a common response to feeling slighted, humiliated, or not respected. The clinician who strives to maintain a respectful stance minimizes risk of angry outbursts.
- **Strike a balance between caring and limit setting.** Clinicians need to be especially respectful and vigilant in maintaining appropriate professional boundaries in the care of survivors of MST, as discussed in the next section. At the same time, since caring often has profound meaning for patients with a prior sexual trauma history, clinicians need to balance professional boundaries with clear, empathic communication.
- **Respond calmly to angry patients.** Clinicians can help to deescalate the situation by speaking slowly and softly, avoiding a defensive stance, and communicating to the patient that his/her concerns have been heard. Since angry outbursts are often responses to intense fear, attempts to increase the patient’s feelings of control over the clinical situation can be helpful. If the clinician perceives that he/she is in immediate danger, the clinician needs to follow local emergency procedures.
- **Consult with colleagues.** It is very difficult to maintain objectivity in these intense interpersonal situations. Talking with a trusted colleague can help the clinician to maintain perspective and develop a clinical approach that minimizes risk of harm to the patient. Ideally, if the patient is followed by a mental health professional, the mental health provider can serve as a resource to the primary care provider in thinking through these issues.

- **Refer to mental health specialists.** In the case of more complicated early life trauma histories and related borderline personality structure, profound interpersonal skill deficits can exist. Substantial improvements can be seen in patients who are taught more adaptive coping and interpersonal skills through a specific manualized treatment called Dialectical Behavioral Therapy.<sup>60, 73</sup> A growing number of VA mental health providers have expertise in this treatment.
- **Develop a consistent team approach to care.** When patients encounter a consistent treatment plan from all members of the team, “splitting” behaviors tend to abate. A written contract between the patient and the care team can help to reinforce a unified message and at the same time reassure the patient about what to expect. It is also sometimes helpful to meet with the patient (and perhaps the patient’s advocate) as an interdisciplinary team to develop a shared understanding of the treatment plan.
- **Follow standard clinical procedure.** Clinicians should avoid a “rescue dynamic” whereby they begin providing “special” care to patients with an MST history. All patients, independent of MST history, should receive high quality care. However, the clinician should avoid after-hours appointments, free availability on pager, and provision of in-depth counseling, etc., if these are not part of the clinician’s standard practice with other patients (See Boundaries section next).

## Part 2: Boundary Violations

### What is a boundary violation?

Boundaries are described as defining “the expected and accepted psychological and social distance between physicians and their patients”.<sup>74</sup> Patient-provider boundaries are especially crucial in the health care of persons who have been victimized.

A boundary crossing occurs when a patient or clinician fails to maintain a socially accepted degree of interpersonal distance.<sup>75</sup> These can be seen as areas of vulnerability for patients and providers. There is a range of severity of boundary crossings. The most extreme examples are sexual boundary violations: the AMA Code of Ethics states that sexual contact between a patient and his/her physician is never acceptable.<sup>76</sup> Other boundary crossings may be less clear-cut. Examples of boundary crossings that could be problematic, depending on the circumstances, include:

- **Time**
  - Spending more time with the patient than is customary
  - Agreeing to see the patient outside of normal clinic hours
- **Place**
  - Addressing the patient’s concerns in a location other than the clinic setting (e.g., in a hallway, at a social gathering, etc.)

- **Interpersonal distance**
  - Self-disclosure (e.g., about the clinician’s own family situation or health)
  - Accepting gifts from the patient [See VA policy]
- **Clinical role**
  - Agreeing to the patient’s request for a hug
  - Joining the patient for social events outside of clinic
  - Entering into business deals with the patient
  - Soliciting or agreeing to a dating or sexual relationship with the patient
- **Clinical role**
  - Consenting to the patient’s request for treatments outside the clinician’s scope of practice

Sometimes it is difficult to recognize when a boundary crossing is occurring. Clinicians can ask themselves the questions in [Appendix G](#) to help recognize warning signs.

When caring for patients with a sexual trauma history, boundary crossings have special implications. A prior sexual assault represents a severe boundary violation. Therefore, when faced with the power differential inherent in the provider-patient relationship, patients may feel they are experiencing boundary violations again. In addition, patients who were sexually traumatized as children may have received perverse messages about what constitutes an appropriate boundary, at a critical point in their development. As a result, they may lack skills at maintaining generally accepted degrees of interpersonal distance.<sup>77</sup>

## What is the harm of a boundary violation?

Boundary violations put the patient, the provider, and the patient-provider relationship at risk. Risks to the **patient** include receipt of low quality care (e.g., if a nonprofessional relationship dulls the clinician’s objectivity or distracts the clinician from routine collection of clinical information, or if the clinician agrees to provide treatments outside his/her scope of practice), or psychological damage (e.g., anxiety caused by the strain of role reversal, if the clinician discloses his/her own problems). The **clinician** risks burnout and family strain (e.g., from working long hours), feelings of guilt (e.g., after accepting an expensive gift), or even malpractice suits, and loss of license to practice (e.g., in the case of sexual contact with the patient or practicing outside of the clinician’s area of expertise). Boundary violations can also damage the patient-provider **relationship**. A common example is that when a clinician allows a patient to idealize him/her (“you’re the only doctor who can help me”), the clinician sets him/herself up for a subsequent fracture of the relationship when he/she fails to live up to these unrealistic expectations. Alternatively, a clinician who submits to the patient’s demands for prolonged or frequent visits may develop feelings of resentment that ultimately boil over, subjecting the patient to an angry outburst or shaming.

## How can clinicians prevent boundary violations?

Human interactions are complex and boundaries are at times ambiguous; there is no way to completely prevent any boundary violations from occurring. However, clinicians can decrease the frequency and severity of boundary crossings if they adhere to several principles:

- **Put the patient first.** The clinician-patient relationship is asymmetrical, with the onus on the *clinician*, not the patient, to maintain appropriate professional boundaries. Consider: *“Is doing this serving my needs, or the patient’s needs?”*
- **Be aware of strong internal feelings.** Common feelings like anxiety about providing non-standard care, or anger at the patient’s demands *might* be a red flag that you are at risk of boundary crossings with the patient. Because it is hard to be fully objective about these issues, it is often helpful for the clinician to review the case with a trusted colleague.
- **Think about whether you are deviating from your usual practice.** Doing special things for a patient (spending more time with the patient, providing unusual treatments, disclosing personal information to the patient, cutting the patient off mid-sentence, shaming the patient, etc.), can also be a clue that boundary crossings may be occurring.
- **Use protocols.** Protocols help to emphasize the professional nature of the relationship. Use of chaperones can reassure the patient and protect the clinician, especially for sensitive procedures like pelvic, genital, rectal, or breast examinations. It is important to remember that one never knows whether a patient may have an undisclosed trauma history. Addressing the patient by title is another way to communicate respect and set bounds. When obtaining informed consent for a procedure, it is important not to rush the patient, instead assuring that he/she has had an opportunity to fully consider the options.
- **Set limits.** It is up to the clinician to set appropriate boundaries. These limits should be stated clearly (in writing in the form of a contract, if necessary), but respectfully and non-confrontationally.

### Part 3: Dissociative Disorders

## What is dissociation?

Dissociation involves “disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment.”<sup>78</sup> It can be nonpathologic, such as brief episodes of staring into space and losing track of time while listening to a lecture, which happen to everyone. Among the pathological forms are:

- **Dissociative Disorder - Repeated episodes of dissociation.** Clinically, the patient might appear to be staring into space with rigid stance (as if in a trance). Alternately, the patient might

exhibit behavioral changes, such as shouting or sobbing, or perhaps speaking about something unconnected with the current reality. Attempts to engage the patient fail to elicit a coherent conversation. Of note, associations between dissociative disorders and “pseudoseizure” have been noted.<sup>79, 80</sup>

- **Dissociative Identity Disorder** (which used to be called Multiple Personality Disorder) - In this disorder, the individual intermittently experiences him/herself as a different person (or as several different people). Clinically, a patient dissociating into an alter identity may suddenly assume different mannerisms, accent, style of dress, range of affect, and even name.

Dissociation can be thought of as a way patients cope with overwhelming emotion. Patients who were repeatedly traumatized in childhood or during military service may have learned that, while they could not flee physically, they could cope with horror by distancing themselves cognitively/emotionally. That is, they learned to “tune out” the trauma. Later, they may apply the same strategy to cope with other intense emotions, especially fear. Fear is common in the medical setting, where many aspects of care are reminiscent of the prior trauma (**Section 11**). Thus, it is not surprising that patients with a sexual trauma history may dissociate during medical encounters.

## Why do patients dissociate?

The most important thing that clinicians can do is to help **prevent** dissociation from occurring in the first place. Since dissociation typically occurs in response to intense fear, this can often be prevented by following the steps described in **Section 11** to make the medical encounter feel as safe as possible for the patient, for example, by clearly explaining to the patient what to expect in the procedure, assuring that the clinical setting is private and calm, etc.<sup>81</sup>

*To see an example of Dissociation, review Video Clip #5. You may review the video at: <https://www.ees-learning.net>.*

Despite these precautions, patients with dissociative disorders will occasionally dissociate during clinical encounters. Knowing about the clinical presentations described above will increase the likelihood that a clinician will **recognize a dissociative episode when it occurs**. When this happens, several types of intervention can be helpful.<sup>81</sup>

1. **Stop doing whatever triggered the reaction.** The clinician should stop touching the patient and discontinue the procedure as soon as it is safe to do so.
2. **Attempt to reorient and soothe the patient.** The clinician can remind the patient of the patient’s name, the date, the fact that he/she is in a doctor’s office to treat a medical problem, or something about the current environment (e.g., that the room is chilly or the fan is making a loud noise).

3. **Ground the patient with concrete tasks.** If the patient needs additional grounding, he/she can be asked to focus on a simple, concrete task such as counting aloud or taking regular, deep breaths.
4. **Refer the patient to mental health.** While it might alarm the clinician, dissociation itself is generally not an emergency; the patient has likely used it as a coping mechanism for years. However, dissociative disorders typically reflect more severe forms of PTSD, indicating a need for expert mental health input. Since the patient may feel embarrassed about the dissociative episode, it is important to normalize the mental health referral (as discussed in [Section 6](#)), so that the patient will not think that he/she is “crazy”.

#### Part 4: Somatization Disorder

### What is somatization disorder?

Patients with [somatization disorder](#) present with multiple physical symptoms of unknown etiology, or that are out of proportion to their diagnosed conditions. The clinical presentation may also include inconsistent histories, vague descriptions of symptoms, lack of reassurance by negative medical findings, and a sense of desperation about finding a medical cause. It can be helpful to conceptualize somatization as an illness-focused behavioral style with multiple contributing factors such as childhood experiences of illness, cultural expressions of emotional distress, beliefs about illness and the causes of illness, learned misinterpretations of bodily sensations, and reinforcement of illness expressions by significant others and health care providers.

*Remember that the suffering of patients with somatization disorder is real*

It is important to note that patients with somatization disorder may have a long history of being over-investigated medically and inappropriately treated. They may engage in “doctor shopping” that can have the iatrogenic effect of being provided a confusing and sometimes contradictory array of explanations for their symptoms that further exacerbates their distress and frustration about their medical care.

Unlike [malingering](#) and [factitious disorders](#) (which are less common), the symptoms experienced in somatization disorder are *not* under the patient’s control. Even if a physiologic basis for the symptoms is not clinically apparent, it is critical for clinicians to remember that the patient’s suffering is real.

### Why is somatization disorder more common following sexual trauma?

It is important not to dismiss physical symptoms in patients who have an MST history, as they can develop serious medical conditions just like anyone else. Indeed, they have an increased prevalence of several serious conditions ([Section 3](#)). That being said, it is important to recognize that the prevalence of somatization disorder is higher among people with a sexual trauma history than among other populations. This association is best documented in the case of childhood sexual trauma, but a heavy burden of physical symptoms

has also been documented following adult sexual trauma, including military sexual trauma (**Section 3**). Symptoms like chronic pain, sexual dysfunction, irritable bowel syndrome, etc., are particularly common, and may flare during periods of stress (for example, during the period when the patient is undergoing exposure therapy in the mental health setting, which may cause the patient's PTSD symptoms to flare temporarily). There is a substantial literature documenting serious physiologic derangements following trauma, such as neuroendocrine dysregulation and immunologic dysfunction (**Section 3**). Thus, physiologic mechanisms may explain the physical symptoms. Other mechanisms that have been proposed include a state of heightened sensitivity to physical sensations, "body memories" of the trauma (such as chronic vulvar pain), or communication of psychological distress.<sup>72</sup>

### How can somatization disorder be managed in patients with an MST history?

The management of somatization disorder in the primary care setting has been reviewed elsewhere.<sup>82</sup> Key concepts to keep in mind when caring for patients with prior sexual trauma who have a somatization disorder include:

- **Take the patient seriously.** The patient's suffering is real, and dismissing the symptoms as psychological in nature will likely alienate the patient. Patients are quick to pick up on indications that their doctors think their symptoms are "all in the head". Furthermore, patients with somatization disorder develop physiologically-based conditions like any other patient, and clinicians need to remain alert to this possibility.
- **Provide an acceptable explanation to the patient.** Patients with somatization disorder may worry that negative findings will be interpreted by the health care provider as meaning that the patient's symptoms are not real or believable. This issue may be especially emotionally charged for sexual trauma survivors with histories of not being believed by people who were supposed to help them. Providing an explanation for the patient's symptoms that is understandable in layperson's language and incorporates as much as possible the patient's beliefs and experiences can facilitate a mutual understanding and collaboration.
- **Avoid extensive diagnostic work-ups.** These can lead to frustration for the patient and can cause iatrogenic harm. While challenging, clinicians need to try to optimize the balance between intervention and restraint.
- **See the patient frequently.** Brief, frequent, regularly scheduled, and well-bounded visits in the primary care setting are perhaps one of the most effective interventions for somatization disorder.<sup>82</sup> When patients feel secure that they are not going to be abandoned, their symptom intensity often decreases, and they often begin to use health services more effectively (e.g., decreasing unscheduled visits and telephone calls).

- **Shift the goal from cure to management of symptoms and optimization of function.** Focus on improving quality of life and behavioral outcomes. Negotiate a treatment plan with the active input of the patient. It can be helpful to use the patient's own words to justify not pursuing ineffective treatments again. It is important to acknowledge patients' efforts to live with their symptoms and to accomplish goals in spite of their symptoms.
- **Set limits.** Patients need to understand protocols for visit duration and frequency, and how interim issues will be addressed. The patient and provider can together work out systems that will facilitate the patient's care. For example, some patients bring in a list that includes all their current concerns, and then the patient and clinician spend the first couple of minutes of the visit scanning the list and negotiating which 1-3 items will be addressed at that visit, and which will be deferred until a future visit. Written contracts can sometimes be very helpful, reassuring the patient of the clinician's commitment to his/her ongoing care, and helping the clinician not to become overwhelmed by frequent telephone calls or long lists of symptoms.
- **Exercise caution around the issue of mental health referral.** The clinician in the strongest position to help a patient with somatoform symptoms is generally the *medical* provider. Mental health referral in the specific case of somatization disorder can have unintended negative consequences. For example, patients who complain of a headache, and are told to see a psychiatrist can feel that the clinician is dismissing their symptoms. However, some mental health interventions may be helpful for patients with somatization disorder. For example, the patient may find it useful to learn stress reduction techniques, interpersonal skills, or strategies for coping with chronic illness. Likewise, treating a comorbid episode of major depression or anxiety disorder may alleviate some physical symptoms. Cognitive behavioral therapy may also be of benefit.<sup>83</sup>

## Part 5: Harm to Self or Others

### What high risk behaviors are common in patients with a sexual trauma history?

As discussed in [Section 3](#), high-risk, self-destructive behavior, and impulsivity are particularly common in patients with a sexual trauma history. These include:

- **Suicide attempts and suicide gestures**
- **Homicide and other violence perpetration** (e.g., perpetration of intimate partner violence or child abuse)
- **Self-mutilation** (e.g., self-cutting)
- **Eating disorders** (including anorexia, bulimia, obesity)
- **Substance abuse** (e.g., tobacco, alcohol, or drugs)



- **High risk sexual behaviors** (increasing risk for pregnancy and sexually transmitted diseases such as HIV)
- **Nonadherence** (e.g., to prescribed medications)
- **Impulse control difficulties**

All of these problems are clearly relevant in the primary care setting. In addition, as will be discussed in [Section 12](#), **revictimization** (e.g., being the victim of intimate partner violence following earlier MST) is also common.

### **What can be done to minimize high risk behaviors?**

The management of high-risk behaviors in patients with a sexual trauma history is similar to their management in other patients.<sup>84</sup> Typically, primary care providers manage these issues in collaboration with mental health experts, who can help to assess acute risk, and develop safety contracts with the patient. Among the important points clinicians should consider are:

- 1. Screen for suicidal and homicidal ideation** - if the clinician is concerned about immediate safety risk, local protocols should be followed to transfer the patient to definitive care. It can be helpful to consider, "Is the patient in crisis, or is crisis a chronic state for this patient?" Some patients exhibit a state of chronic distress. However, risk of completed suicide is increased in patients with PTSD or borderline personality disorder, so threats should be taken seriously.
- 2. If ongoing victimization or perpetration of violence is detected** (e.g., child abuse, elder abuse, intimate partner violence), **adhere to state and local reporting requirements.**

Complex conditions like self-mutilation or eating disorders typically require an interdisciplinary team approach to care; contracts between the patient and the treatment team are often helpful. Effective mental health treatments are available to address these maladaptive coping mechanisms, including therapies like **Dialectical Behavioral Therapy**, which is discussed in [Section 7](#). [Section 6](#) discusses the approach to the high-risk patient who declines mental health referral.





# Medical Procedures for MST Survivors: Avoiding PTSD Flares

## Learning Objectives

1. Recognize the importance of gender in evaluating MST.
2. Identify medical interventions that could potentially cause flares of trauma symptoms and how the PTSD flare may manifest itself.
3. Describe how to minimize PTSD flares during medical encounters.

## Why do medical encounters and clinical procedures cause flares of PTSD symptoms?

It is not uncommon to find that aspects of the medical encounter and clinical procedures can be traumatic for patients with a sexual trauma history. Indeed, some aspects of the medical setting may bring back painful memories of the trauma. The power differential between patient and provider has parallels with the power differential between victim and perpetrator. For example, an examination table may be reminiscent of a bed upon which the patient was sexually assaulted, or a small exam room may resemble the closet in which the attack occurred. Some characteristics of the clinician (gender, race, build, cologne) may overlap with characteristics of the assailant. Patients who are receiving medical care often feel intensely powerless (especially when diagnosed with serious illness), as may people who are being sexually assaulted. Thus, the medical encounter can threaten patients who have a sexual assault history.<sup>72</sup>

## What kinds of interventions can cause flares of trauma symptoms?

Medical interventions in particular can trigger PTSD symptoms.<sup>30</sup> In the course of an examination or a medical procedure, the patient may be touched in parts of his/her body that were touched during a prior sexual assault, or in ways that remind him/her of the trauma. Even minor touching like taking a blood pressure can cause distress, but more commonly this is seen with examinations or procedures targeted at the pelvic, genital, rectal, oral, nasal, or breast areas. Sudden, unexpected movements by clinicians can be particularly alarming. Examinations that require the provider to be close to the patient (e.g., fundoscopic examination), above the patient (e.g., abdominal exam), or behind the patient (e.g., lung or thyroid examination) can also cause anxiety. Provider positioning (e.g., unintentionally stepping

between the patient's leg to get close enough for a nasal examination) can have unanticipated effects upon the patient. Use of physical restraints (e.g., wrist restraints for a breast biopsy under sedation) can obviously upset a patient. Even sedatives used in an effort to minimize a patient's procedure-related anxiety can have an unanticipated effect, if the patient's assailant used alcohol or other sedatives to complete the assault.

## What does a PTSD flare look like?

There are several ways a PTSD flare might present in a clinical setting. These include:

- **Anxiety**
- **Angry outbursts**
- **Irritability**
- **Avoidant behavior** - (e.g., failing to show up for a scheduled appointment, or appearing withdrawn)
- **"Re-experiencing"** - in which the patient experiences being back in the traumatic situation: the patient's thoughts, body sensations, and emotions realistically emulate the trauma.
- **Dissociation** - is one way patients may cope with overwhelming emotions triggered by the medical encounter (**Section 10**). During dissociation, the patient experiences an episode of disorientation. He/she may appear unresponsive, staring into space. Alternatively, he/she may express strong emotion (e.g., sobbing, hostility) or be speaking nonsensically about topics unconnected to the current reality.

## What can I do to prevent PTSD flares during exams and procedures?

PTSD flares are typically triggered by a strong emotion, usually intense fear. Therefore, to prevent these symptoms, steps should be taken to minimize the patient's anxiety and **maximize the patient's feelings of control** over the clinical encounter. Some practical steps can help:

1. **Informed consent is critical.** Explaining to the patient what to expect from an examination or procedure, and proceeding only with his/her consent, is essential. (For example: "I'd like to check your breast next; is that ok?")
2. **Offer options.** The patient needs to understand the alternatives, including even his/her right to decline an examination or procedure or ask that it be stopped midway. By brainstorming with the patient about what might make him/her feel more comfortable (e.g., calming music through headphones during a pelvic examination, having a friend outside the door during a procedure, seeing the operating room suite, and meeting the surgical nurse prior to the day of surgery, etc.), the clinician communicates ways in which the patient is in control of what might otherwise feel like a helpless state.

- 3. Establish a setting that will help the patient feel secure.**  
Simple measures like speaking in a slow, calm voice, sitting at eye level with the patient, taking the history before the patient changes into a gown, and making sure the room is comfortably warm and perhaps with pleasant pictures on the walls, can be reassuring. Establishing a respectful partnership with the patient and soliciting his/her input is advocated for all patients,<sup>85, 86</sup> and can pay large dividends in the care of trauma survivors.
- 4. Consider sedation.** Sedation may be of benefit if the patient feels this will help him/her to feel more comfortable. However, if the patient was sedated by the perpetrator of a prior sexual assault, sedation for a medical procedure could potentially awaken traumatic memories. The risks and benefits must be weighed.



**Learning Objectives**

1. Recognize MST patients who may be at an elevated risk for being sexually and/or physically assaulted now or in the future.
2. State two reasons why a provider should screen for current domestic violence/intimate partner violence.
3. List factors that contribute to the phenomenon of revictimization.
4. List factors that may contribute to a patient remaining in a physically violent relationship.

**What is revictimization?**

*MST survivors are at elevated risk for future assaults. Primary care providers can help patients to prevent such revictimization.*

“Revictimization” is the idea that patients who have experienced violence once are more likely to experience violence repeatedly. Specifically, people who have experienced MST have a higher risk of having experienced other forms of violence in the past (including other sexual assaults, intimate partner violence, or

child abuse). They are also at higher risk of experiencing interpersonal violence again in the future. Primary care providers are in a position to help prevent these future episodes of violence.

- **Victimization prior to the MST:** Studies of women with a sexual trauma history have documented that revictimization is common.<sup>87-89</sup> The prevalence of childhood abuse and other pre-military trauma is higher in women veterans with a history of MST.<sup>5, 90</sup> Furthermore, 37% of women acknowledging a history of MST reported that they had been raped at least twice during their military service.<sup>3</sup> Among a sample of over 1000 U.S. Army soldiers, about 7% of men and 23% of women reported a lifetime history of sexual assault, the majority of these assaults being pre-military.<sup>91</sup>
- **Victimization following the MST:** Patients with a prior sexual trauma history are also more likely to experience later sexual assault and physical revictimization in close interpersonal relationships; this effect is best documented for the effect of childhood sexual abuse upon risk of later revictimization.<sup>88, 89, 92</sup> Women are more likely than men to experience severe forms of IPV.<sup>93</sup> When women veterans report intimate partner violence, the

physical violence that they experienced is frequently severe including hitting, punching, kicking, choking, and beating or other life-threatening assaults.<sup>94, 95</sup>

Understanding the concept of revictimization can help primary care providers cope with patient behaviors they may find frustrating, and can position them to potentially save a patient's life. Knowing that a patient has a remote history of MST, the clinician should screen for ongoing violence exposure. By identifying ongoing risk and assessing current safety, the clinician has taken the first steps towards preventing future exposure to violence, breaking the "cycle of violence". Safety assessment and other management issues for ongoing intimate partner violence are discussed in [Section 13](#).

## Why is revictimization relevant to me?

Clinicians can feel frustrated when caring for a patient who has been repeatedly traumatized, especially cases of ongoing intimate partner violence. Clinicians may wonder why the patient keeps returning to abusive situations; it is easy for anyone to fall into the trap of "blaming the victim". Why don't victims just leave?

Sexual revictimization is multiply determined.<sup>96</sup> One important factor is personal history: witnessing violence as a child or being physically abused as a child may contribute to the adoption of violence as a conflict tactic.<sup>97</sup> However, it is important to remember that many individuals exposed to intimate partner violence deny ever having witnessed or experienced such abuse as children, and most individuals with a history of childhood abuse do not become victims or perpetrators of intimate partner violence.<sup>98</sup>

Contextual factors may also contribute to risk of sexual revictimization. Examples of contextual predictors of rape in the military setting are experiencing physical intimidation on duty or unwanted sexual advances in sleeping quarters, or working in an environment where ranking officers allow troops to make sexually harassing comments or gestures in the woman's presence.<sup>3</sup> Economic factors, such as living in a poorer neighborhood and being required to work late hours, may increase vulnerability to sexual assault.<sup>96</sup>

While a primary care provider may not be in a position to address these contextual risk factors and cannot reverse the patient's childhood trauma experiences, providers *are* able to help with some of the common psychological sequelae of trauma that increase patients' vulnerability to revictimization. Examples of potentially reversible vulnerabilities include:

- **Difficulty interpreting whether interpersonal situations are dangerous:** PTSD symptoms may interfere with the patient's ability to perceive situations as dangerous and to act accordingly.<sup>99</sup>
- **Dissociation:** Patients who engage in trauma-related dissociative behaviors may appear confused and vulnerable and as a result may be more likely to be targeted by perpetrators.<sup>28</sup>



- **Substance use problems:** When patients use substances to temporarily relieve distressing PTSD symptoms,<sup>100</sup> they may also reduce other internal signals that would otherwise alert them to dangerous situations. Substance use may further decrease their ability to resist unwanted sexual advances.
- **High risk sexual behaviors:** A history of childhood sexual abuse is associated with greater sexual risk taking behaviors, including having multiple sexual partners and briefer relationships, engaging in greater unprotected sexual activity, and engaging in prostitution.<sup>101, 102</sup> In addition to increasing sexual health risks, engaging in these sexual risk behaviors also places patients at risk for experiencing sexual revictimization.

*Psychological vulnerabilities that place patients at increased risk of revictimization can be addressed through mental health referral*

Fortunately, such vulnerabilities can be effectively addressed by a referral to a mental health provider.<sup>103</sup> For example, cognitive-behavioral skills training can help patients learn to identify risky situations and engage in more effective interpersonal behaviors that

help protect them from further harm. These interpersonal skills may also help revictimized patients more effectively interact with their primary practitioners.

There are also pragmatic reasons why patients (especially women) do not leave relationships marred by intimate partner violence. Common reasons for staying in or returning to a violent relationship include:<sup>104</sup>

- the perpetrator's promises to change;
- length of commitment to the relationship;
- lack of financial and housing alternatives;
- lack of child care alternatives;
- doubt in ability to develop another relationship;
- lack of employment and education; and
- fear that trying to leave will lead to further abuse for themselves or their children.

This latter concern of victims is substantiated by research: women are at a particularly high risk of escalation of violence and death during the period when they are attempting to leave the abusive relationship.<sup>105, 106</sup> Therefore, providers should not be cavalier about advising patients to leave the relationship before all the implications have been explored and a safety plan developed. Patients may make several attempts to leave and subsequently return before eventually ending an abusive relationship.<sup>107</sup> The next section discusses how providers can help the patient to get to this point.



# 13

## Intimate Partner Violence

### Learning Objectives

1. State two examples of questions that can be used to assess patient and family safety.
2. Identify resources for dealing with domestic violence/intimate partner violence.
3. Identify the elements of safety needs assessment and planning.

Intimate partner violence (IPV, also referred to as domestic violence) is more common among patients who have previously experienced military sexual trauma, as [Section 12](#) showed. Therefore, primary care providers may be called upon to manage IPV as part of their overall care for sequelae of MST. A detailed discussion of IPV is beyond the scope of this text, but core management issues are presented here. Further information is included in [Appendix H](#), and several excellent references review this topic in detail.<sup>40, 108, 109</sup>

### What is IPV and how common is it?

Intimate partner violence is:

a cycle of control and power “characterized by a pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation, and/or intimidation.”<sup>109, 110</sup>

IPV is common. An estimated 20-30% of women and 0.1% of men experience intimate partner violence in their lives.<sup>111-115</sup> Among women visiting one VA facility, 24% of those under age 50 and 7% of those over age 50 reported past year domestic violence experiences.<sup>95</sup>

### How can I help?

Medical providers can do a great deal to help patients who are currently in abusive relationships. The primary care response involves:

- **Identifying IPV** (through screening or by noting red flags)
- **Treating injuries**
- **Assessing immediate safety**
- **Connecting the patient with mental health and community**

- resources who can address psychological distress and help the patient develop a safety plan
- **Documenting the findings**
- **Following local laws about reporting**
- **Providing ongoing care**

As discussed in relation to MST, patients can find it extremely therapeutic simply to have the opportunity to disclose the abuse to a clinician who can provide empathy and validation.

## How can I screen for IPV?

Identification of IPV, like identification of MST, is best accomplished by directly screening for it. Patients do not typically volunteer a history of IPV spontaneously, but are generally open to discussing it, although a minority will not yet be ready to share their stories when asked.<sup>31, 116-118</sup> A number of major organizations (e.g., the American Medical Association and the Joint Commission on the Accreditation of Healthcare Organizations) and experts<sup>119, 120</sup> recommend that clinicians attempt to identify and refer patients who have been abused. The rationale for screening is even greater in patients who have experienced MST, given the higher prevalence of IPV in this population (**Section 12**).

**So, how to ask?** Many of the principles are the same as for MST screening (**Section 4**). For example, inquiry should occur in a private setting, should be preceded by normalizing statements, and should describe behaviors (like “hitting”) rather than using loaded terms (like “abuse”).

One aspect of IPV screening that differs from MST screening is that it may be a **current** issue rather than a historical event. Therefore, family members and friends should not be present for the screening, in case they are perpetrators of IPV or support the perpetrator. Often family members can be asked to step out for the physical examination, and the clinician can pursue private questions at that point. Another difference is that MST screening only needs to occur once (assuming that the patient is no longer in the military and repression of memories is not suspected), whereas IPV screening needs to be ongoing (perhaps annually) to detect incident problems.

Examples of specific questions include:<sup>110, 109, 121</sup>

*“Because violence is so common in many people’s lives, I’ve begun to ask all my patients about it. Are you in a relationship with a person who physically hurts or threatens you?”*

*“[If injured:] Did someone cause these injuries? Who?”*

*“Have you ever been hit, kicked, slapped, pushed, or shoved by your boyfriend/husband/partner?”*

*Is the patient’s abuser present?  
Interview patients in a safe and private room. Patients and partners should understand that it is routine to see all patients privately.*

Another brief screen is the STaT. A positive response to any one item on the STaT has a 97% sensitivity for lifetime IPV.<sup>40, 122</sup> This screen includes three questions:

Have you ever been in a relationship in which your partner has...

*To see an example of the above screening questions, there are two (2) Case examples Grace-1 (part 4) (page 118) and Carlotta-3 (part 1) (page 126) for review. You may also view a short video related to these screening questions by going to <https://www.ees-learning.net>.*

1. pushed or **Slapped** you?
2. **Threatened** you with violence?
3. thrown, broken, or punched **Things**?

Similar questions can be asked on a written intake form. Examples of written questions for patients can be found on the Internet. [Family Violence Prevention Fund Web site, Clinical Guidelines on Routine Screening, pages 22-25. [http://www.endabuse.org/programs/health\\_care/files/screpol.pdf](http://www.endabuse.org/programs/health_care/files/screpol.pdf)] Additional information about the "RADAR" approach to domestic violence identification and management can be found at:

[http://www.opdv.state.ny.us/health\\_humsvc/health/radar.html](http://www.opdv.state.ny.us/health_humsvc/health/radar.html).

## What clues should increase my index of suspicion for IPV?

In addition to directly screening for violence, some aspects of the clinical presentation may point to this possibility. Certain clues and red flags should increase the provider's index of suspicion,<sup>110, 123</sup> such as:

- **Presence of injuries:** Patients who present with acute injuries should be asked whether someone hurt them.
- **Characteristics of the injury:** Clinically implausible explanation of the mechanism of injury; injuries to head, neck, chest, breasts, and abdomen; injuries during pregnancy; multiple sites of injury; repeated or chronic injuries; delay in seeking medical care for injury.
- **Psychological symptoms:** PTSD symptoms, anxiety, problems with sleep and appetite, fatigue, decreased concentration, difficulty coping, feelings of isolation, evasiveness, suicide attempts, and substance abuse.
- **Physical symptoms:** Chronic pain, headaches, gastrointestinal symptoms, palpitations, dizziness, paresthesias, dyspnea, sexual dysfunction.
- **Utilization characteristics:** Frequent clinic visits with vague complaints; multiple ER visits, frequent use of prescription tranquilizers or pain medications; delay in seeking care.
- **Partner characteristics:** Partner appears overly protective or controlling during clinic visits; partner abuses substances; patient appears reluctant to speak in front of partner.

While these clues are helpful, it is important to remember that they lack specificity (that is, not everyone who presents this way has a history of violence exposure) and they lack sensitivity (that is, some patients in IPV relationships show none of these characteristics).

## My patient screened positive for IPV. Is it safe for me to send him/her home?

The clinician should evaluate the patient's immediate and future safety before the patient leaves the medical setting. Questions to ask the patient include:<sup>109, 110</sup>

- *"Are you in immediate danger?"*
- *"Are you afraid to go home?"/"Is it safe for you to go home?"*
- *"Have there been threats of homicide or suicide?"*
- *"Are there weapons in your home?"*
- *"Has your partner ever used or threatened to use a weapon?"*
- *"Are others at home being abused or threatened? (e.g., children, elders)"*
- *"Does your partner abuse or threaten to abuse household pets?"*
- *"Has your partner hurt you in other ways, such as keeping you away from your family and friends, and/or preventing you from having money or transportation?"*

*To see an example of the above questioning techniques go to Case example, Carlotta-3 (part 2) (page 126) for review. You may also view a short video related to these questioning techniques by going to <https://www.ees-learning.net>.*

## What should I do if my patient appears to be acutely unsafe?

If the safety assessment indicates that the patient is in immediate danger, the clinician should follow local facility procedures to assure his/her safety. This usually involves emergency consultation with a domestic violence advocate (on-site, in an emergency room, or by telephone to a local domestic violence shelter hotline). The advocate will help the patient address urgent issues like emergency shelter and legal protection. In remote rural areas, health care facilities need to have a procedure for referring patients to safe haven or shelter and counseling services in acute situations.

Development of a safety plan is also urgently needed if the patient is planning to leave the abusive situation, because the greatest risk of severe injury or death occurs in the period of leaving. Typically, primary care clinicians connect patients with experts at their facility or in their community who can help the patient develop a safety plan. Some of the basic elements of advice patients typically receive from such counselors include:

*The greatest risk of death occurs when the patient is trying to leave the abuser*

- **Be ready to leave.** Make sure you have quick access to important papers (social security cards, car title, birth certificates), credit

cards, and ATM cards, medications, and children's items; have some cash stored away; keep an extra set of keys to car and home; have a clothing pack ready in case you need to leave quickly.

- **Keep a list of important phone numbers:** friends, family, doctors, lawyers, and helping agencies.
- **Plan an escape route.** What is the safest escape from your home if you or children are in a threatening situation? Make an escape plan with more than one escape route and teach your children how to respond (e.g., be sure your children know how to dial 911).
- **Think through your alternatives.** Who can you call if you need a safe place to stay? Which neighbors can help you? What shelters are available?
- **Prepare your workplace.** Plan what to do if your abuser tries to find you at work, know the escape routes, and alert your work site that you might have to exit quickly in an emergency.

Health care providers cannot effectively predict future violence, nor should they try. However, a medical encounter may be one of the few windows of opportunity, and possibly the only window of opportunity, to intervene and break the cycle of violence.

Additional information regarding screening issues is provided in **Appendix H** and at the following Web sites:

<http://www.abanet.org/tips/dvsafety.html> (American Bar Association "Domestic Violence, Safety Tips for You and Your Family")

[http://www.endabuse.org/resources/gethelp/personal\\_plan.php3](http://www.endabuse.org/resources/gethelp/personal_plan.php3) (End Abuse Personal Safety Plan)

<http://www.aardvarc.org/dv/plan.shtml> (An Abuse, Rape, and Domestic Violence Resource Collection Personal Safety Plan)

## What resources are available to patients in abusive relationships?

Primary care providers can connect patients with various important resources. Some resources are described below (as well as listed in **Appendix C**).

- **Mental health referral.** Mental health and substance use problems are common in patients with IPV histories.<sup>124-126</sup> Offering the patient mental health referral (using approaches similar to those described in **Section 6**) is an important element of management.
- **Advocacy services.** Domestic violence hotlines and local domestic violence shelters can help the patient with problem-solving and support. Clinicians need to know about their local resources in advance, so that information is readily available when the need arises. Each VA facility has a designated Women Veterans Program Manager who can be an excellent resource.

- **Patient education materials.** For example, the Family Violence Prevention Fund (<http://www.fvvpf.org>) and the National Coalition Against Domestic Violence (<http://www.ncadv.org>) are excellent resources for on-line information for ordering patient education materials (e.g., screening and assessment tools, domestic violence awareness posters, informational pamphlets, and palm cards). Patients who bring such pamphlets home should be sure their partners do not find the materials, which could enrage the partner and lead him/her to retaliate.

## How should I document the encounter?

The patient's medical records may become central to a legal case. It is important to provide complete and detailed documentation of **suspected**, as well as reported violence and abuse. Documentation should occur at the time of the encounter, and should be properly and confidentially stored. Care should be exercised and Vet Center referral strongly considered in the case of a veteran employee due to privacy concerns.

In addition to typical patient encounter information (e.g., date and time of arrival, reason for visit), written records should include:<sup>109</sup>

- patient's abuse history (who, what, when, where, how); use patient's exact words in quotation marks when possible
  - relationship to perpetrator(s)
  - description of event(s) (current and prior)
  - when the event(s) took place
  - where they took place
  - any reported injuries (type and how inflicted)
  - names of any witnesses
- a detailed description of any injuries, their nature and their causes
- an injury map (which can be downloaded from [http://www.endabuse.org/programs/health\\_care/files/screpol.pdf](http://www.endabuse.org/programs/health_care/files/screpol.pdf) page 25)
- photographs of injuries (ideally taken in color and prior to treatment, but only with the patient's written informed consent)
- details of any report made to police or other authorities (including officer's name, badge, phone numbers, and any actions taken)

## Do I need to report the abuse?

Some states require health care providers to report injuries from domestic violence. Clinicians need to be familiar with their state's mandated reporting laws for domestic violence, elder abuse, child abuse, and disabled persons abuse. The local state government authority can provide updated information on relevant laws. Additional information about reporting laws can be found at: <http://www.endabuse.org>



## What are ongoing care issues?

Patients are not always ready to leave abusive situations immediately. Sometimes this makes the clinician feel like the patient is not taking the abuse seriously enough. The patient may decline help or fail to follow through with appointments. While this can be frustrating to the clinician, it can be helpful to remember some of the reasons patients remain in these situations (**Section 12**). After a full discussion of options, the clinician needs to respect the patient's choices, and offer support, information, and referral. Patients perceive clinicians who respond non-judgmentally as respectful and trustworthy. Such an approach communicates the seriousness of the situation, but leaves the ultimate decisions to the patient, and lets the patient accept assistance on his/her own terms, and only when ready.





# Acute Sexual Trauma

## Learning Objectives

1. Explain how to assist an acute rape victim.
2. Identify key resources in management of an acute rape victim.

## What should I do for a patient who has just experienced acute sexual assault?

Because of the revictimization risk discussed in [Section 12](#), VA patients with a prior MST history may become victims of acute sexual assault. The focus of this text is upon *military* sexual trauma; details of the management of acute rape are beyond its scope. However, some basic elements of management of a patient presenting to a VA setting after acute rape are presented next.

- **Stabilize the patient.** The first priority is the patient's medical status. Immediate threats to life, such as hemodynamic instability or acute suicidality, must be addressed first.
- **Do not destroy evidence.** Unless medically necessary, fluids or other evidence should not be cleaned or removed from the patient. The clinician needs to explain to the patient why he/she should not bathe or change clothing. Any clothing that has been removed should be considered evidence and turned over for evidence collection.
- **Identify where definitive** management and evidence collection will occur. Acute care, when possible, should be handled in an emergency department with a trained rape response team. Evidence collection protocols vary by state, but are typically very involved and require expertise. For example, steps in evidence collection might include procedures like collection of fingernail clippings, combing of pubic hair, fixation of vaginal smears, etc. In addition, there are a number of other issues to address, such as sexually transmitted disease treatment, post-exposure prophylaxis for HIV, pregnancy risk, and emotional sequelae of acute trauma. Therefore, every VA facility needs to have a protocol for management of acute rape victims, which may include transport to a facility that handles such cases more frequently.

- **Move expeditiously to the evidence collection phase.** Because of the nature of the crime of sexual assault, the need for expert and timely evidence collection must be carefully balanced with the need to medically stabilize the patient. Evidence collection should occur within 72 hours of the assault. Therefore, it is important to calmly explain to the patient the need for transport to a facility that can conduct the evidence examination and follow-up care as quickly as is possible.<sup>127</sup>
- **Arrange the patient's transport.** If the patient is to be transported to another facility, he/she should not be left to manage transport independently. Each VA setting should have a protocol in place for transport.
- **Attend to the patient's emotional well-being.** Throughout the evaluation, it is important to maintain a calm atmosphere, speaking softly and slowly despite the urgent nature of the problem, and explaining what the patient can expect at every step. The patient should never be left alone. Asking the patient if there is someone he/she would like to have present for the evaluation (e.g., friend, family member, rape crisis counselor) can also help to increase his/her feelings of control over the situation.
- **Document the encounter carefully.** Evidence from the initial encounter following rape may become part of a future criminal case, even if the patient is ultimately transported to another facility for definitive care. Therefore, it is essential to document the history and physical findings in detail. The approach mirrors documentation of domestic violence (see **Section 13**). Additional documentation should include details about transportation to the appropriate setting for evidence collection and management.
- **Address any mandated reporter requirements.** Clinicians need to be aware of local reporting laws to determine whether they are mandated reporters.
- **Provide the patient with resources.** Even if the patient is being transported to another facility, it is helpful to provide him/her with a follow-up primary care appointment (to assess post-trauma emotional status, perform follow-up screening for pregnancy and sexually transmitted diseases, etc.). It is also helpful to provide him/her with community resources; the Women Veterans Program Manager or on-site social workers can provide information about local options. Some national sexual assault resources are listed in Table 1 (next page), and in **Appendix C**; these can also be a source of information for clinicians.

<b>National Sexual Assault Resources</b>	
Rape, Abuse, and Incest National Network (RAINN) 1-800-656-HOPE	<a href="http://www.rainn.org">http://www.rainn.org</a>
Office for Victims of Crime	<a href="http://www.ojp.usdoj.gov/ovc">http://www.ojp.usdoj.gov/ovc</a>
Violence Against Women Office	<a href="http://www.ojp.usdoj.gov/vawo">http://www.ojp.usdoj.gov/vawo</a>
Office for Victims of Crime Resource Center	<a href="http://www.ncjrs.org">http://www.ncjrs.org</a>
Sexual Assault Resource Service	<a href="http://www.sane-sart.com">http://www.sane-sart.com</a>
National Alliance of Sexual Assault Coalitions	<a href="http://www.taasa.org">http://www.taasa.org</a>
	<hr/>

Table 1





## Epilogue: How Clinicians can Care for Themselves and Avoid Burnout

### Learning Objectives

1. Recognize potential emotional and physical reactions providers may experience when treating trauma survivors.
2. Describe the physical, emotional and behavioral changes involved with burnout.
3. Describe the impact that burnout can have on provider's therapeutic abilities, personal health and well-being.

### How can treating a patient with MST history affect me?

Although 60% of physicians see the patient relationship as their greatest source of professional satisfaction,<sup>128</sup> countless physicians leave the practice of medicine yearly due to the toll this relationship has on their well-being. This toll may be even more pronounced for primary care providers who treat survivors of military sexual trauma (MST). MST survivors may see their primary care provider as an important anchor in their lives. While serving in this role can be rewarding for the provider, it can also be draining, and even potentially threaten the provider's own health and well-being. Indeed, the same special qualities that attract people to careers in medicine (empathy, compassion, a capacity to give selflessly, a desire to positively affect others' lives) can also make them vulnerable to stress and burnout.

A provider may experience a host of different emotional and physical reactions when he/she is exposed to the painful legacy left by MST. These reactions are common, and have been given various terms, such as compassion stress, compassion fatigue, vicarious traumatization, and burnout. The underlying idea is that providers who work closely with survivors of trauma can develop symptoms that often mimic the survivors' psychological distress.<sup>129, 130</sup>

There is a continuum of effects that treating trauma survivors may have on providers' emotional health. *Compassion stress* is thought of as a natural, milder reaction to caring for trauma survivors. The symptoms of compassion stress include a sense of helplessness, confusion, isolation, and some degree of secondary traumatic stress symptoms (hyper-arousal, anxiety, depression, avoidance, and intrusive symptoms) that mimic the Post-traumatic Stress Disorder symptoms.

Chronic exposure to compassion stress can lead to psychological and physiological dysfunction in the clinician. Among the more severe reactions is *“burnout”*. Burnout has been conceptualized to include three main areas:

1. **Emotional exhaustion:** being psychologically drained with a sense of frustration, helplessness and hopelessness related to one’s work.
2. **Depersonalization:** having a detached, negative, or cynical interactive style with patients.
3. **Decreased personal achievement:** feelings of inadequacy and incompetence in relation to one’s work.

These symptoms may affect the clinician in numerous ways. While the core symptoms are *emotional*, the *physical effects* may be mediated in part through the known neuroendocrine and immunologic effects of chronic stress. The *behavioral effects* can wreak havoc on the clinician’s personal and professional life. Committed to providing quality care, the primary care clinician may make diligent efforts to ensure that patients are not the targets of their distressing emotions (e.g., irritability, depression, and feelings of worthlessness). However, clinicians may discharge these emotions as home, straining relations with loved ones.

Needless to say, unchecked distress and burnout can also impact the clinician’s work satisfaction and increase the likelihood that a provider will leave the practice of medicine. The work organization also suffers with increased absenteeism, lateness, and turnover, in addition to decreased effectiveness and productivity. Patients also suffer when practitioners experience burnout. In short, it is just good business and good sense for everyone to recognize the importance of appropriately addressing practitioner wellness.

Emotional, physical, and behavioral manifestations of burnout can include:

**Emotional signs of burnout:**

- Depression
- Irritability
- Cynicism
- Anxiety or fear
- Boredom
- Decreased compassion or empathy
- Voyeuristic or sexual reactions to clients
- Emotional numbing, disconnection from self and others

**Physical signs of burnout:**

- Headaches
- Muscle aches and tension
- Back pains
- Muscle twitches
- Gastrointestinal distress
- Palpitations
- Obesity
- Memory difficulties
- Frequent colds
- Heart disease



**Behavioral signs of burnout:**

**Boundary rigidity:**

Overly strict, rigid interaction style to distance self from patient  
"Us versus them" attitude

**Boundary violations:**

Becoming overly involved with patients  
Attempting to "rescue" patients by staying late  
Meeting patient's needs at the expense of own or family's well-being  
Engaging in social or sexual relationship with patient  
Providing non-standard care to patient

**Avoidance:**

Avoiding calls from patient  
Relief when patient cancels or no-shows

**Sleep difficulties:**

Insomnia

**Increased daydreaming:**

Tuning out patient  
Decreased concentration and memory

**Relationship difficulties:**

Being judgmental of others

**Isolation:**

Decreased interest in social activities and relationships

**Feelings of vulnerability:**

Heightened awareness of personal risk of victimization  
Taking steps to protect self and loved ones

Clinicians who want to assess themselves for compassion fatigue can go to <http://www.ace-network.com/> for a self-administered instrument. Self-assessment for other mental health issues can be found at: <http://www.mentalhealth.com>.

## **What feelings are common in clinicians caring for MST survivors?**

A provider may experience a host of feelings during an interaction with a MST patient, such as sadness, disbelief, powerlessness, frustration, and anger. Providers may also experience a sense of voyeurism in response to hearing the patient's MST history. Clinicians may find themselves pulled to get more details than are appropriate, in an almost morbid fascination, similar to being drawn to look at a car crash on the highway. It is also not uncommon for primary care providers to have sexualized thoughts or feelings when interacting with patients with MST histories, or in response to hearing accounts of the sexual trauma. These reactions may bring up feelings of shock and shame for providers who perceive themselves as caring, ethical professionals who would never exploit a patient. Table 1 (next page) illustrates that a clinician's feelings can also evolve over time.

Clinician's Feelings and MST Survivors	
Feelings	Triggers
Sadness or disbelief ↓	Patient discloses MST history.
Helplessness ↓	Desire to protect the patient coupled with realization that your impact is limited.
Powerlessness ↓	Patient's problems are not "solvable." Patient does not accept referrals or advice. Patient nonadherence to recommendations.
Frustration ↓	Patient's symptoms relapse, or are refractory to treatment attempts. Patient makes unrealistic demands to have all symptoms disappear, to have problems "fixed". Patient does not accept the possibility that physical symptoms may be related to MST, and declines psychiatric treatment.
Anger	Patient lumps you into the category of "everybody" who does not believe him or her. Patient does not appreciate your efforts. Patient responds to you as if you are part of the military or government that abused him/her. Feelings of powerlessness, fear, or sadness in the clinician can present as anger.

Table 1

## What factors could put me at risk of burnout?

Some of the risk factors for development of compassion fatigue and burnout include:

- **Clinician is a trauma survivor.**<sup>130</sup> At one academic medical center, 14% of physicians and medical students had experienced physical and/or sexual abuse during their lives.<sup>131</sup> If the provider's trauma experience is unresolved, it could impact on the care he/she provides to patients with MST histories, and impact on the clinician's ability to self-care.

- **Clinician’s work environment is perceived as non-supportive.** The risk of burnout increases when providers believe that their facility does not provide sufficient opportunities to develop or apply their professional skills and abilities, promotes irrational or counter-productive policies and procedures, fails to foster supportive relationships with colleagues and supervisors, or to provide meaning or reward to the clinician’s work. These circumstances coupled with heavy caseloads, insufficient resources to meet patient needs, and long work days may leave the provider feeling frustrated, helpless, and angry.
- **Clinician disregards his/her own feelings.** Medical training tends to de-emphasize the importance of being aware of and responsive to one’s emotions. *“In medical school and residency, physicians often are not taught to give credence to their own personal feelings of anger, beleaguerment, sexual arousal, and even outrage. These human reactions cannot be disavowed, however, because they tend to emerge in one’s working relationships with patients”*<sup>32</sup> (page 148). This, coupled with the belief that as healers, providers are expected to give, not receive help, leaves many health care professionals at a loss to effectively deal with the reality of compassion fatigue or burnout. If providers believe that asking for help is a weakness or an indication of inadequacy, they are less likely to recognize the emotions associated with compassion stress or the events that may trigger these feelings.

### **What steps can I take to prevent or address burnout, and improve my ability to care for patients with MST histories?**

- **Maintain professional boundaries (see [Section 10](#) and [Appendix G](#)):** To prevent burnout, it is especially important to avoid attempts to “rescue” the patient, e.g., by permitting extended visits or excessive telephone access. Setting realistic expectations for patients is critical; clinicians should not try to be everything to the patient. These expectations need to take into account the patient’s disabilities and the patient’s resources (e.g., level of social support). It is also appropriate to set limits to the depth and timing of MST discussions.
- **Recognize and accept your own limitations:** Much as they would like to, clinicians cannot undo the MST history or “fix” the patient’s life. Clinicians should be aware of their own limitations related to professional knowledge base and scope of practice as well as personal needs, and be willing to make referrals when needed. While clinicians should provide high quality care to all patients, they are not expected to meet every request, every time.
- **Respect the patient’s autonomy:** Clinicians should respect patient choices, recognizing that the patient (not the clinician) is responsible for his/her own choices and behaviors. Instead, the

clinician’s role is to help the patient make informed decisions and develop a sense of independence and self-worth. Clinicians do this by providing the patient with information, assuming a supportive stance, and acknowledging the patient’s accomplishments over time.

- **Be cognizant of your own feelings:** The daily demands that primary care providers must meet in the work setting, coupled with pressures of competing personal roles can result in an unbalanced life. When clinicians ignore complex feelings that commonly arise from caring for MST survivors, they can go on to develop burnout. Fortunately, these feelings can be managed through self-awareness and consultation with other professionals or by seeking mental health care. It may be difficult for some providers to utilize therapeutic interventions, as this would challenge the belief that they cannot ask for help. Clinicians can check with their facility’s Employee Assistance Program, or with their state medical society to explore the availability of supportive programs.
- **Take care of yourself.** Table 2 describes important elements of self-care. While they may be obvious, clinicians frequently counsel patients to adhere to self-care, but neglect these tenets themselves.

Self-care for Clinicians	
Regular exercise	Exercise contributes to physical and emotional health and well-being.
Adequate sleep	Sleeping at least 6 hours a night is key in managing stress.
Balanced eating	Eat regular, healthy meals emphasizing whole grains, fruits and vegetables and limiting processed foods.
Avoid substance use	Avoid or limit caffeine, alcohol, refined sugars, nicotine, and other mood altering substances.
Take breaks form work	<p>Leave your clinic for lunch.</p> <p>Take quick breaks to stretch or do relaxation exercises.</p> <p>Take a 5 minute break to get a breath of fresh air.</p> <p>Take a vacation.</p> <p>Leave work on time!</p>
Relaxation techniques	With simple techniques (meditation, massage, deep breathing) you can learn to bring on a “relaxation response” with physiologic and emotional benefits.

Table 2

Table 2 (cont.)

Self-care for Clinicians	
Talk, talk, talk	<p>Consult with colleagues (MST coordinator, mental health staff, and other providers) to ensure appropriate referrals for patients and gain support for yourself.</p> <p>In order to debrief and process your emotions related to treating MST patients, you may benefit from talking with a psychotherapist or your clergy.</p>
Life apart from work	<p>Engage regularly in leisure activities and hobbies.</p> <p>Interact with friends who are not in the medical field.</p> <p>Schedule in “down time” where you can be alone and relax; start with 15 minutes a day and build up to 30 to 60 minutes.</p>
Use humor	<p>Laughter is medicine for the soul.</p> <p>When dealing with the intensity of MST, incorporating humor into your daily life can be renewing. Watch comedies, allow yourself to laugh at jokes.</p>
Find meaning	<p>Remind yourself why you entered medicine.</p> <p>Examine your beliefs: how does your present work fit into these beliefs?</p>

Table 2

## How can I incorporate these suggestions into my life?

After many years of training to heal the physical problems patients present with, it may be difficult for some primary care providers to put the same level of effort into maintaining their *own* physical and psychological health. In order to minimize the risk of burnout or compassion fatigue, the provider must *take active steps* to make self-care a priority.

### Action Steps:

1. Make a contract with yourself *today* to incorporate at least one self-care strategy into your daily schedule.
2. Set an established time and place to begin, and hold yourself accountable to meet this commitment.
3. If you need additional support, ask a friend, spouse, or colleague to be your “accountability buddy” in the area of self-care.

In the busy life of a clinician, it is almost impossible to *make* time to add anything new, so the clinician must *find* time by blocking off periods devoted to self-care.

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## Conclusion

Working with survivors of MST can put providers at risk of burnout. However, the majority of professionals caring for trauma survivors report that they gain rewards of increased purpose, meaning, a heightened sense of connection to others, and increased strength from their interactions with patients. Hearing their stories may help the clinician to develop a greater appreciation for the resiliency of the human spirit and to gain self-insights. Using effective and appropriate coping skills to manage the emotional responses triggered by working with MST survivors allows clinicians not just to survive, but also to thrive. And, in the process, they put themselves in a stronger position to help their patients with MST histories move towards greater function and wellness.

1. Bastian L, Lancaster A, Reyst H. *Department of Defense 1995 Sexual Harassment Survey (Report No. 96-014)*. Arlington, VA: Defense Manpower Data Center; 1996.
2. Martindale M. *Sexual Harassment in the Military*. Washington DC: Department of Defense; 1988. SPR2.3.
3. Sadler AG, Booth BM, Cook BL, Doebbeling BN. Factors associated with women's risk of rape in the military environment. *Am J Ind Med*. 2003;43(3):262-273.
4. Skinner KM, Kressin N, Frayne S, et al. The prevalence of military sexual assault among female Veterans' Administration outpatients. *Journal of Interpersonal Violence*. Mar 2000;15(3):291-310.
5. Coyle BS, Wolan DL, Van Horn AS. The prevalence of physical and sexual abuse in women veterans seeking care at a Veterans Affairs Medical Center. *Mil Med*. 1996;161(10):588-593.
6. Golding JM. Sexual Assault History and Physical Health in Randomly Selected Los Angeles Women. *Health psychology: the official journal of the Division of Health Psychology, American Psychological Association*. Mar 1994;13(2):130.
7. Cloutier S, Martin SL, Poole C. Sexual assault among North Carolina women: prevalence and health risk factors. *J Epidemiol Community Health*. 2002;56(4):265-271.
8. Harned MS, Ormerod AJ, Palmieri PA, Collinsworth LL, Reed M. Sexual assault and other types of sexual harassment by workplace personnel: a comparison of antecedents and consequences. *J Occup Health Psychol*. 2002;7(2):174-188.
9. Kimerling R, Calhoun KS. Somatic Symptoms, Social Support, and Treatment Seeking Among Sexual Assault Victims. Additional Info: Methodological Developments. *Journal of consulting and clinical psychology*. April 1994;62(2):333-340.
10. Frayne SM, Skinner KM, Sullivan LM, et al. Medical profile of women Veterans Administration outpatients who report a history of sexual assault occurring while in the military. *J Womens Health Gend Based Med*. 1999;8(6):835-845.

11. Stein MB, Barrett-Connor E. Sexual assault and physical health: Findings from a population-based study of older adults. *Psychosomatic Medicine*. Nov-Dec 2000;62(6):838-843.
12. Koss MP, Woodruff WJ, Koss PG. Criminal victimization among primary care medical patients: prevalence, incidence, and physician usage. *Behav Sci Law*. 1991;9(1):85-96.
13. van der Kolk BA, McFarlane AC, Weisaeth L, eds. *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. New York: Guilford Press; 1996.
14. Resnick HS, Yehuda R, Pitman RK, and Foy DW. Effect of previous trauma on acute plasma cortisol level following rape. *Am J Psychiatry*. 1995;152(11):1675-1677.
15. Sapolsky RM. Why stress is bad for your brain. *Science*. 1996;273(5276):749-750.
16. Yehuda R. Post-traumatic stress disorder. *N Engl J Med*. Jan 10 2002;346(2):108-114.
17. Golding JM, Cooper ML, George LK. Sexual Assault History and Health Perceptions: Seven General Population Studies. *Health psychology: the official journal of the Division of Health Psychology, American Psychological Association*. 1997;16(5):417.
18. Koss MP, Kilpatrick DG. Rape and sexual assault. In: Gerrity E, Keane T, eds. *The mental health consequences of torture: Plenum series on stress and coping*. Dordrecht, Netherlands: Kluwer; 2001:177-193.
19. Resnick H, Acierno R, Holmes M, Dammeyer M, Kilpatrick D. Emergency evaluation and intervention with female victims of rape and other violence. *J Clin Psychol*. Oct 2000;56(10):1317-1333.
20. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic Stress Disorder in the National Comorbidity Survey. *Archives of general psychiatry*. 1995;52(12):1048.
21. Isely PJ, Gehrenbeck-Shim D. Sexual assault of men in the community. *Journal of Community Psychology*. 1997;25(2):159-166.
22. Moscicki E. Gender differences in completed and attempted suicides. *Ann Epidemiol*. 1994;4(2):152-158.
23. Merrill LL, Newell CE, Milner JS, et al. Prevalence of premilitary adult sexual victimization and aggression in a Navy recruit sample. *Mil Med*. Apr 1998;163(4):209-212.
24. Butterfield MI, McIntyre LM, Stechuchak KM, Nanda K. Mental Disorder Symptoms in Veteran Women: Impact of Physical and Sexual Assault. *Journal of the American Medical Women's Association*. 1998.



25. Friedman MJ, Schnurr PP, McDonagh-Coyle A. Post-traumatic stress disorder in the military veteran. *Psychiatr Clin North Am*. 1994;17(2):265-277.
26. Follette VM, Polusny MA, Bechtle AE, Naugle AE. Cumulative trauma: the impact of child sexual abuse, adult sexual assault, and spouse abuse. *J Trauma Stress*. 1996;9(1):25-35.
27. Classen C, Field NP, Koopman C, Nevill-Manning K, Spiegel D. Interpersonal problems and their relationship to sexual revictimization among women sexually abused in childhood. *Journal of Interpersonal Violence*. Jun 2001;16(6):495-509.
28. Cloitre M, Scarvalone P, Difede J. Posttraumatic Stress Disorder, Self- and Interpersonal Dysfunction Among Sexually Retraumatized Women. *Journal of traumatic stress*. 1997(3).
29. Kimerling R, Rellini A, Kelly V, Judson PL, Learman LA. Gender differences in victim and crime characteristics of sexual assaults. *Journal of Interpersonal Violence*. 2002;17(5):526-532.
30. Robohm JS, Buttenheim M. The gynecological care experience of adult survivors of childhood sexual abuse: A preliminary investigation. *Women & Health*. 1996;24(3):59-76.
31. Friedman LS, Samet JH, Roberts MS, Hudlin M, Hans P. Inquiry about victimization experiences. A survey of patient preferences and physician practices. *Arch Intern Med*. 1992;152(6):1186-1190.
32. Collings SJ. The long-term effects of contact and noncontact forms of child sexual abuse in a sample of university men. *Child Abuse Negl*. Jan 1995;19(1):1-6.
33. Gordon M. Males and females as victims of childhood sexual abuse: an examination of the gender effect. *Journal of Family Violence*. 1990;5:321-332.
34. Herman J. *Trauma and Recovery*. New York: Basic Books; 1992.
35. McIntyre LM, Butterfield MI, Nanda K, et al. Validation of a Trauma Questionnaire in veteran women. *J Gen Intern Med*. Mar 1999;14(3):186-189.
36. Ellis CD. Male rape—the silent victims. *Collegian*. 2002;9(4):34-39.
37. Donaldson S. *Rape of Males*. *Encyclopedia of Homosexuality*. NY: Garland Publications; 1990.
38. Garnets LD, Herek GM, Levy B. Violence and victimization of lesbians and gay men: mental health consequences. In: Garnets LD, Kimmel DC, eds. *Psychological Perspectives on Lesbian and Gay Male Experiences*. New York: New York: Columbia University Press; 1993.

39. Donnelly DA, Kenyon S. "Honey, we don't do men": gender stereotypes and the provision of services to sexually assaulted males. *Journal of Interpersonal Violence*. 1996;11(3):441-448.
40. Liebschutz J, Frayne S, Saxe G, eds. *Violence Against Women: A Physician's Guide to Identification and Management*. Philadelphia: American College of Physicians; 2003.
41. Goodman LA, Salyers MP, Mueser KT, et al. Recent victimization in women and men with severe mental illness: prevalence and correlates. *J Trauma Stress*. 2001;14(4):615-632.
42. Chu JA. Ten traps for therapists in the treatment of trauma survivors. Dissociation: *Progress in the Dissociative Disorders*. Dec 1988;1(4):24-32.
43. Campbell R, Ahrens CE, Sefl T, Wasco SM, Barnes HE. Social reactions to rape victims: Healing and hurtful effects on psychological and physical health outcomes. *Violence & Victims*. Jun 2001;16(3):287-302.
44. Ruzek J, Watson P, eds. *Post-Traumatic Stress Disorder: Implications for Primary Care (also at Web site <http://www.va.gov/VHI/>)*. Washington, DC: Department of Veterans Affairs Employee Education System and the National Center for PTSD; 2002.
45. Frayne SM, Saxe G, Robinson P. Referral to mental health and social services. In: Liebschutz JM, Frayne SM, Saxe GN, eds. *Violence Against Women*. Philadelphia: American College of Physicians; 2003.
46. Kimerling R, Ouimette P, Wolfe J, eds. *Gender and PTSD*. New York: The Guilford Press; 2002.
47. Brady K, Pearlstein T, Asnis GM, et al. Efficacy and safety of sertraline treatment of posttraumatic stress disorder: a randomized controlled trial. *JAMA*. 2000;283(14):1837-1844.
48. Davidson J, Pearlstein T, Lonnberg P, et al. Efficacy of sertraline in preventing relapse of posttraumatic stress disorder: results of a 28-week double-blind, placebo-controlled study. *Am J Psychiatry*. Dec 2001;158(12):1974-1981.
49. Davidson JR, Rothbaum BO, van der Kolk BA, Sikes CR, Farfel GM. Multicenter, double-blind comparison of sertraline and placebo in the treatment of posttraumatic stress disorder. *Arch Gen Psychiatry*. 2001;58(5):485-492.
50. Marshall RD, Beebe KL, Oldham M, Zaninelli R. Efficacy and safety of paroxetine treatment for chronic PTSD: a fixed-dose, placebo-controlled study. *Am J Psychiatry*. Dec 2001;158(12):1982-1988.
51. Connor KM, Sutherland SM, Tupler LA, Malik ML, Davidson JR. Fluoxetine in post-traumatic stress disorder. Randomized, double-blind study. *Br J Psychiatry*. Jul 1999;175:17-22.

52. Davidson JR, Landerman LR, Farfel GM, and Clary CM. Characterizing the effects of sertraline in post-traumatic stress disorder. *Psychol Med*. May 2002;32(4):661-670.
53. Foa EB, Dancu CV, Hembree EA, Jaycox LH, Meadows EA, Street GP. A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *J Consult Clin Psychol*. Apr 1999;67(2):194-200.
54. Foa EB, Rothbaum BO, Riggs D, Murdock T. Treatment of post-traumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling. *Journal of consulting and clinical psychology*. 1991;59:715-723.
55. Resick PA, Nishith P, Weaver TL, Astin MC, Feuer CA. A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *J Consult Clin Psychol*. Aug 2002;70(4):867-879.
56. Resick PA, Schnicke MK. Cognitive processing therapy for sexual assault victims. *Journal of consulting and clinical psychology*. 1992;60:748-756.
57. Carlson JG, Chemtob CM, Rusnak K, Hedlund NL, Muraoka MY. Eye movement desensitization and reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder. *J Trauma Stress*. Jan 1998;11(1):3-24.
58. Marcus SV, Marquis P, Sakai C. Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy*. 1997;34:307-315.
59. Devilly GJ, Spence SH. The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of posttraumatic stress disorder. *J Anxiety Disord*. Jan-Apr 1999;13(1-2):131-157.
60. Linehan MM, Tutek DA, Heard HL, Armstrong HE. Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *Am J Psychiatry*. 1994;151(12):1771-1776.
61. Linehan M. *Cognitive-behavioral treatment of borderline personality disorder*. New York: The Guilford Press; 1993.
62. Jacobson NS, Dobson KS, Truax PA, et al. A component analysis of cognitive-behavioral treatment for depression. *J Consult Clin Psychol*. Apr 1996;64(2):295-304.
63. Dobson KS. A meta-analysis of the efficacy of cognitive therapy for depression. *J Consult Clin Psychol*. Jun 1989;57(3):414-419.
64. Ouimette PC, Brown PJ, Najavits LM. Course and treatment of patients with both substance use and posttraumatic stress disorders. *Addict Behav*. Nov-Dec 1998;23(6):785-795.

65. Henderson R, Sparr L. Psychiatric File Reviews in the Compensation and Pension Assessment Process. Determining psychiatric disability and compensation is a complicated process that poses unique problems and challenges. *Federal practitioner: for the health care professionals of the VA, DoD, and PHS*. Oct 1994;11(10):92.
66. ARC. *Annual Workload and Cost Report (formerly SR4)*: VHA Allocation Resource Center; 2001.
67. Bound J. The health and earnings of rejected disability insurance applicants. *Am Econ Rev*. 1989;79(3):482-503.
68. Ritchie EC. Reactions to rape: A military forensic psychiatrist's perspective. *Military Medicine*. Aug 1998;163(8):505-509.
69. Leyland M, Lundberg K. The disability compensation process: implications for clinicians involved in the treatment of sexually traumatized women veterans. *Federal Practitioner*. 1998;15(5S):16-21.
70. Herman JL, Perry JC, van der Kolk BA. Childhood trauma in borderline personality disorder. *Am J Psychiatry*. Apr 1989;146(4):490-495.
71. Rosen LN. The measurement of childhood trauma among male and female soldiers in the U.S. army. *Military Medicine*. 1996;161:342-345.
72. Saxe G, Frayne S. Ongoing management of patients with post-traumatic stress disorder. In: Liebschutz J, Frayne S, Saxe G, eds. *Violence Against Women*. Philadelphia: American College of Physicians Press; 2003.
73. Linehan MM, Schmidt H, 3rd, Dimeff LA, Craft JC, Kanter J, Comtois KA. Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *Am J Addict*. 1999;8(4):279-292.
74. Linklater D, MacDougall S. Boundary issues. What do they mean for family physicians? *Can Fam Physician*. 1993;39:2569-2573.
75. Gabbard GO, Nadelson C. Professional boundaries in the physician-patient relationship. *JAMA*. 1995;273(18):1445-1449.
76. AMA Council on Ethical and Judicial Affairs. *Code of Medical Ethics*. Chicago: American Medical Association; 1997.
77. Butterfield M, Frayne S. Boundary issues in the management of patients with previous victimization. In: Liebschutz J, Frayne S, Saxe G, eds. *Violence Against Women*. Philadelphia: American College of Physicians Press; 2003.
78. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders, fourth edition: primary care version (DSM-IV-PC)*. Washington, DC: American Psychiatric Association; 1995.
79. Harden CL. Pseudoseizures and dissociative disorders: a common mechanism involving traumatic experiences. *Seizure*. 1997;6(2):151-155.

80. Bowman ES, Markand ON. Psychodynamics and psychiatric diagnoses of pseudoseizure subjects. *Am J Psychiatry*. 1996;153(1):57-63.
81. Bradley A. Dissociation. In: Liebschutz J, Frayne S, Saxe G, eds. *Violence Against Women*. Philadelphia: American College of Physicians Press; 2003.
82. Servan-Schreiber D, Kolb R, Tabas G. The somatizing patient. *Prim Care*. Jun 1999;26(2):225-242.
83. Kroenke K, Swindle R. Cognitive-behavioral therapy for somatization and symptom syndromes: a critical review of controlled clinical trials. *Psychother Psychosom*. Jul-Aug 2000;69(4):205-215.
84. Bongar B. *The suicidal patient: clinical and legal standards of care*. Washington, DC: American Psychological Association; 1991.
85. Kaplan SH, Gandek B, Greenfield S, Rogers W, Ware JE. Patient and visit characteristics related to physicians' participatory decision-making style. Results from the Medical Outcomes Study. *Med Care*. 1995;33(12):1176-1187.
86. Greenfield S, Kaplan SH, Ware JE, Jr., Yano EM, Frank HJ. Patients' participation in medical care: effects on blood sugar control and quality of life in diabetes. *Journal of General Internal Medicine*. 1988;3(5):448-457.
87. Breitenbecher KH. Sexual revictimization among women. A review of the literature focusing on empirical investigations. *Aggression & Violent Behavior*. Jul-Aug 2001;6(4):415-432.
88. Messman TL, Long PJ. Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical Psychology Review*. 1996;16(5):397-420.
89. Polusny MA, Follette VM. Long term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied and Preventive Psychology*. 1995;4:143-166.
90. Merrill LL, Newell CE, Thomsen CJ, et al. Childhood abuse and sexual revictimization in a female Navy recruit sample. *J Trauma Stress*. 1999;12(2):211-225.
91. Martin L, Rosen LN, Durand DB, Stretch RH, Knudson KH. Prevalence and timing of sexual assaults in a sample of male and female U.S. Army soldiers. *Mil Med*. Apr 1998;163(4):213-216.
92. Messman-Moore T, Long P. The role of childhood sexual abuse sequelae in the sexual revictimization of women. An empirical review and theoretical reformulation. *Clin Psychol Rev*. Jul 2003;23(4):537-571.
93. Langhinrichsen-Rohling J, Neidig P, Thorn G. Violent marriages: gender differences in levels of current violence and past abuse. *Journal of Family Violence*. 1995;10(2):159-176.

94. Caralis PV, Musialowski R. Women's experiences with domestic violence and their attitudes and expectations regarding medical care of abuse victims. *Southern Medical Journal*. Nov 1997;90(11):1075.
95. Murdoch M, Nichol K. Women veterans' experiences with domestic violence and with sexual harassment while in the military. *Arch Fam Med*. May 1995;4(5):411-418.
96. Grauerholz L. An ecological approach to understanding sexual revictimization: linking personal, interpersonal, and sociocultural factors and processes. *Child Maltreat*. 2000;5(1):5-17.
97. Leonard KE, Senchak M. Prospective prediction of husband marital aggression within newlywed couples. *J Abnorm Psychol*. 1996;105(3):369-380.
98. Riggs DS, Caulfield MB, Street AE. Risk for domestic violence: Factors associated with perpetration and victimization. *Journal of Clinical Psychology*. Oct 2000;56(10):1289-1316.
99. Chu J. The revictimization of adult women with histories of childhood abuse. *Journal of Psychotherapy Practice and Research*. 1992;1:259-269.
100. Ruzek JI, Polusny MA, Abueg FRAVAPAHCSNCfPPACAUS. Assessment and treatment of concurrent posttraumatic stress disorder and substance abuse. In: *Follette, Victoria M.; Ed; Ruzek, Josef I.; et al., Ed; Cognitive-behavioral therapies for trauma; p. 226-255; New York, NY, U.S.: Guilford Press, 1998 xii, 431; 1998.*
101. Wyatt GE, Notgrass CM, Gordon G. The Effects of African American Women's Sexual Revictimization: Strategies for *Prevention*. *Prevention in human services*. 1995;12(2):111.
102. West CM, Williams LM, Siegel JA. Adult sexual revictimization among black women sexually abused in childhood: a prospective examination of serious consequences of abuse. *Child Maltreat*. 2000;5(1):49-57.
103. Naugle AE, Bell KM, Polusny MA. Clinical considerations for treating sexually revictimized women. *National Center for PTSD Clinical Quarterly*; In press.
104. Bell KM, Naugle AE. Understanding intimate partner violence: A behavior analytic approach: an unpublished manuscript. 2003.
105. Stout K. Intimate femicide: A study of men who have killed their mates. *Journal of Offender Rehabilitation*. 1993;19:81-94.
106. McFarlane J, Campbell J, Wilt S, Sachs C, Ulrich Y, Xu X. Stalking and intimate partner femicide. *Homicide Studies: An Interdisciplinary & International Journal*. 1999;3:300-316.
107. Schutte NS, Malouff JM, Doyle JS. The relationship between characteristics of the victim, persuasive techniques of the batterer, and returning to a battering relationship. *J Soc Psychol*. 1988;128(5):605-610.

108. Alpert EJ. Violence in intimate relationships and the practicing internist: new "disease" or new agenda? *Ann Intern Med.* 1995;123(10):774-781.
109. Brown R. *Roadmaps for clinical practice: case studies in disease prevention and health promotion-intimate partner violence.* Chicago, IL: American Medical Association; 2002.
110. Family-Violence-Prevention-Fund. *Preventing domestic violence. Clinical guidelines on routine screening.* Retrieved March 15, 2003 from [http://www.endabuse.org/programs/health\\_care/files/screpol.pdf](http://www.endabuse.org/programs/health_care/files/screpol.pdf). San Francisco, CA: The Family Violence Prevention Fund; 1999.
111. McCauley J, Kern D, Kolodner K, et al. The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Ann Intern Med.* Nov 1995;123(10):737-746.
112. Dearwater SR, Coben JH, Campbell JC, et al. Prevalence of intimate partner abuse in women treated at community hospital emergency departments. *JAMA.* 1998;280(5):433-438.
113. Rennison C. *Intimate partner violence.* Washington, DC: U.S. Dept. of Justice Office of Justice Programs Bureau of Justice Statistics; 2000.
114. National Institute of Justice and Centers for Disease Control and Prevention. *Prevalence, incidence, and consequences of violence against women. Findings from the national violence against women survey.* Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention; 1998.
115. U.S. Department of Justice. *Violence by intimates: analysis of data on crimes by current or former spouses, boyfriends, and girlfriends.* Washington, DC: U.S. Department of Justice; 1998.
116. Glass N, Dearwater S, Campbell J. Intimate partner violence screening and intervention: data from eleven Pennsylvania and California community hospital emergency departments. *J Emerg Nurs.* 2001;27(2):141-149.
117. Gielen AC, O'Campo PJ, Campbell JC, et al. Women's opinions about domestic violence screening and mandatory reporting. *Am J Prev Med.* 2000;19(4):279-285.
118. Runyan D. Universal precautions for domestic violence. *BMJ.* 2002.
119. Cole TB. Is domestic violence screening helpful? *JAMA.* 2000;284(5):551-553.
120. Waalen J, Goodwin MM, Spitz AM, Petersen R, Saltzman LE. Screening for intimate partner violence by health care providers. Barriers and interventions. *Am J Prev Med.* 2000;19(4):230-237.

121. Medical Board of California. Practitioner reference card. *Medical Board of California Action Report*; 1999:5.
122. Paranjape A, Liebschutz J. STaT: A Three-Question Screen for Intimate Partner Violence. *J Womens Health (Larchmt)*. Apr 2003;12(3):233-239.
123. Campbell JC. Health consequences of intimate partner violence. *Lancet*. Apr 2002;359(9314):1331-1336.
124. Abbott J, Johnson R, Koziol-McLain J, Lowenstein SR. Domestic violence against women. Incidence and prevalence in an emergency department population. *JAMA*. Jun 14 1995;273(22):1763-1767.
125. Freund KM, Bak SM, Blackhall L. Identifying domestic violence in primary care practice. *J Gen Intern Med*. Jan 1996;11(1):44-46.
126. Samson AY, Bensen S, Beck A, Price D, Nimmer C. Posttraumatic stress disorder in primary care. *J Fam Pract*. Mar 1999;48(3):222-227.
127. American Medical Association. *Featured CSA Report. AMA data on violence between intimates (I-00). Policy H-515.965 Family and intimate partner violence. Adopted December 2000*. Retrieved 4/14/03 from <http://www.ama-assn.org/ama/pub/print/article/2036-5298.html>.
128. Proctor J. Treating physicians' woes. *AAMC News Room Reporter*. Available at: <http://www.aamc.org/newsroom/reporter/july2000/woes.htm>.
129. Ramirez AJ, Graham J, Richards MA, Cull A, Gregory WM. Mental health of hospital consultants: the effects of stress and satisfaction at work. *Lancet*. 1996;347(9003):724-728.
130. Figley CR. *Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel; 1995.
131. deLahunta EA, Tulsy AA. Personal exposure of faculty and medical students to family violence. *JAMA*. Jun 26 1996;275(24):1903-1906.
132. Zerbe KJ. *Women's Mental Health in Primary Care*. Philadelphia; 1999.





# Veterans Health Initiative “Military Sexual Trauma” Case Studies

## **Case Study Disclaimer**

The case studies contained in this Veterans Health Initiative are fictitious. They were developed by the contributing authors of this Independent Study Guide, and are for educational purposes only. Any similarity to actual persons, places, or events is purely coincidental. Questions or concerns related to the case studies can be addressed to:

Bob Smith; EdD, MCP  
Employee Education System  
Medical Forum Building  
950 22nd Street North  
Birmingham, AL 35204

(205) 731-1812 Ext. 317 or  
e-mail [bob.smith@lrn.va.gov](mailto:bob.smith@lrn.va.gov)



# Case Studies: Case 1

## Grace

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The case studies contained in this Veterans Health Initiative are fictitious. They were developed by the contributing authors of this Independent Study Guide, and are for educational purposes only. Any similarity to actual persons, places, or events is purely coincidental.

### Grace 1: Screening

#### Background:

Grace is a 33 y/o married mother of two and a Gulf war veteran, in for her annual check-up. She has no complaints.

With the door closed, the nurse reviews the clinical reminders and Grace's self administered questionnaire. The nurse, making eye contact, slowly and calmly continues:

**Nurse:** "One of the questions we now ask all veterans pertains to their military experiences, primarily negative experiences like unwanted sexual attention or forced sexual experiences. During your military experience, did anyone ever force you to have unwanted sexual contact OR did anyone ever repeatedly do any of the following: ask for sexual favors, pressure you for sex, corner you, make sexist jokes or demean you because you were female?"

**Grace:** "Why are you asking about things like that?"

**Nurse:** "The VA is very concerned about those types of experiences and the effect they can have on people's health. We also have specialized services to help those veterans who want help addressing any health issues related to such experiences".

Grace stares at the wall and informs the nurse about an episode of date rape during her military experience, which she did not report and for which she did not seek medical attention. However, she did discuss the situation with her close friend. She reports having difficulty sleeping for a month after the date rape.

**Grace:** "I was assaulted once but I was in the wrong place at the wrong time with the wrong guy. I was drunk, off-base at the time, and on a date with this guy who ended up being a jerk."

Making eye contact the nurse empathically states, "I'm sorry that happened. Unfortunately, experiences like that happen too frequently, and what you experienced would be called, 'military sexual trauma'. We have special services available for those who want them."

### Grace 2: Screening, offering referral

The **nurse** tells Grace about the type of services provided: "Oh, things like counseling, talk therapy, psychiatry, medical care for related medical issues."

**Grace:** "Hmmm, interesting. Well, I had problems right after it happened, but after about 6 months and talking my best friend's ear off, (smiles), I'm certainly OK now. I'm happy, have a great family, love my job, and don't have any real health issues."

**Nurse:** "That's great", the nurse smiles back. "I will document that you have experienced what we call, Military Sexual Trauma, but the information will be kept confidential. You shouldn't be asked again about such experiences. If, at any time in the future, you wish to talk about your experience, please let us know so we can get the right staff involved."

The **nurse** continues on, "Let's complete the rest of these questions, OK?" After completing the questions, the nurse enters all the information into CPRS and gives Grace a locally developed brochure about MST.

During the physical exam with her usual primary care provider, Grace spontaneously relays the MST experience to her female, primary care provider.

### Grace 3: Offering referral

**Grace:** "You know, it's so nice that VA has special services for women who've been raped in the military."

The **provider** concurs: "Yes, we've developed some unique services that any veteran can access."

The **provider** pauses, makes direct eye contact with Grace, and asks, "If you want to talk with anyone about your experience, just let me know, ok?"

Grace nods.

**Provider:** "You know it's common that women have more than one such experience; or end up in unhappy relationships. Has that happened with you?"

### Grace 4: Screening for domestic violence

**Grace:** "No, I just had the one experience. And my husband is a dear."

**Provider:** "So, you feel happy and safe with your husband?"

**Grace:** "Yes."

### **Grace 5: Compensation and Pension**

One week later, Grace calls the clinic and talks with the nurse.

**Grace:** “You know, I went home and read that brochure you gave me. It mentions something about benefits. Can you tell me more about that?”

The nurse briefly relays the VBA claims process and suggests contacting the Veterans Service Officer at the local VA Regional Office or facility MST Coordinator for more information. She sends additional information to Grace. Grace never files a claim, but she shares this “new” information with some women she knows who served in the military.



# Case Studies: Case 2

## Kevin

### Case Study Disclaimer

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### Kevin 1: Screening in setting possible markers of MST

#### Background:

Kevin is a 53-year-old, unemployed, divorced, Vietnam era veteran who uses tobacco and drinks alcohol excessively. He has been medically hospitalized at least once for severe alcohol-related withdrawal symptoms. His medical problems include hypertension, chronic obstructive pulmonary disease, and chronic hepatitis C. Some progress notes describe Kevin as “having difficulty with interpersonal relationships.” Kevin’s VA medical record documents his medical problems and the general overview of his childhood and military services. No mention of violence or abuse exists in his medical record.

#### Presenting Problem:

Kevin presents with abdominal pain. His provider is out sick. In the past, he has refused to be seen by a medical resident in training. He doesn’t want to wait to be evaluated and reluctantly agrees to be seen by a female resident.

The nurse ushers Kevin into an exam room and quickly takes his vitals, asks him the reason for his visit (“I need to talk with someone about this pain”).

The nurse meets the covering resident in the hallway and mentions that Kevin is ready to be seen, that his vitals are ‘OK’, and that he wants to talk about abdominal pain.

The resident enters the room shortly thereafter, introduces herself politely and shakes his hand, and then sits down near Kevin.

**Resident:** “Give me a minute here, while I bring up your record. Then we can get down to business.”

She signs onto CPRS, bringing up Kevin’s record. Quickly noting Kevin’s problem list, she scans the last progress note from the attending and the clinical reminders that are due. Colorectal cancer screening and MST are

the only visible clinical reminders. She calmly turns to Kevin and begins asking about his abdominal pain, which has been occurring intermittently since he was discharged from the military, but is progressing in severity. She completes a review of systems targeting abdominal pain, with negative results, but also has Kevin agree to complete the colorectal cancer screening. She then asks about his use of alcohol.

**Kevin:** "Nah, I've been trying to avoid that stuff. It's caused too many problems in my life. You know, it's really hard to quit drinking. I keep relapsing, but this time, I think I've got it. I've finally started attending AA about a month ago and haven't had a drink since."

**Resident:** "That's great, when did you start drinking?"

**Kevin** (guardedly states): "When I was stationed in Vietnam."

**Resident:** "May I ask why you started using alcohol?"

**Kevin gruffly states,** "Aren't you getting a little personal here?"

The resident meets Kevin's agitated eyes calmly and warmly.

**Resident:** "I'm here to help figure out what your pain is from so we can try to make it better. Alcohol may be a factor so I'm asking."

Kevin nods, his face relaxing somewhat.

**The resident pauses and continues:** "People start using alcohol for many reasons, including peer pressure and to deal with stressful situations. Might that be true for you?"

**Kevin sighs,** staring at the ceiling: "Maybe."

The **resident** recognizes the opportunity and goes on, "Some people have had stressful, negative experiences in the military, including unwanted sexual experiences and unwanted sexual attention. Did anything like that happen to you?"

Kevin closes his eyes tightly, but it doesn't stop the tears that slowly trickle down his face.

**Resident:** "Do you want to talk about it?" The resident quietly asks, avoiding the temptation to reach out and touch Kevin's hand lying on the desk.

A prolonged silence commences.

**Kevin:** "No, I don't think I want to talk."

**Resident:** "Well, if you do, you don't have to go into detail. That might be too hard."

**Kevin then slowly says,** his voice breaking, "You know, I've never had anyone ask me about that, not even my usual doc. And, I've never told anyone about what happened."

**Resident:** "Are you telling me that you had such an experience?"

Kevin nods purposefully, tears still flowing, but looking directly at the resident.



## Kevin 2: Responding

She continues in an empathic tone, "I'm sorry that happened. You know those kind of experiences happened to a lot of men and women in the military. And we have special

services for those people who want them."

Another pause follows.

**Kevin:** "I always thought that I could use the alcohol to chase away the nightmares, the anxiety, the feeling that it would happen again...."

**Resident:** "Have you been having those reactions recently?"

**Kevin:** "Yes," wiping away the tears, "and I'm scared that I'll start drinking again, but I don't know how to get rid of the nightmares, and the pain in my gut. Every time I begin thinking about it, the pain comes and I can barely stand it. I mean the pain is starting now."

**Resident:** "I think we can help you."

The resident briefly mentions that physical pain is sometimes related to other kinds of pain. She tells him that treatment is available; that medications might also help reduce his anxiety and nightmares. She reassures him that confidentiality will be maintained as much as possible.

## Kevin 3: Offering medications and referral

Kevin relaxes some more, but appears skeptical.

**Resident:** "If you want, we can use some initial medicine to control the anxiety and

hopefully the nightmares. That might also help with the abdominal pain; if not, we can try something else. It might be very helpful if you talked with a specialist about what happened. I've seen many veterans benefit from seeing a specialist. If you want, I can get a specialist involved."

**Kevin:** "Let me think about it."

**Resident:** "No problem. Here's a brochure that explains more about what we call Military Sexual Trauma and the services we offer."

**Kevin:** "I know, I've read the brochures out in the waiting room about a dozen times and was wondering if anyone would ever ask me, and how I'd react. Now, I know. You think it'll help?"

Resident {nods}:

**Kevin:** "Well, let's give that medicine you mentioned a try." He pauses, and then continues, "Yeah, let's get that specialist involved. Is it going to be a guy? Cause if it's a guy, I'm not interested!"

The resident reassures him that a female counselor can be requested. The referral is made. The veteran is given some trazodone to try at bedtime. An appointment is made for follow-up in one month, with the resident, at Kevin's request.

Kevin keeps the appointment with the MST Counselor, a female. He also returns for his follow-up with the resident. After 6 months, Kevin quietly transfers his medical care totally to the resident. Kevin continues to abstain from alcohol, but does agree to have psychiatry involved in his care, also, where an SSRI is added to his trazodone. He is diagnosed with chronic, complex PTSD. His abdominal pain lessens, and then disappears in about 6 months. The nightmares and anxiety also lessen.

Eighteen months later, Kevin's abdominal pain returns and worsens. The resident, now an attending, sees him in her Continuing Care Clinic. She completes a Review of Systems with negative results. He remains abstinent from alcohol and hasn't used illicit drugs.

#### **Kevin 4: Stress related to C & P application**

**Provider:** "What else has been going on in your life?"

**Kevin:** "Well, nothing's changed, if that's what you're asking. I still see the counselor, the psychiatrist, and attend AA. My kids and grandchildren see me more often," he pauses, and then states, "Now that I think of it, I have filed a VA disability claim. But that shouldn't make a difference."

**Provider:** "Have you told your counselor or your psychiatrist that you've filed a VA claim?"

**Kevin:** "No, it's none of their business. They might think that I'm just trying to get money."

The provider then explains that physical symptoms can worsen when a disability claim is filed, but that improvement is usually seen when the claim is completed. She stresses the importance of involving his other health care providers in his care during this time. Kevin agrees to talk with his other providers about filing a disability claim.

# Case Studies: Case 3

## Carlotta

### Case Study Disclaimer

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### Carlotta 1: Screening for Intimate Partner Violence

#### Background:

Carlotta is a 72 year old, single, Vietnam veteran, who in the mid-late 1960's as a nurse cared for injured troops. She smokes tobacco, but doesn't use alcohol or illicit drugs. Her medical problems include hypertension, diabetes mellitus type II, obesity, gastro-esophageal reflux disease, fibromyalgia, chronic pelvic pain resulting in total hysterectomy, and depression. She accesses VA care for her depression and chronic medical issues because she is pleased with the quality of care she receives. Her medical record clearly outlines her medical problems and preventive health care. Mention is made that she was never involved directly with combat. No mention of intimate partner violence, childhood abuse, or MST exists in Carlotta's medical record.

#### Presentation:

Carlotta comes in for a routine medical visit to follow-up on whether Aquatic Therapy is helping her fibromyalgia. Her usual provider is Dr. W. Military Sexual Trauma screening has just been implemented so clinic staff are still somewhat unsure about the process. The nurses who usually complete all the Clinical Reminders that are due have told providers that asking about MST is a "provider function." Dr. W just completed an in-depth training on asking about violence in people's lives and has been routinely asking all her patients about such experiences for the last 6 weeks.

Dr. W and Carlotta begin their discussion in an exam room, with the door closed. Dr. W has noticed that the Hepatitis C clinical reminder and the MST Clinical Reminder are due. Dr. W starts by asking about the Aquatic Therapy.

**Carlotta** (beaming): "It's been great, doc! I haven't felt this great in years."

**Dr. W:** "That's wonderful, Carlotta,"

**Carlotta** (proudly): "Yeah, I even kicked out my boyfriend!"

**Dr. W,** not knowing the nature of that relationship, asks: "Really? May I ask why?"

**Carlotta:** "Yeah, I had enough of his 'stuff' and told him to get lost."

**Dr. W:** "Was some of his 'stuff' hurting you?"

**Carlotta** (softly): "Yeah," maintaining her gaze at the opposite wall.

**Dr. W:** "Sometimes people in relationships hurt each other. Sometimes with words, sometimes with physical actions like pushing, shoving, hitting, kicking, slapping. Sometimes with forced, unwanted sexual activities. Has any of that been happening to you?"

**Carlotta** looked at Dr. W with a slightly quizzical look, judging. "Yes," she said purposefully. "He got to hitting me one time too many, and making me 'do him' one time too many. I kicked him out."

**Dr. W empathically replied:** "I'm sorry that happened. Many people end up in abusive relationships, both males and females. You're not alone. I'm glad you ended the relationship. Sometimes, however, the ending of a relationship can be a dangerous time. Are you feeling frightened or threatened right now?"

**Carlotta 2: Responding,  
Safety assessment**

**Carlotta:** "No, he went back to New Jersey. I feel safer than I have for a while."

**Dr. W then went on:** "I'm really glad you are feeling safe now. You know, we are now asking all veterans about experiences of violence during their military service. I also ask about other types of violence, like the violence you just told me about or violence experienced when a child. During your military career, did you ever experience any unwanted sexual contact or any unwanted sexual attention? Examples might include forced intercourse, pressure for sex, sexual jokes, cornering, fondling. Has anything like that ever happened to you?" Dr. W quietly asks.

**Carlotta 3: Screening for MST**

**Carlotta:** "Maybe."

**Dr. W** responds with an empathic, normalizing, validating statement. She also briefly describes available specialized services. Dr. W also includes questioning about childhood abuse, which Carlotta denies. Carlotta then agrees to talk with a mental health counselor.

#### **Carlotta 4: Compensation & Pension**

dramatically after the repeated sexual harassment started. The counselor also knows that Carlotta was formally enrolled in an Anger Management course because she had become more irritable with her peers, and several times, pushed and shoved staff that infuriated her. The counselor does not

know if these activities are documented in Carlotta's Service Medical Records. The counselor also knows that Carlotta's health prior to enlistment in the military and during her first 10 years of service was "excellent." Carlotta and the counselor discuss filing a VBA claim. Carlotta never files a claim.

*To see the entire Case Study related to Carlotta and Intimate Partner Violence you may also view the short video related to Intimate Partner Violence at:*

<https://www.ees-learning.net>.

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# Case Studies: Case 4

## Norman

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### Norman 1: Screening in setting of possible markers of MST

#### Background:

Norman is a 45 year old, employed, married, African-American male veteran. Norman retired from the military after 20 years. He has no history of childhood victimization and no history of MST. His only medical

problems are peptic ulcer disease (PUD) and smoking. He's had one episode of clinical depression, which was effectively treated.

#### Presentation:

Norman comes in for a routine clinic visit. The male nurse ushers him into an exam room and asks about all the clinical reminders that are due, except the MST clinical reminder. The male nurse, a fellow retired military man, feels uncomfortable asking this particular gentleman about MST. The male nurse does mention to the provider that asking about MST was not completed. The provider sighs, "OK" and enters the exam room, closing the door behind him. He politely greets Norman and shakes his hand, then sits down. They discuss Norman's use of tobacco; he is not interested in stopping.

**Norman:** "I'm never going to stop smoking. It's my only vice and I enjoy it, and you know that. Thank you very much"

**Provider:** "Yes, I know, but I ask about it anyway, because sometimes after awhile people DO consider stopping."

Norman's symptoms related to his PUD remain quiescent.

**Provider:** "You know the VA is very interested in providing preventive care and high quality of care for a variety of health conditions. That's why we talk about your smoking; that's why we talk about screening for certain types of cancer. We are also asking about other conditions or experiences

that might affect health. For example, some veterans have had unwanted experiences of sexual attention or forced sexual contact during their military service. Has that ever happened to you?"

Norman pauses, then leans forward and winking, quickly taps the provider's hand.

**Norman:** "Nope, nothing like that ever happened to me. I never got enough sex during that time! (winks) You know what I mean."

**Provider:** "I'm not sure I do know what you mean, but what I do know is that sexual harassment and sexual assault can happen to anyone, including you, and it can affect one's health. We also have specialized services available to help. That's why we ask." After a slight pause, the provider asked again, "Have you ever had any unwanted sexual attention or sexual contact during your military service? That might include sexual favors, pressure for sex, fondling, repeated sexual jokes demeaning you, unwanted oral sex, or unwanted penetration."

**Norman** stopped laughing, recognizing the provider's seriousness. "OK, since you asked, No, I didn't have any such experience! Now, can we go on to something else?"

**Provider:** "Thank you for taking this issue seriously. Yes, let's move on."



# A

## Appendix A: Military Sexual Trauma Program in the Department of Veterans Affairs

The Military Sexual Trauma Program in VA is established under law. In the early 1990's, the increased awareness of the magnitude and consequences of sexual trauma in the military led to programs aimed at providing diagnosis and treatment for sexual trauma. This increased awareness has also increased research into the long-term consequences of sexual trauma on veterans' health.

While rape and sexual trauma occur in both males and females, attention in VA was first directed to the problem among women. Following the June 1992 Congressional hearings, Public Law 102-585 was signed into law by the President in November 1992. This legislation authorized health care services including outreach and counseling for women veterans who experienced sexual trauma while serving on active military duty. It authorized counseling for psychological trauma, "which in the judgment of mental health professionals employed in the Department of Veterans Affairs, resulted from physical assault or sexual harassment that occurred while the veteran was serving on active duty." Sexual trauma counseling and treatment is defined as the provision of mental health services for the diagnosis, treatment, and prevention of mental and emotional residuals of sexual trauma experienced while on active duty. Counseling interventions include, but are not limited to, individual, and group psychotherapeutic techniques. These services are provided by qualified (advance-degree) mental health practitioners with expertise and experience working with victims of trauma, (i.e., psychiatrists, psychologists, social workers, clinical nurse specialists, and trained chaplains). The law also defined sexual harassment as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."

In addition, the law required that referral services be made available to those who were not eligible for care in VA as well as an information program on sexual trauma. Although the law only specified counseling, the VA program was established so that the provision of counseling could be coordinated with other care or services needed for trauma (including a full spectrum, from social services to specialized medical care and hospitalization). That same year the VA's Appropriations Committees earmarked \$7.5 million dollars for women veterans' health services. With this money, VA established four comprehensive women veterans' health centers (expanded to eight the following year), four stress disorder treatment teams, sexual trauma counselors at 64 Vet Centers, and fulltime

Women Veterans Coordinators at selected VA medical centers. These interlinked actions established a key concept: the diagnosis and treatment of military sexual trauma is a legitimate part of mainstream health care in VA. An extensive education and training program was launched that continued through most of the 1990's.

In 1994, Public Law 103-452, also known as the Veterans Health Programs Extension Act of 1994, amended the law to authorize treatment to men in addition to women so that ALL eligible veterans can now receive services. It also repealed the limitations on time the veteran had to seek services, as well as the limitation on the duration of the time those services could be provided. It also expanded the coordination of care to recognize physical conditions resulting from sexual trauma. VA clinicians were already seeing that sexual trauma victims often did not seek care from mental health, but presented to their primary care providers with what might have appeared to the uninformed to be unrelated physical and behavioral symptoms.

In November 1996, when a popular national TV news magazine focused on a sexual abuse scandal involving recruits at an Army Ordnance Center, VA was able to have the VA Help Line number broadcast during the program. Over 2,300 calls seeking assistance were received in the two weeks following the broadcast. In January 1997, the then Secretary of Veterans Affairs, Jesse Brown sent all women veterans a "Dear Fellow Veteran:" letter. In it, he stated VA's commitment to meeting the needs of women veterans and told them about the counseling and other services available to survivors of sexual trauma. In one paragraph, he said, "If you were a victim of sexual assault or harassment while you were in the military, I want to tell you how much I regret that such an incident could have occurred. It is wrong for it to happen to any woman while she is in-service to her country. It is wrong for any woman to undergo such a devastating experience." Response to the letter was overwhelmingly positive and while it was not possible to track those who came to VA as a result of it, clinicians in the field reported that the numbers of women seeking care for sexual trauma rose dramatically at many facilities.

In 1999, Public Law 106-117, the Veterans Millennium Health Care and Benefits Act, extended the Department's authority to provide counseling and treatment for sexual trauma through December 31, 2004, and mandated that the existing program providing sexual trauma care and services continue.

# B

## Appendix B: Advantages of Screening for MST

Health care providers in primary care clinics are busy people, with increasingly broadened roles and responsibilities. Asking about MST may seem like just another mandate being added to the already heavy burden of required chronic and preventive health screening. On the other hand, asking about MST may be pivotal in understanding a patient's health status and ongoing health issues. Asking may help a patient end the cycle of violence that he/she may be enmeshed in.

Asking may foster a healthier patient-provider relationship with a patient being more invested in his/her own health care. Most importantly, providers have skills available to help improve a patient's health status that are easily incorporated into the process of health care. Furthermore, asking about MST can, ultimately, allow an over-worked primary care provider achieve a more valuable role for him/herself. This, in turn, may help alleviate some of the burnout that providers experience. Over time, the benefits of screening accumulate, resulting in increased professional satisfaction. Table 1 summarizes some clinical benefits of asking about MST.

<b>Clinical Benefits of Asking about MST &amp; Other Experiences of Violence</b>
<b>Your worst fears will NOT be realized!</b>
Most people who have experienced MST cope well and have no adverse health effects.
<b>You can see the effect that MST may have upon a patient's health status and current health issues!</b>
Allows practitioner to directly appreciate the effect violence may have on patients' lives and health status.
Helps provider understand a patient's health more fully & more effectively address issues such as: <ul style="list-style-type: none"> <li>• Adherence to medication regimens</li> <li>• Adherence to clinic appointment attendance</li> <li>• Chronic pain</li> <li>• Somatization</li> </ul>
<b>You can help the patient who has experienced violence, if needed!</b>
"If you don't ask, they won't tell".

Table 1

Table 1 (cont.)

<b>Clinical Benefits of Asking about MST &amp; Other Experiences of Violence</b>
Fosters trust in the patient-provider relationship.
Gives the provider opportunity to develop a “therapeutic relationship” with patient by: <ul style="list-style-type: none"> <li>• Promoting empathic listening</li> <li>• Building trust and support</li> <li>• Promoting safety</li> <li>• Empowering patient by involving him/her in the process of health care</li> <li>• Applauding small successes</li> <li>• Educating the patient</li> </ul>
Validates the patient’s experience(s) and the violence as a legitimate health issue.
Normalizes the patient’s experience, lessening his/her potential sense of isolation.
Provides opportunity to give options and resources to the patient.
Allows the provider to label the violence for the patient to recognize and, possibly address on his/her own.
Provides the opportunity to help patients gain more control over their lives, thereby offering: <ul style="list-style-type: none"> <li>• Hope (both directly and indirectly) that abuse is not a necessary part of life</li> <li>• Hope that a patient possesses the skills to survive and, even, thrive</li> </ul>
Allows opportunity to offer effective therapeutic options, which may improve health status.
Opens the door for future disclosure and discussion.
<b>You can potentially benefit in other ways! Connecting to goals that are more global.</b>
Implies to patient and surrounding community that violence is a legitimate health issue and that violence is not an acceptable response to conflict.
Enhances interactions between health care disciplines and, possibly, community resources.
Gives the provider an opportunity to review his/her own behavior and stereotypes about victims.
Offers the provider the chance to model appropriate, non-violent behavior.

Table 1

# C

## Appendix C: Resources and Information about Sexual Trauma and Abuse

Resources and Information about Sexual Trauma and Abuse		
Resource	Description	Web Site 800 - Number
<b>GENERAL</b>		
An Abuse, Rape & Domestic Violence Aid & Resource Collection. (AARDVARC)	AARDVARC was started by a group of volunteers to provide resources to those who have experienced violence.	<a href="http://www.aardvarc.org">http://www.aardvarc.org</a>
Office for Victims of Crime Resource Center	Federally funded program that provides information & resources for victims of wide variety of crimes such as victim's rights & services.	<a href="http://www.ncjrs.org">http://www.ncjrs.org</a>
Office for Victims of Crime	Office of Justice Program to provide information about diverse programs that benefit victims of crime.	<a href="http://www.ojp.usdoj.gov/ovc">http://www.ojp.usdoj.gov/ovc</a>
<b>MST</b>		
MST Web Site	MST-related information and resources for VA staff.	N/A
<b>SEXUAL ASSULT</b>		
Rape, Abuse and Incest National Network (RAINN)	Focuses on preventing sexual assault, helps victims and ensures, that rapists are brought to justice. Operates a hotline that provides free, confidential services.	<a href="http://www.rainn.org">http://www.rainn.org</a> 1-800-656-HOPE (4673)

Table 1

Table 1 (cont.)

<b>Resources and Information about Sexual Trauma and Abuse</b>		
<b>Resource</b>	<b>Description</b>	<b>Web Site 800 - Number</b>
<b>PTSD</b>		
National Center for PTSD	Web site created by the Department of Veterans Affairs. Educational resources about military-related PTSD & sexual trauma. Information about VA services & links to other Web sites.	<a href="http://www.ncptsd.org">http://www.ncptsd.org</a>
Sidran	Nonprofit organization that provides education and advocacy to those who have experienced trauma.	<a href="http://www.sidran.org">http://www.sidran.org</a>
<b>DOMESTIC VIOLENCE</b>		
National Domestic Violence Hotline	24 hours a day, 365 days a year hotline that provides crisis intervention & info about local shelters and domestic violence programs. Non-English translators & TTY line for deaf are available. Web site also provides education & advocacy.	<a href="http://www.ndvh.org">http://www.ndvh.org</a> 1-800-799-SAFE (7233)
Family Violence Prevention Fund	Provides education & promotes policies to end violence in the family & community. Provides information about interpersonal violence.	<a href="http://www.fvpf.org">http://www.fvpf.org</a> or <a href="http://www.endabuse.org">http://www.endabuse.org</a>

Table 1

Table 1 (cont.)

<b>Resources and Information about Sexual Trauma and Abuse</b>		
<b>Resource</b>	<b>Description</b>	<b>Web Site 800 - Number</b>
<b>SAME SEX ISSUES</b>		
Community United Against Violence (CUAV)	Gay Men's Domestic Violence Project. Provides support groups, peer counseling, and help in getting restraining orders.	<a href="http://www.cuav.org">http://www.cuav.org</a> 1-415-333-4357 Note: Crisis hotline but not an 800 number
LAMBDA Services Anti-Violence Project	Provides a 24-hour hotline for gays & lesbian who have experienced anti-gay violence.	<a href="http://www.lambda.org">http://www.lambda.org</a> 1-800-259-1536
<b>CHILD ABUSE</b>		
Child Help USA	Provides multilingual crisis intervention and professional counseling on child abuse. Gives referrals to local social service groups offering counseling on child abuse.	<a href="http://www.childhelpusa.org">http://www.childhelpusa.org</a> 1-800-4-A-CHILD (422-4453)
Child Abuse Hotline		1-800-792-5200
Resource Center On Child Protection & Custody		1-800-527-3223
<b>VA BENEFITS</b>		
Veterans Benefits Administration	Provides information on VA benefits-related questions. Staff at the 800 number can help caller locate local VBA women veterans' coordinator who is trained to assist both women and men in the claims process for military sexual trauma.	<a href="http://www.vba.va.gov">http://www.vba.va.gov</a> 1-800-827-1000

Table 1





# D Appendix D: Information about Sexual Trauma & VA Services

**In this appendix, the following fact sheets are provided:**

1. VA Counseling and Disability Compensation for Sexual Trauma - (Department of Veterans Affairs fact sheet)
2. Effects of Traumatic Experiences - (VA National Center for PTSD fact sheet)
3. Men and Sexual Trauma - (VA National Center for PTSD fact sheet)
4. Sexual Assault against Females - (VA National Center for PTSD fact sheet)

**Appendix D-1**



**Department of  
Veterans Affairs**

Office of Public Affairs  
Media Relations

Washington, DC 20420  
(202) 273-6000  
[www.va.gov](http://www.va.gov)

# Fact Sheet

May 2003

## Counseling and Disability Compensation for Sexual Trauma

Some veterans — both women and men—suffered personal assault or sexual trauma while serving on active military duty, including service at one of the military academies. Continuing feelings of fear, anxiety, embarrassment, or profound anger resulting from these experiences can plague veterans for years afterwards. Veterans suffering from the effects of sexual trauma in the service can get help from VA.

### How Do We Define Sexual Trauma?

Personal or sexual assault are events of human design that threaten or inflict harm. Sexual trauma is defined as any lingering physical, emotional, or psychological symptoms resulting from a physical assault of a sexual nature, or battery of a sexual nature. Examples of this are:

- Rape;
- Physical assault;
- Domestic battering; and
- Stalking.

### Compensation for Disabilities

Disability compensation is a monthly payment to a veteran disabled by an injury or a disease incurred or aggravated during active service. Veterans who have been discharged **under other than dishonorable** conditions and currently are suffering from disabling symptoms may be eligible to receive compensation.

### Post-Traumatic Stress Disorder (PTSD) Secondary to Sexual Trauma

PTSD is a recurrent emotional reaction to a terrifying, uncontrollable, or life-threatening event. The symptoms may develop immediately after the event or may be delayed for years. They include:

- Sleep disturbances and nightmares;
- Emotional instability;
- Feelings of fear and anxiety;
- Impaired concentration;
- Flash-backs; and
- Problems in intimate and other interpersonal relations.

### **How the Application Process Works**

Veterans can apply for service-related disability compensation by filling out VA Form 21-526, Veterans Application for Compensation or Pension. A counselor or Women Veterans Coordinator can assist. The Women Veterans Coordinator at a local VA Regional Office can be reached by calling 1-800-827-1000.

### **Veterans Sexual Trauma Counseling**

VA's specially trained Women Veteran Coordinators and Sexual Trauma Coordinators or counselors are available at VA Regional Offices, medical centers, or Vet Centers to assist veterans with military sexual trauma benefits and services.

Vet Centers are located in many communities throughout the United States. These centers offer sexual trauma counseling to all veterans who experienced sexual assault or sexual harassment while on active duty in the military. There is no requirement that the sexual trauma had to be reported when it occurred or at any time during active military service to be eligible to receive help. Sexual trauma services often include related health care from a VA medical center. The location of the nearest Vet Center can be obtained by calling VA at 1-800-827-1000.

## Appendix D-2

# Effects of Traumatic Experiences A National Center for PTSD Fact Sheet

by Eve B. Carlson, Ph.D. and Josef Ruzek, Ph.D.

Sometimes, when they find themselves suddenly in danger, people are overcome with feelings of fear, helplessness, or horror. These events are called traumatic experiences. Some common traumatic experiences include being physically attacked, being in a serious accident, being in combat, being sexually assaulted, and being in a fire or a disaster like a hurricane or a tornado. After traumatic experiences, people can find themselves having problems that they didn't have before the event. If these problems are severe and the survivor does not get help for them, they can begin to cause problems in the survivor's family. This brochure will begin by explaining how traumatic experiences affect people who go through them. Next family members' reactions to the traumatic event and to the trauma survivor's symptoms and behaviors will be described. Finally, suggestions will be made about what a veteran and his or her family can do to get help for PTSD.

### How Do Traumatic Experiences Affect People?

People who go through traumatic experiences often have symptoms and problems afterwards. How serious the symptoms and problems are depends on many things, including a person's life experiences before the trauma, a person's own natural ability to cope with stress, how serious the trauma was, and what kinds of help and support a person gets from family, friends, and professionals immediately following the trauma.

Because most trauma survivors don't know how trauma usually affects people, they often have trouble understanding what is happening to them. They may think it is their fault that the trauma happened, that they are going crazy, or that there is something wrong with them because other people who were there don't seem to have the same problems. They may turn to drugs or alcohol to make them feel better. They may turn away from friends and family who don't seem to understand. They may not know what they can do to get better.

### What Do Trauma Survivors Need to Know?

- Traumas happen to many competent, healthy, strong, good people. No one can completely protect themselves from traumatic experiences.
- Many people have long-lasting problems following exposure to trauma. Up to 8% of persons will have PTSD at some time in their lives.
- People who react to traumas are not going crazy. What is happening to them is part of a set of common symptoms and

- problems that are connected with being in a traumatic situation.
- Having symptoms after a traumatic event is not a sign of personal weakness. Many psychologically well-adjusted and physically healthy people develop PTSD. Given exposure to a trauma that is bad enough, probably all people would develop PTSD.
  - By understanding trauma symptoms better, a person can become less fearful of them and better able to manage them.
  - By recognizing the effects of trauma and knowing more about symptoms, a person will be better able to decide about getting treatment.

### **What are Common Basic Effects of Trauma?**

Because they get overwhelmed with fear during a trauma, survivors often have particular symptoms that begin soon after the traumatic experience. The main symptoms are re-experiencing of the trauma - mentally and physically - and avoidance of trauma reminders. Together, these symptoms create a problem that is called Post-Traumatic Stress Disorder (PTSD). PTSD is a specific set of problems resulting from a traumatic experience that is recognized by medical and mental health professionals.

### **Re-experiencing Symptoms**

Trauma survivors commonly continue re-experiencing their traumas. Re-experiencing means that the survivor continues to have the same mental, emotional, and physical experiences that occurred during or just after the trauma. This includes thinking about the trauma, seeing images of the event, feeling agitated, and having physical sensations like those that occurred during the trauma. Trauma survivors find themselves feeling and acting as if the trauma is happening again: feeling as if they are in danger, experiencing panic sensations, wanting to escape, getting angry, thinking about attacking, or harming someone else. Because they are anxious and physically agitated, they may have trouble sleeping and trouble concentrating. These experiences are not usually voluntary; the survivor usually can't control them or stop them from happening. Mentally re-experiencing the trauma can include:

- Upsetting memories such as images or other thoughts about the trauma.
- Feeling as if the trauma is happening again ("Flashbacks").
- Bad dreams and nightmares.
- Getting upset when reminded about the trauma (by something the person sees, hears, feels, smells, or tastes).
- Anxiety or fear - feeling in danger again.
- Anger or aggressive feelings and feeling the need to defend oneself.
- Trouble controlling emotions because reminders lead to sudden anxiety, anger, or upset.
- Trouble concentrating or thinking clearly.

People also can have physical reactions to trauma reminders such as:

- Trouble falling or staying asleep.
- Feeling agitated and constantly on the lookout for danger.
- Getting very startled by loud noises, something, or someone coming up on you from behind when you don't expect it.
- Feeling shaky and sweaty.
- Having your heart pound or having trouble breathing.

Because they have these upsetting feelings, trauma survivors often act as if they are in danger again when they get stressed or reminded of their trauma. They might get overly concerned about keeping safe in situations that really aren't very dangerous. For example, a person living in a good neighborhood might still feel that he has to have an alarm system, double locks on the door, a locked fence, and a guard dog. Because traumatized people often feel like they are in danger even when they aren't, they may be overly aggressive, lashing out to protect themselves when there is no need. For example, a person who was attacked might be quick to yell at or hit someone who seems to be threatening. This happens because, when threatened, people have a natural physical "fight or flight" reaction that prepares them to respond to the danger.

Although re-experiencing symptoms are unpleasant, they are a sign that the body and mind are actively struggling to cope with the traumatic experience. These symptoms are automatic, learned responses to trauma reminders: trauma has become associated with lots of things so that they remind the person of the trauma and give them the feeling that they are in danger again. It is also possible that re-experiencing symptoms are actually part of the mind's attempt to make sense of what has happened.

### **Avoidance Symptoms**

Because thinking about the trauma and feeling as if you are in danger is so upsetting, people who have been through traumas want to avoid reminders of trauma. Sometimes they are aware of this and avoid trauma reminders on purpose and sometimes they do it without realizing what they are doing. Ways of avoiding thoughts, feelings, and sensations associated with the trauma can include:

- Actively avoiding trauma-related thoughts and memories.
- Avoiding conversations and staying away from places, activities, or people that might remind you of trauma.
- Trouble remembering important parts of what happened during the trauma.
- "Shutting down" emotionally or feeling emotionally numb.
- Trouble having loving feelings or feeling any strong emotions.
- Finding that things around you seem strange or unreal.
- Feeling strange or "not yourself".
- Feeling disconnected from the world around you and things that happen to you.

- Avoiding situations that might make you have a strong emotional reaction.
- Feeling weird physical sensations.
- Feeling physically numb.
- Not feeling pain or other sensations.
- Losing interest in things, you used to enjoy doing.

Avoiding thinking about trauma or avoiding treatment for your trauma-related problems may keep a person from feeling upset in the short run, but avoiding treatment of continuing trauma symptoms prevents progress on coping with trauma so that people's trauma symptoms don't go away.

### **What are Common Secondary and Associated Post-Traumatic Symptoms?**

Secondary symptoms are problems that come about **because of having post-traumatic re-experiencing and avoidance symptoms**. For example: because a person wants to avoid talking about a traumatic event that happened, she might get cut off from friends and begin to feel lonely and depressed. As time passes after a traumatic experience, more and more secondary symptoms may develop. Over time, secondary symptoms can become more troubling and disabling than the original re-experiencing and avoidance symptoms.

Associated symptoms are problems that don't come directly from being overwhelmed with fear, but happen because of other things that were going on at the time of the trauma. For example: a person who gets psychologically traumatized in a car accident might also get physically injured and then get depressed because he can't work or leave the house.

### **All of these problems can be secondary or associated trauma symptoms:**

**Depression:** can happen when a person has losses connected with the trauma situation or when a person avoids other people and becomes isolated.

**Despair and hopelessness:** can happen when a person is afraid that he or she will never feel better again.

**Loss of important beliefs:** can happen when a traumatic event makes a person lose faith that the world is a good and safe place.

**Aggressive behavior toward oneself or others:** can happen due to frustration over the inability to control PTSD symptoms (feeling that PTSD symptoms "run your life"). It can also happen when other things that happened at the time of trauma made the person angry (the unfairness of the situation). Some people are aggressive because they grew up with people who lashed out when they were angry and never taught them how to cope with angry feelings. Because angry feelings keep people away, they also stop a person from having positive connections and getting help. Anger and aggression can cause job problems, marital and relationship problems, and loss of friendships.

**Self-blame, guilt, and shame:** can happen when PTSD symptoms make it hard to fulfill current responsibilities. It can also happen when people fall into the common trap of second-guessing what they did or didn't do at the time of a trauma. Many people, in trying to make sense of their experience, blame themselves. This is usually completely unfair. At best, it fails to take into account the other reasons why the events occurred. Self-blame causes a lot of distress and can prevent a person from reaching out for help. Society sometimes takes a "blame-the-victim" attitude, and this is wrong.

**Problems in relationships with people:** can happen because people who have been through traumas often have a hard time feeling close to people or trusting people. This may be especially likely to happen when the trauma was caused or worsened by other people (as opposed to an accident or natural disaster).

**Feeling detached or disconnected from others:** can happen when a person has difficulty in feeling or expressing positive feelings. After traumas, people can get wrapped up in their problems or get numb and then stop putting energy into their relationships with friends and family.

**Getting into arguments and fights with people:** can happen because of the angry or aggressive feelings that are common after a trauma. Also, a person's constant avoidance of social situations (such as family gatherings) may annoy family members.

**Less interest or participation in things the person used to like to do:** can happen because of depression following a trauma. Spending less time doing fun things and being with people means a person has less of a chance to feel good and have pleasant interactions.

**Social isolation:** can happen because of social withdrawal and a lack of trust in others. This often leads to loss of support, friendship, and intimacy, and grows fears and worries.

**Problems with identity:** can happen when PTSD symptoms change important things in a person's life, like relationships or whether a person can do their work well. It can also happen when other things that happened at the time of trauma make a person confused about their own identity. For instance, a person who thinks of himself as unselfish might think he acted selfishly by saving himself during a disaster. This might make him question whether he is really who he thought he was.

**Feeling permanently damaged:** can happen when trauma symptoms don't go away and a person doesn't think they will get better.

**Problems with self-esteem:** can happen because PTSD symptoms make it hard for a person to feel good about him or herself. Sometimes, because of things they did or didn't do at the time of trauma, survivors feel that they are bad, worthless, stupid, incompetent, evil, and so on.

**Physical health symptoms and problems:** can happen because of long periods of physical agitation or arousal from anxiety. Trauma survivors may also avoid medical care because it reminds them of their trauma and causes



anxiety, and this may lead to poorer health. Habits used to cope with post-traumatic stress, like alcohol use, can also cause health problems. Also, other things that happened at the time of trauma may cause health problems (for example, an injury).

**Alcohol and/or drug abuse:** can happen when a person wants to avoid bad feelings that come with PTSD symptoms, or when other things that happened at the time of trauma lead a person to take drugs. This is a common way to cope with upsetting trauma symptoms, but it actually leads to more problems.

**Remember:**

Although PTSD symptoms and other trauma-related problems may take up most of a person's attention when they are suffering, people who have PTSD also have strengths, interests, commitments, relationships with others, past experiences that were not traumatic, desires, and hopes for the future.

Treatments are available for individuals with PTSD and associated trauma-related symptoms. Understanding the effects of trauma on relationships can also be an important step for family members or friends the effects of trauma.

## Appendix D-3

# Men and Sexual Trauma A National Center for PTSD Fact Sheet

by Julia M. Whealin, Ph.D.

At least 10% of men in our country have suffered from trauma as a result of sexual assault. Like women, men who experience sexual assault may suffer from depression, PTSD, and other emotional problems as a result. However, because men and women have different life experiences due to their different gender roles, emotional symptoms following trauma can look different in men than they do in women.

### Who are the perpetrators of male sexual assault?

Those who sexually assault men or boys differ in a number of ways from those who assault only females.

Boys are more likely than girls to be sexually abused by strangers or by authority figures in organizations such as schools, the church, or athletics programs.

Those who sexually assault males usually choose young men and male adolescents (the average age is 17 years old) as their victims and are more likely to assault many victims, compared to those who sexually assault females.

Perpetrators often assault young males in isolated areas where help is not readily available. For instance, a perpetrator who assaults males may pick up a teenage hitchhiker on a remote road or find some other way to isolate his intended victim.

As is true about those who assault and sexually abuse women and girls, most perpetrators of males are men. Specifically, men are perpetrators in about 86% of male victimization cases.

Despite popular belief that only gay men would sexually assault men or boys, most male perpetrators identify themselves as heterosexuals and often have consensual sexual relationships with women.

### What are some symptoms related to sexual trauma in boys and men?

Particularly when the assailant is a woman, the impact of sexual assault upon men may be downplayed by professionals and the public. However, men who have early sexual experiences with adults report problems in various areas at a much higher rate than those who do not.

**Emotional Disorders** – Men and boys who have been sexually assaulted are more likely to suffer from PTSD, other anxiety disorders, and depression than those who have never been abused sexually.

**Substance Abuse** – Men who have been sexually assaulted have a high incidence of alcohol and drug use. For example, the probability for alcohol problems in adulthood is about 80% for men who have experienced sexual abuse, as compared to 11% for men who have never been sexually abused.

**Encopresis** – One study revealed that a percentage of boys who suffer from encopresis (bowel incontinence) had been sexually abused.

**Risk Taking Behavior** – Exposure to sexual trauma can lead to risk-taking behavior during adolescence, such as running away and other delinquent behaviors. Having been sexually assaulted also makes boys more likely to engage in behaviors that put them at risk for contracting HIV (such as having sex without using condoms).

### **How does male gender socialization affect the recognition of male sexual assault?**

- Men who have not dealt with the symptoms of their sexual assault may experience confusion about their sexuality and role as men (their gender role). This confusion occurs for many reasons. The traditional gender role for men in our society dictates that males be strong, self-reliant, and in control. Our society often does not recognize that men and boys can also be victims. Boys and men may be taught that being victimized implies that they are weak and, thus, not a man.
- Furthermore, when the perpetrator of a sexual assault is a man, feelings of shame, stigmatization, and negative reactions from others may also result from the social taboos.
- When the perpetrator of a sexual assault is a woman, some people do not take the assault seriously, and men may feel as though they are unheard and unrecognized as victims.
- Parents often know very little about male sexual assault and may harm their male children who are sexually abused by downplaying or denying the experience.

### **What impact does gender socialization have upon men who have been sexually assaulted?**

Because of their experience of sexual assault, some men attempt to prove their masculinity by becoming hyper-masculine. For example, some men deal with their experience of sexual assault by having multiple female sexual partners or engaging in dangerous “macho” behaviors to prove their masculinity. Parents of boys who have been sexually abused may inadvertently encourage this process.

Men who acknowledge their assault may have to struggle with feeling ignored and invalidated by others who do not recognize that men can also be victimized.

Because of ignorance and myths about sexual abuse, men sometimes fear that the sexual assault by another man will cause them to become gay. This belief is false. Sexual assault does not cause someone to have a particular sexual orientation.

Because of these various gender-related issues, men are more likely than women to feel ashamed of the assault, to not talk about it, and to not seek help from professionals.

### **Are men who were sexually assaulted as children more likely to become child molesters?**

Another myth that male victims of sexual assault face is the assumption that they will become abusers themselves. For instance, they may have heard that survivors of sexual abuse tend to repeat the cycle of abuse by abusing children themselves. Some research has shown that men who were sexually abused by men during their childhood have a greater number of sexual thoughts and fantasies about sexual contact with male children and adolescents. However, it is important to know that most male victims of child sexual abuse do not become sex offenders.

Furthermore, many male perpetrators do not have a history of child sexual abuse. Rather, sexual offenders more often grew up in families where they suffered from several other forms of abuse, such as physical and emotional. Men who assault others also have difficulty with empathy, and thus put their own needs above the needs of their victims.

### **Is there help for men who have been sexually assaulted?**

It is important for men who have been sexually assaulted to understand the connection between sexual assault and hyper-masculine, aggressive, and self-destructive behavior. Through therapy, men often learn to resist myths about what a “real man” is and adopt a more realistic model for safe and rewarding living.

It is important for men who have been sexually assaulted and who are confused about their sexual orientation to confront misleading societal ideas about sexual assault and homosexuality.

Men who have been assaulted often feel stigmatized, which can be the most damaging aspect of the assault. It is important for men to discuss the assault with a caring and unbiased support person, whether that person is a friend, clergyman, or clinician. However, it is vital that this person be knowledgeable about sexual assault and men.

A local rape crisis center may be able to refer men to mental-health practitioners who are well-informed about the needs of male sexual assault victims.

## Summary

There is a bias in our culture against viewing the sexual assault of boys and men as prevalent and abusive. Because of this bias, there is a belief that boys and men do not experience abuse and do not suffer from the same negative impact that girls and women do. However, research shows that at least 10% of boys and men are sexually assaulted and that boys and men can suffer profoundly from the experience. Because so few people have information about male sexual assault, men often suffer from a sense of being different, which can make it more difficult for men to seek help. If you are a man who has been assaulted and you suffer from any of these difficulties, please seek help from a mental-health professional who has expertise working with men who have been sexually assaulted.

### Recommended Books

**Victims No Longer: Men Recovering from Incest and Other Sexual Child Abuse** by Mike Lew, Foreword by Ellen Bass. (1990). HarperCollins; ISBN 0060973005

**Wounded Boys, Heroic Men: A Man's Guide to Recovering from Child Abuse** by Danial Jay Sonkin and Lenore E. A. Walker. (1998). Adams Media Corporations; ISBN 1580620108

### Selected References

Bauserman, R. B., & Rind, B. (1997). Psychological correlates of male child and adolescent sexual experiences with adults: A review of the nonclinical literature. *Archives of Sexual Behavior*, 26, 105-139.

Black, C. A., & DeBlassie, R. R. (1993). Sexual abuse in male children and adolescents: Indicators, effects, and treatments. *Adolescence*, 28, 123-133.

Briggs, F., & Hawkins, R. M. F. (1995). Protecting boys from the risk of sexual abuse. *Early Child Development and Care*, 110, 19-32.

Carballo-Dieiguez, A., & Dolezal, C. (1995). Association between history of childhood sexual abuse and adult HIV-risk sexual behavior in Puerto Rican men who have sex with men. *Child Abuse and Neglect*, 19, 595-605.

Collings, S. J. (1995). The long-term effects of contact and noncontact forms of child sexual abuse in a sample of university men. *Child Abuse and Neglect*, 19, 1-6.

Darves-Bornoz, J. M., Choquet, M., Ledoux, S., & Manfredi, R. (1998). Gender differences in symptoms of adolescents reporting sexual assault. *Social Psychiatry & Psychiatric Epidemiology*, 33, 111-117.

Etherington, K. (1995). Adult male survivors of childhood sexual abuse. *Counseling Psychology Quarterly*, 8, 233-241.

Garnefski, N., & Diekstra, R. F. W. (1997). Child sexual abuse and emotional and behavioral problems in adolescence: Gender differences. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36, 323-329.

Gordon, M. (1990). Males and females as victims of childhood sexual abuse: An examination of the gender effect. *Journal of Family Violence*, 5, 321-332.

Hepburn, J. M. (1994). The implications of contemporary feminist theories of development for the treatment of male victims of sexual abuse. *Journal of Child Sexual Abuse*, 3, 1-18.

Lisak, D. (1994). The psychological impact of sexual abuse: Content analysis of interviews with male survivors. *Journal of Traumatic Stress*, 7, 525-548.

Marrow, J., Yager, C. A., & Otnow Lewis, D. (1997). Encopresis and sexual abuse. *Child Abuse and Neglect*, 21, 11-18.

Porter, E. (1986). *Treating the young male victim of sexual assault*. Syracuse, NY: Safer Society Press.

Winder, J. H. (1996). Counseling adult male survivors of childhood sexual abuse: A review of treatment techniques. *Journal of Mental Health Counseling*, 18, 123-133.

## Sexual Assault against Females A National Center for PTSD Fact Sheet

by Sue Orsillo, Ph.D.

Although anyone - men, women, and children - can be assaulted, this fact sheet will focus on adult female victims of sexual assault.

### What is sexual assault?

Sexual assault is defined as any sort of **sexual activity** between two or more people in which one of the people is involved **against his or her will**.

The **sexual activity** involved in an assault can include many different experiences. Women can be the victims of unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse.

There are a lot of ways that women can be involved in sexual activity against their will. The force used by the aggressor can be either physical or non-physical. Some women are forced or pressured into having sex with someone who has some form of authority over them (e.g., doctor, teacher, boss). Women can be bribed or manipulated into sexual activity against their will. Others may be unable to give their consent because they are under the influence of alcohol or drugs. In some cases, the sexual aggressor threatens to hurt the woman or people that she cares about. Finally, some assaults include physical force or violence.

### Who commits sexual assaults?

Often, when we think about who commits sexual assault or rape, we imagine the aggressor is a stranger to the victim. Contrary to popular belief, sexual assault does not typically occur between strangers. The National Crime Victimization Survey, conducted by the U.S. Department of Justice, found that 76% of sexually assaulted women were attacked by a current or former husband, cohabitating partner, friend, or date. Strangers committed only 18% of the assaults that were reported in this survey.

### How often do sexual assaults happen?

Estimating rates of sexual violence against women is a difficult task. Many factors stop women from reporting these crimes to police and to interviewers collecting statistics on the rate of crime in our country. Women may not want to report that they were assaulted because it is such a personal experience, because they blame themselves, because they are afraid of how others may react, and because they do not think it is useful to make such a report. However, there are statistics that demonstrate the magnitude of this problem in our country. For instance, a large-scale study

conducted on several college campuses found that 20% of women reported that they had been raped in their lifetime. Another national study found that approximately 13-17% of women living in the U.S. have been the victims of completed rape, and an additional 14% of women were the victims of another form of sexual assault. The National Crime Victimization Survey estimated that 500,000 sexual assaults occurred in the U.S. from 1992 to 1993. Of those assaults, about one third were completed rapes and an additional 28% were attempted rapes.

### **What happens to women after they are sexually assaulted?**

After a sexual assault, women can experience a wide range of reactions. It is extremely important to note that there is no one pattern of response. Some women respond immediately, others may have delayed reactions. Some women are affected by the assault for a long time whereas others appear to recover rather quickly.

In the early stages, many women report feeling shock, confusion, anxiety, and/or numbness. Sometimes women will experience feelings of denial. In other words, they may not fully acknowledge what has happened to them or they may downplay the intensity of the experience. This reaction may be more common among women who are assaulted by someone they know.

### **What are some early reactions to sexual assault?**

In the first few days and weeks following the assault, it is very normal for a woman to experience intense and sometimes unpredictable emotions. She may have repeated strong memories of the event that are difficult to ignore, and nightmares are not uncommon. Women also report having difficulty concentrating and sleeping, and they may feel jumpy or on edge. While these initial reactions are normal and expected, some women may experience severe, highly disruptive symptoms that make it incredibly difficult to function in the first month following the assault. When these problems disrupt the woman's daily life, and prevent her from seeking assistance or telling friends and family members, the woman may have **Acute Stress Disorder (ASD)**. Symptoms of ASD include:

- Feeling numb and detached, like being in a daze or a dream, or feeling that the world is strange and unreal
- Difficulty remembering important parts of the assault
- Reliving the assault through repeated thoughts, memories, or nightmares
- Avoidance of things (places, thoughts, feelings) that remind the woman of the assault
- Anxiety or increased arousal (e.g., difficulty sleeping, concentrating, etc.)



**What are some other reactions that women have following a sexual assault?**

**Major Depressive Disorder (MDD)** is a common reaction following sexual assault. Symptoms of MDD can include a depressed mood, an inability to enjoy things, difficulty sleeping, changes in patterns of sleeping and eating, problems in concentration and decision-making, feelings of guilt, hopelessness, and decreased self-esteem. Research suggests that almost 1/3 of all rape victims have at least one period of MDD during their lives. And for many of these women, the depression can last for a long period of time. Thoughts about suicide are also common. Studies estimate that 1/3 of women who are raped contemplate suicide, and 17% of rape victims actually attempt suicide.

Many victims of sexual assault report struggling with anger after the assault. Although this is a natural reaction to such a violating event, there is some research that suggests that prolonged, intense anger can interfere with the recovery process and further disrupt a woman's life.

**Shame and guilt** are common reactions to sexual assault. Some women blame themselves for what has happened or feel shameful about being an assault victim. This reaction can be even stronger among women who are assaulted by someone that they know, or who do not receive support from their friends, family, or authorities, following the incident. Shame and guilt can also get in the way of a woman's recovery by preventing her from telling others about what happened and getting assistance.

**Social problems** can sometimes arise following a sexual assault. A woman can experience problems in her marital relationship or in her friendships. Sometimes an assault survivor will be too anxious or depressed to want to participate in social activities. Many women report difficulty trusting others after the assault, so it can be difficult to develop new relationships. Performance at work and school can also be affected.

**Sexual problems** can be among the most long-standing problems experienced by women who are the victims of sexual assault. Women can be afraid of and try to avoid any sexual activity; they may experience an overall decrease in sexual interest and desire.

**Alcohol and drug use** can sometimes become problematic for women who are the victims of assault. A large-scale study found that compared to non-victims, rape survivors were 3.4 times more likely to use marijuana, 6 times more likely to use cocaine, and 10 times more likely to use other major drugs. Often, women will report that they use these substances to control other symptoms related to their assault.

**Post-traumatic Stress Disorder (PTSD)** involves a pattern of symptoms that some individuals develop after experiencing a traumatic event such as sexual assault. Symptoms of PTSD include repeated thoughts of the assault; memories and nightmares; avoidance of thoughts, feelings, and situations related to the assault; and increased arousal (e.g., difficulty sleeping and concentrating, jumpiness, irritability). One study that examined PTSD

symptoms among women who were raped found that 94% of women experienced these symptoms during the two weeks immediately following the rape. Nine months later, about 30% of the women were still reporting this pattern of symptoms. The National Women's Study reported that almost 1/3 of all rape victims develop PTSD sometime during their lives and 11% of rape victims currently suffer from the disorder.

### **What should I do if I have been sexually assaulted?**

#### **Where can I go for help?**

If you were sexually assaulted and are experiencing symptoms that are distressing to you, or symptoms that are interfering with your ability to live a fulfilling and productive life, we urge you to talk to a mental-health professional. Depending on the nature of the problems that you are having, a number of [therapeutic techniques](#) may be extremely helpful to you.

The treatment you receive will depend on the symptoms you are experiencing and will be tailored to your needs. Some therapies involve talking about and making sense of the assault in order to reduce the memories and pain associated with the assault. Attending therapy may also involve learning skills to cope with the symptoms associated with the assault. Finally, therapy can help survivors restore meaning to their lives.

Unfortunately, sexual assault is fairly prevalent in our society today. Survivors of sexual assault can experience a wide variety of symptoms, but they do not have to suffer in silence. Mental-health professionals can offer a number of effective treatments tailored to the individual woman's needs. We urge you to seek help today.

# E

## Appendix E: Pharmacotherapy for PTSD

Pharmacotherapy for PTSD			
Medication	Daily Dosage Range <sup>b</sup>	Study Type <sup>c</sup>	Outcome
<b>SSRIs</b>			
Sertraline <sup>a</sup>	150–200 mg	RCTs	+
Paroxetine <sup>a</sup>	10–40 mg	RCTs	+
Fluoxetine	20–80 mg	RCTs	+/-
Fluvoxamine	250–300 mg	OL	+
<b>Tricyclic antidepressants</b>			
Amitriptyline	160 mg	RCT	+
Imipramine	150–300 mg	RCT	+
Desipramine	200 mg	RCT	-
<b>MAOIs</b>			
Phenelzine	45–75 mg	RCT	+
Brofaromine	Up to 150 mg	RCT	+/-
<b>Other antidepressants</b>			
Nefazodone	100–600 mg	OL	+/-
Trazodone	25–500 mg	OL	+
Mirtazapine	15–45 mg	RCT	+
Venlafaxine	75–300 mg	OL	+

Table 1

Table 1 (cont.)

<b>Pharmacotherapy for PTSD</b>			
Medication	Daily Dosage Range <sup>b</sup>	Study Type <sup>c</sup>	Outcome
<b>Benzodiazepines</b>			
Alprazolam	0.5-2.5mg	OL	-
Clonazepam	0.5-3mg	OL	-
<b>Mood stabilizers</b>			
Valproic acid	1250-1400 mg	OL	+
Carbamazepine	400-1600 mg	OL	+
Lamotrigine	25-500 mg	RCT	-
Topiramate	12.5-500 mg	OL	+
<b>Atypical antipsychotics</b>			
Olanzapine	5-20 mg	RCT, OL	+/-
Quetiapine	25-300 mg	CR	+
Risperidone	1-3 mg	CR, RCT	+
<b>Adrenergic inhibitors</b>			
Clonidine	0.2-0.6 mg	OL	+
Guanfacine	1-3 mg	CR	+
Prazosin	5-10 mg	RCT	+
Propranolol	40-160 mg	RCT	+

Table 1

<sup>a</sup> FDA approved for treatment of PTSD

<sup>b</sup> note that these dosages are derived from PTSD treatment studies available at the time of this review.

<sup>c</sup> RCT = randomized controlled trial; OL = open-label study; CR = case report or series

Source: Connor KM, & Butterfield MI. Posttraumatic Stress Disorder (PTSD): A Comprehensive Review. Focus (2003 in press).

# F Appendix F: Supplement - Additional Compensation & Pension Claims Issues

## **PRACTICAL TECHNICAL ADVICE TO GIVE VETERANS APPLYING FOR PTSD DISABILITY BENEFITS RELATED TO IN-SERVICE SEXUAL TRAUMA**

- Inform veterans how important it is to document evidence of their in-service trauma.
- Assess the veterans' functional competency. Ironically, persons with the greatest psychiatric disability are often those least likely to receive disability benefits (Swartz, Lurigio, & Goldstein, 2000), possibly because they cannot follow through on the paperwork and processes required.
- If you have concerns about your patient's ability to follow through and complete paperwork, suggest that he or she find an advocate for assistance. The choice of an advocate should be left up to the veteran, but might include a family member, a service Officer (e.g., national, county, or state representatives of a Veterans' Service Organization), or even a lawyer. Veterans' service officer will represent them free of charge.
- Educate veterans that, even though the VBA has a duty to assist veterans in developing a claim, much of the burden will still fall to them. The claimant should either provide documentation in support of their claim or give the VA sufficient information so that the office will know what evidence the claimant believes is pertinent and who possesses it so that it can be requested. For example, it is not helpful to say, "I saw a doctor off base" when what should be said is that "I saw a private physician in town, Dr. Green, about two weeks after the incident." Veterans should make sure that their assigned claims processor collects appropriate data (i.e., not just the "combat files" of their military record) and that the claims processor fully develops their records for alternative markers of sexual assault (such as changes in job proficiency ratings, transfers, etc.).
- Encourage veterans and their families to be knowledgeable about their claim and the claims process in general.
- Encourage veterans to collect evidence in support of their MST claim. They should not wait for the claims processor to ask them

- about diaries, journals, letters, civilian police reports, rape crisis centers they called, Internet services they accessed, and so on. Remind veterans to take advantage of the testimony of friends, family, co-workers, or clergy. Letters from such individuals stating that they remember being told about the event can be used to establish a claim of sexual assault. Even if the veteran did not specifically tell others about his or her assault, if friends and family noticed that the veteran developed a change in personality, behavior, etc., around the time of the assault, a written statement to this effect could help bolster the veteran's claim.
- If the veteran has difficulty completing the "Alternative Sources of Evidence" questionnaire asking about their military sexual trauma, suggest they complete it with the help of their mental health counselor, their VBA Women Veterans Coordinator, their service officer, or some other trusted helper.
  - Victims of sexual trauma, whether male or female, often feel more comfortable if a woman conducts their C&P exam. Veterans may request a female (or male) examiner. However, depending on the pool of available C&P examiners, VA cannot always comply with this request. Veterans may also request that a family member or friend accompany them during the examination.
  - Veterans should know that it is a VBA standard and in the veteran's best interest to have his or her claim file present at the time of the clinical exam (assuming that all the evidence has been collected). However, this ideal is not always achieved (CPEP, 2002). Veterans may prefer to reschedule their appointment for a time when the chart is available. Veterans should also consider bringing their own copies of their medical and military records to their C&P examinations.
  - Veterans should know that it can take a long time for a claim's determination after the disability examination. Because of the variety of evidence sources that must be developed and normally the length of time between the MST and the actual claim, the time to decide such a claim can be quite lengthy and is normally measured in months rather than days. Reinforce the use of healthy coping strategies during this waiting period.

## What if Service-Connection isn't Granted?

Veterans should be prepared for the possibility that their claim will not be successful. Unsuccessful claimants should be referred to their power of attorney representative to consider their options, which might include an appeal. They might also want to talk with a mental health provider about their feelings if their claim is denied.

While a denial of service-connection may be interpreted by the veteran as meaning that the VA did not believe that he or she was a victim of MST, it may in fact mean that the claim was not sufficiently developed (e.g., their

was insufficient evidence of link between the trauma and their current medical condition) or that their examination was insufficient (e.g., the trauma was not adequately described). Veterans denied service-connection should be encouraged to evaluate how thoroughly their trauma was documented and the quality of their examination. A veteran service officer can help them do this. Veterans whose claims were denied prior to 1995 might wish to re-file now that the evidentiary requirements for establishing a claim have been liberalized.

Reassure the veteran that failure to receive service-connection for military sexual trauma does not mean the VA thinks he or she was lying about what happened, but rather that the evidentiary standards for service-connection were not met.

Veterans should know that PTSD is not the only psychiatric condition that can arise from MST. With the exception of personality disorders and primary drug and alcohol dependency, veterans are eligible for service-connection for other psychiatric disorders so long as there is competent evidence of a medical (psychiatric) diagnosis, the MST, and a nexus between the two.

Veterans who disagree with the VBA's rating board determination can file an appeal within one year of the date of notification of the claim denial. Veterans should be informed that the appeals process may be time-consuming and protracted. They should be referred to a service officer or other specialist for assistance if they decide to appeal a claim.

Finally, remind veterans with denied disability claims that under the mandates of Public Law 103-452 they remain eligible for MST counseling and treatment regardless of their SC status.

## **Technical Issues for Veterans Filing Disability Claims Related to Military Sexual Trauma**

Although veterans might be eligible for service-connection for a variety of conditions related to in-service sexual assault (e.g., complications of or "residuals" of sexually transmitted disease (STD), chronic STD's, infertility), most veterans who seek VA service-connection for disability related to military sexual trauma do so on the basis of PTSD. Service-connection prior to the introduction of PTSD required in-service treatment for a mental illness whatever the cause of that illness. In October of 1980, the Schedule for Rating Disabilities (38 CFR Part 4) was revised to include the specific, separate diagnosis of PTSD and to allow service-connection based on delayed onset of disabling symptoms. To obtain service-connection for PTSD, therefore, the veteran does not need to demonstrate that the disorder became manifest during or within a limited time after military service. Consequently, for those who did not receive psychiatric diagnoses during or soon after their military discharge, the evidentiary basis for a PTSD claim may be less burdensome compared with other mental disorders.

PTSD is the only psychiatric condition explicitly connected to an in-service trauma in the Code of Federal Regulations. However, generally the Congress identifies the characteristics of a condition that can be service-connected (i.e., incurred in-service, not due to misconduct, not be constitutional or developmental abnormality, restricted to a particular kind of service such as in-country Viet Nam Service etc.). The Department of Veterans Affairs (VA) actually publishes the rating schedule and enumerates many disabilities. While other psychiatric disorders may also result from trauma, establishing the link between these conditions and military service may be more challenging; thus, it may be more difficult to become service-connected for them. Personality disorders are not currently compensative. Alcohol and substance abuse, common sequelae of sexual trauma, are compensative only when they arise as the consequence of having some other compensative disability, such as PTSD. Primary alcohol and substance abuse and abuse that precede another disability are not compensative.

## **Gender/Trauma-Type Disparities in Rates of PTSD Disability Awards**

The first woman applied for VA PTSD disability benefits in 1982, followed by 6 women in 1984 (Murdoch, Nelson, & Fortier, in press). By 1991, the year Gulf War I ended, the numbers of women applying for PTSD disability benefits began to increase geometrically. Thus, while women represent just 3% of all PTSD disability claimants overall, they represent 17% of all Gulf War I disability claimants and 51% of all post-Gulf War I disability claimants (Murdoch, Nelson et al., in press). Between 1982 and 1998, however, the claims approval rate of women filing disability claims for PTSD lagged men's by almost 12 full percentage points (Murdoch, Nelson et al., in press). This gender discrepancy is almost completely mediated by men's higher rate of combat exposure. Almost 94% of male PTSD disability applicants claim combat as their in-service stressor, compared to 29% of women applicants (Murdoch, Hodges et al., in press). Whether this apparent combat preference in PTSD disability awards is appropriate, however, is unclear. Combat veterans applying for VA disability benefits for PTSD do not have more severe PTSD symptoms than sexually assaulted veterans, and their work, role, and social functioning is actually better (Murdoch, Hodges et al., in press).

## **Evidentiary Difficulties in Sexual Trauma Claims for PTSD**

Greater evidentiary difficulties in establishing a claim among sexually traumatized veterans compared to combat veterans could account for the gender difference in PTSD disability awards. Unlike certain combat trauma claims, self-report of sexual trauma does not qualify as "credible supporting



evidence” of such a stressor. Furthermore, while military decorations, such as a Purple Heart, establish the legitimacy of a combat trauma claim, there are no such public verifications of having endured sexual trauma. As might be imagined, there are rarely eyewitnesses to sexual assault beyond victim and perpetrator. Service men and women sexually assaulted by other military personnel frequently experience intense pressure to conceal or deny their attack (Bastian et al., 1996; Furey, 1996; Ritchie, 1998). Thus, it is uncommon for military records to contain any official documentation of a sexual assault, and it is likewise uncommon for victims to tell anyone in the military about their trauma on even an unofficial basis (Bastian et al., 1996; Furey, 1996).

Recognizing this, VBA expanded and liberalized types of data they would accept as evidence for a military sexual assault claim in 1995. Now considered are:

- second-party testimonials of friends, family, peers, and clergy (saying that they remember being told about the assault at the time it occurred);
- statements from friends, families, or others testifying that they observed behavior or personality changes in the claimant after the alleged assault;
- contemporaneous personal letters, diaries, or journals written by the claimant describing the assault or its after-effects;
- phone logs from rape or crisis centers;
- civilian police records; and
- private medical records.

Claims processors are also charged with seeking “alternative sources of evidence” consistent with markers of a “post-rape syndrome.” Examples might include

- private or military medical records documenting sudden, proximal (to the assault) increases in use of sick call or leave;
- increased use of counseling services (even if the counseling did not directly deal with sexual assault);
- requests for HIV, STD, or pregnancy testing;
- increased use of over-the-counter medications, prescription drugs, or street drugs;
- increased use of alcohol;
- sudden changes in job performance ratings, military occupational specialties (MOS), or duty assignments;
- the breakup of a primary relationship (e.g., divorce); and
- behavioral changes, such as increased isolation or promiscuity.

## **Documenting the Occurrence of an In-Service Stressor is Critically Important in Obtaining Service-Connection for PTSD**

When veterans' claims folders contain data supporting the occurrence of an in-service stressor (either combat or sexual assault), C&P examiners are up to 20 times as likely to diagnose veterans with PTSD as when the claims folder does not support evidence of an in-service stressor (Murdoch, 2000). Thus, supporting evidence of an in-service stressor in the claims file has exceptional influence on whether or not clinicians will diagnose disability claimants with PTSD.

## **The "Alternative Sources of Evidence" Questionnaire**

Currently, all victims of military sexual trauma who file a disability claim related to that trauma are sent a questionnaire asking detailed information about alternative sources of evidence that might exist in their particular case. Although this questionnaire can be very difficult for veterans to complete, they should be encouraged to do their best. Veterans may wish to complete it with the help of a mental health counselor, service officer, or other trusted helper.

## **Diagnostic Suspicion for PTSD among Disability Applicants who are Women/Sexual Trauma Victims**

If clinicians who conduct PTSD disability evaluations do not accept or are unaware of an association between sexual assault and PTSD, then sexually assaulted veterans might be less likely than combat veterans to receive disability benefits for PTSD (Murdoch, Hodges et al., in press). Willer and Grossman (Willer & Grossman, 1995) have noted a disproportionately lower rate of PTSD diagnoses among help-seeking women veterans compared to men, despite women's "sharply" higher rates of non-combat trauma. Murdoch and colleagues showed that men who applied for VA service-connection for PTSD were 1.7 times as likely as women to receive a diagnosis of PTSD from a VA clinician (Murdoch, Hodges et al., in press). Under unusual circumstances, a private clinician's examination can sometimes be substituted for a VA C&P exam. Even if these records are not substituted for the C&P examination, men and women who have been treated by non-VA clinicians for PTSD may want copies of those records added to their claims files to support evidence of a medical diagnosis.

## References

- Bastian L, Lancaster A, & Reyst H. *Department of Defense 1995 Sexual Harassment Survey* (Report No. 96-014). Arlington, VA: Defense Manpower Data Center; 1996.
- Furey J. *Women Veterans Issues, Part 1: Developing PTSD Sexual Assault Claims in: C&P Training Operations Teleconference*. Washington, DC 1996.
- Murdoch M. Final Report for HSR&D GEN97-002: Gender differences in Compensation and Pension claims approval rates for PTSD. 2000.
- Ritchie EC. Reactions to rape: A military forensic psychiatrist's perspective. *Military Medicine*. Aug 1998;163(8):505-509.
- Swartz JA, Lurigio AJ, Goldstein P. Severe mental illness and substance use disorders among former supplemental security income beneficiaries for drug addiction and alcoholism. *Archives of General Psychiatry*. Jul 2000;57(7):701-707.
- Willer JK, Grossman LS. Mental health care needs of female veterans. *Psychiatr Serv*. 1995;46(9):938-940.
- CPEP. (2002). Compensation and Pension Examination Project Office Report: Quality Measurement of Compensation and Pension Examinations (report). Nashville, TN: Compensation and Pension Examination Project.
- Murdoch, M., Hodges, J., Cowper, D., Fortier, L., & vanRyn, M. (2003). Racial disparities in VA service-connection for posttraumatic stress disorder disability. *Med Care*, 41(4), 536-549.
- Murdoch, M., Hodges, J., Hunt, C., Cowper, D., Kressin, N., & O'Brien, N. (2003). Gender differences in service-connection for PTSD. *Med Care*, 41(8), 950-961.
- Murdoch, M., Nelson, D., & Fortier, L. (2003). Time, gender, and regional trends in the application for service-related PTSD disability benefits, 1980-1998. *Mil Med*. in press.



# G

## Appendix G: Danger signals in Staff - Patient Relationships

### **DANGER SIGNALS IN STAFF-PATIENT RELATIONSHIPS**

by Nancy Dillon Ph.D., RN, CNS  
Minneapolis VA Medical Center

- 1. YOU ONLY FEEL APPRECIATED AT WORK.**  
This might be an indicator that you are using the work setting and the patient(s) to get your socio-emotional needs met. Examine what needs are being met at work that are not being met, but would be better if met, in other settings.
- 2. YOU CAN'T DO ENOUGH FOR YOUR PATIENT AND/OR YOU ARE SPENDING A DISPROPORTIONATE AMOUNT OF TIME WITH A PATIENT.**  
Look at your responsibility to the total unit as well as assessing the nature of the relationship with the patient. Examine your motives for the relationship and use feedback from other staff as guidelines in evaluating the type, professional or social, of the relationship with the patient.
- 3. YOU ARE WITH THE PATIENT WHEN YOU ARE "OFF DUTY".**  
Since the patient must learn, as everyone must, how and when to appropriately meet needs, seeing patients during your mealtime, before, or after duty, is destructive. Ask yourself, "Why is this particular patient so important?"
- 4. YOUR PATIENT REMAINS UP TO SEE YOU WHEN YOU ARE ON THE NIGHT SHIFT.**  
These are indicators that the patient may be perceiving a relationship with you that is different than a professional staff/patient relationship. Examine how you have encouraged its development.

**5. YOU FEEL THAT YOU ARE THE ONLY ONE WHO CAN HELP THE PATIENT, THE OTHER STAFF ARE TOO CRITICAL OF THE PATIENT, OTHERS ARE JEALOUS OF YOUR RELATIONSHIP WITH THE PATIENT, AND THAT THEIR CRITICISM OF YOUR RELATIONSHIP IS "THEIR OWN PROBLEM."**

This is a sure sign that your objectivity and perception of the interpersonal process are defective and it is imperative that you evaluate your feelings and motives immediately. You must be willing to get feedback from other staff as well as from your immediate supervisor. You must also be willing to act constructively on the feedback. If this situation is not relieved, communication and teamwork will break down at the expense of the patient's treatment.

**6. YOU TEND TO KEEP SECRETS WITH THE PATIENT.**

Certain information is not charted or reported. Reporting and charting is screened differently than on other patients. The tendency to rationalize and subsequently "color" or delete from reporting or charting of patient behaviors because "it is not important", "people would not understand", "staff would exaggerate the importance", results in sabotaging the treatment. You are unethically assuming full treatment of the patient when this occurs. Lack of value for the established treatment program is communicated by your behavior.

**7. YOU TEND TO REPORT AND COMMUNICATE ONLY NEGATIVE OR POSITIVE ASPECTS OF THE PATIENT'S BEHAVIOR.**

Your perception and observation is being influenced by negative or positive feelings toward the patient, possibly resulting in your reinforcing selective and inappropriate behavior in the patient. Look at how your reporting is censored and observations influenced.

**8. YOU "SWAP" PATIENT ASSIGNMENTS.**

Teamwork, consistency, and patient care are affected by "swapping" of patient assignments and it is essential to investigate your motives for "swapping". Do you exchange patients because it satisfies personal needs of yours or is it done to meet the needs of patients? No exchange of patients should be done without prior investigation and approval from your supervisor. You need to share your concerns with your nurse manager.

**9. YOU ARE GUARDED AND DEFENSIVE WHEN SOMEONE QUESTIONS YOUR INTERACTION OR RELATIONSHIP WITH THE PATIENT.**

Your reaction indicates some cause for concern. If all is well with the relationship, why the need for defensiveness? When other staff give you

feedback regarding their perception of your relationship with the patient, do you play the “yes, but” game? This implies “You are right, but this situation is different”. Ask yourself if you feel immune from errors in judgment.

**10. YOUR PATIENT TALKS FREELY AND SPONTANEOUSLY WITH YOU, ESPECIALLY IN LIGHT SUPERFICIAL CONVERSATION AND PERHAPS EVEN WITH SEXUAL OVERTONES, BUT REMAINS SILENT AND DEFENSIVE WITH OTHER STAFF, OR MAY AVOID THEM ALL TOGETHER.**

Examine the relationship to determine if it is the result of a long working relationship between you and the patient or if it is a social/sexual relationship as perceived by your patient and unconsciously reinforced by you. Consider that you may be reinforcing the very problem that the patient deserves help in learning to recognize and work through. Examine your motives for the relationship to determine whose needs are being met.

**11. YOUR STYLE OF DRESS FOR WORK HAS CHANGED SINCE YOU STARTED WORKING WITH THIS PATIENT.**

Examine how your style of dress has changed. Are you becoming more aware of professional attire or are you dressing to impress the patient? Investigation is again important here to determine whose needs are being met.

**12. YOU RECEIVE GIFTS, CARDS, LETTERS, OR PHONE CALLS FROM THE PATIENT AFTER THE PATIENT’S DISCHARGE.**

It is important to determine what the patient’s perception of the relationship is, as well as to examine your own behavior to see if you are unconsciously reinforcing a nonprofessional relationship, which may influence future, helping relationships the patient may require. Remember that accepting more than a thank you or written comments make you a “caretaker, not a caregiver.” Look at other ways the patient can express appreciation.

**13. YOU TEND NOT TO ACCEPT THE FACT THAT THE PATIENT IS A PATIENT.**

By relating to the patient as only a “victim of circumstances” denies the patient the care he rightly deserves. Determine what is interfering with your ability to remain objective regarding this patient.

**14. YOU VIEW THE PATIENT AS “YOUR” PATIENT IN A POSSESSIVE WAY.**

You feel that nobody else cares about or can help this patient. Possessiveness inhibits the patient from learning to interact with others and inhibits your professional growth. Work on building self-confidence in your ability as a team member so you will not need a tight one-to-one bond with this particular patient unless it is part of the treatment plan.

**15. YOU CHOSE SIDES WITH THE PATIENT AGAINST HIS SIGNIFICANT OTHERS.**

Ask yourself, “What value is there in taking sides?” Examine whether you are being an advocate for the patient or you have lost objectivity. You may need to help the patient look at all sides of the issue and to help him develop problem-solving skills.

**16. YOU DISCLOSE MORE INFORMATION ABOUT YOURSELF TO THE PATIENT THAN IS NECESSARY IN THE COURSE OF TREATMENT AND MORE THAN YOU DISCLOSE TO OTHER PATIENTS.**

Inappropriate self-disclosure changes the boundaries from professional to personal. These boundary violations may impair the patient’s right to receive professional care. The patient may then find you less credible as a professional. You need to find the fine line between inappropriate self-disclosure and appearing cold and rejecting.

**17. YOU ANSWER YOUR PATIENT’S PERSONAL QUESTIONS IN A VAGUE MANNER OR YOU GIVE YOUR PATIENT DOUBLE MESSAGES.**

Your patient asks if he will see you after discharge and you answer “maybe” or your patient indicates that he would like a close relationship with you (physically or personally) and you answer, “It’s against the rules of the hospital.” On the other hand, you continually sit in ways or places that encourages the patient’s close proximity. Not only does this type of answer and behavior give the patient a vague, double message, but also ignores further exploration of the patient’s perceptions that prompted him to ask such questions or to seek such a relationship.

**18. YOU RESPOND TO A REQUEST FOR MEDICATION, PASSES, AND THE LIKE DIFFERENTLY FOR DIFFERENT PATIENTS.**

Investigate your motives if you find that when one patient requests medication you refuse or make him wait, yet you may respond to another patient even before he asks. Additionally, self-examination is in order when you are approaching team members, attempting to influence patient’s passes, privileges, or the like, in a secretive manner rather than follow the established routine for discussion and granting such requests.



**19. THE PATIENT CONTINUES TO TURN TO YOU BECAUSE  
"ALL OTHER STAFF MEMBERS ARE BUSY", OR  
"DON'T UNDERSTAND ME."**

Unless this approach has been identified as part of the treatment approach, the patient may have discovered a staff member who will treat them differently. Examine the value to this patient of this differential treatment.

**20. YOU THINK YOU ARE IMMUNE FROM FOSTERING A  
NON-PROFESSIONAL RELATIONSHIP.**

"The above danger signals may apply to others, but I know better. It could never happen to me." Inaccurate ideas regarding one's own ability are dangerous because they may foster destructiveness in the staff/patient relationship as well as inhibit the staff's professional growth and personal growth. Because direct care nursing staff are the most accessible and potentially caring persons available to the patients, they are most vulnerable to the stresses inherent in the maintenance of professional staff/patient relationships.

## References

Gafner, G. Trudeau, V. (1990). Drawing the boundaries in staff-patient relationships. *VA Practitioner*, March 39-45.

Peteet, J., Ross, DM, Medeiros, C, Walsh-Burke, K & Rieker, P (1992). Relationships with patients in oncology: can a clinician be a friend? *Psychiatry* 55, 223-229.

Peterson, M. (1992). *At personal risk: Boundary violations in professional-client relationships*. New York: Norton.



# H

## Appendix H: Domestic Violence Screening: Special Issues

Many medical organizations recommend providers make efforts to identify and refer patients who have experienced abuse, though sufficient evidence for the effectiveness of provider screening for intimate partner violence is lacking (Rhodes & Levinson 2003). Expert opinion (Cole 2000, Waalen, et al., 2000) suggests that including questions about physical abuse during routine history taking may be justified on the basis of the substantial prevalence of undetected abuse, the potential value of this information in caring for the patient, the low risk of harm in asking, and the possible influence on assessment and treatment of other health problems.

Recommendations regarding IPV/DV screening of a number of medical and professional organizations are provided in the following table.

### Clinical Practice Guidelines/Position Statements

Organization	Statement
American Academy of Family Physicians	Evaluate each patient for domestic violence issues, and offer referral to anyone involved in a violent relationship of any kind to appropriate community and mental health resources.
American Academy of Pediatrics	Attempt to recognize evidence of family or intimate partner violence. Questions about family violence should become part of anticipatory guidance.
American College of Emergency Physicians	Encourage screening patients for domestic violence and appropriately refer those patients who indicate domestic violence may be a problem in their lives.
American College of Obstetricians and Gynecologists	Screening all patients is the key to identifying abuse. Screen all patients for intimate partner violence.
American Medical Association	Routine screening of all women patients in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. Routinely inquire about family violence histories. Refer appropriately, have resources available.

Table 1

Table 1 (cont.)

Organization	Statement
Canadian Task Force on Preventive Health Care	Insufficient evidence is available to recommend for or against using specific screening for violence against either women who are pregnant or who are not pregnant, or of men. This is distinct from the need for clinicians to include questions about exposure to domestic violence as part of their diagnostic assessment of women. This information is important in caring for the patient and may influence assessment and treatment of other health problems.
Family Violence Prevention Fund	Routine screening for all female patients over the age of fourteen in primary care, obstetrics/gynecology, and family planning, emergency department, in-patient, pediatrics, and mental health settings.
Joint Commission on the Accreditation of Healthcare Organizations	The hospital has objective criteria for identifying and assessing possible victims of abuse and neglect, and they are used throughout the organization. Make appropriate referrals for victims of abuse and neglect. Maintain a list of private and public community agencies that provide help for abuse victims.
U.S. Preventive Services Task Force	Insufficient evidence to recommend for or against the use of specific screening instruments to detect domestic violence, but recommendations to include questions about physical abuse may be made on other grounds.

Table 1

Some special issues can arise when screening for domestic violence in the primary care setting. Primary care providers may find these suggestions helpful:

- **Become sensitive to the specific cultural issues that you may encounter with your patients.** For example, in some cultures, physical and financial dominance over a wife may be more acceptable than in others. Therefore, your intervention may need to be particularly sensitive to potential intervention barriers such as patient resistance, lack of social supports, or lack of concrete supports such as safe alternative housing.
- **Let the patient know what she can expect.** For example, be knowledgeable about what the patient might expect if she follows through with an order of protection or if she follows through with a mental health referral that you have provided.

- **Availability of an on-site advocate or use of off-site, on-call advocates.** Make sure that your setting has an ongoing relationship with any on-site domestic violence advocates or counselors and/or off-site domestic violence advocates and legal services. Being able to easily refer your patient to immediate help can be vital to an effective intervention and will better ensure that your patient receives assistance from trained and dedicated personnel.
- **If patient chooses psychosocial intervention.** Most domestic violence organizations have the ability to assist your patient in receiving individual and group counseling services. These services generally focus on providing support (e.g., a survivors group, safety planning) and advocacy (e.g., legal assistance). If your patient is experiencing mental health and/or substance abuse problems, a referral for disorder-specific counseling is indicated. In addition, it is important to encourage your patient to inform the counselor of the abuse history and any current abuse events.
- **Sexual orientation.** Patients with same-sex partners are as at-risk for domestic violence as are your heterosexual patients (Tjaden & Thoennes, 2000). Gay and lesbian patients face added stress due to stigmatization, sexual orientation disclosure threats, and lack of social support. You can help by keeping local gay and lesbian social service and counseling referral numbers in your office. In addition, your local domestic violence organizations may have gay and lesbian services available (see [Appendix C](#)).
- **Males can be victims of domestic violence too.** Some men may be embarrassed to admit that they are being abused. Treating your male patients with respect and treating their abusive situations as seriously as you do your female patients' situations will help to ease some of their shame and embarrassment. Community resources for your male patients will be more limited. For example, it is not likely that a male patient will have access to local domestic violence shelter services. However, many domestic violence organizations will have counseling resources for your male patients. In addition, keeping a list of local counselors in your area who have experience working with male victims is essential.
- **When children are involved.** If you suspect that your patient's children are being abused and/or neglected then you must follow your state's reporting laws. Your abused patients with children are particularly vulnerable to on-going domestic violence. Many women fear that if they try to leave their abuser, he will take her children. In addition, some women have been forced to be financially and socially dependent on their abusers, and they have very real fears of not being able to financially care for their children if they leave their abusers. Some women will tell you that their abuser never hurts the children. Being sensitive to their concerns is important. You can help them by gently educating them about the harm to children that domestic violence causes.

In addition, because you are aware of the services available in your community, you can assure your patients that there is help for both them and their children.

- **She just keeps going back.** There are many reasons why many women (and men) do not leave their abusers or they leave only to return. Some of the more common reasons include the fact that most abusers will beg their partners to stay and to give them another chance. The abusers will tell their partners that they will never hurt them again. Many make other promises such as stopping drinking and going to counseling. Often abusers will convince their victims that the abuse is the victims' fault. Most of the victims fell in love with the people that are now abusing them. They often want their relationships to work and they hold out hope that their abusers will change. In addition, for many women, leaving is difficult because they do not have adequate income, they fear that their children will be placed in foster care, or they will lose their homes. Also, many abusers threaten to kill their partners (or kill pets, other family members) if they ever leave. All of these reasons are rooted in reality. It is important to validate your patients' choices while at the same time continuing to assess their safety, provide information and referral, and offer support when they are ready to accept it. If your patient is suffering from mental health and/or substance abuse problems, continue to encourage her to follow through with treatment for these disorders. Always be sure that your patient has a safety plan.

## Make Your Setting a Domestic Violence Prevention Focused Environment

- Place domestic violence prevention posters in your examination rooms and in the bathrooms.
- Keep domestic violence prevention pamphlets in your examination rooms and in the waiting areas.
- Keep palm cards in your bathrooms.
- Have your staff get domestic violence training from your local domestic violence organization or an on-site source.

## References

Cole TB. Is domestic violence screening helpful? *JAMA*. 2000;284(5):551-553.

Tjaden PG, Thoennes NCANIoJ, Centers for Disease C, Prevention. *Full report of the prevalence, incidence, and consequences of violence against women: findings from the National Violence Against Women survey*. Washington, DC: U.S. Dept. of Justice Office of Justice Programs National Institute of Justice; 2000.

Waalén J, Goodwin MM, Spitz AM, Petersen R, Saltzman LE. Screening for intimate partner violence by health care providers. Barriers and interventions. *Am J Prev Med*. 2000;19(4):230-237.



## CME Exam

1. Which of the following is **NOT** a clinical reason for screening all veterans for a history of military sexual trauma?
  - a. Women usually appreciate being asked by their providers about sexual trauma
  - b. Sexual trauma can affect utilization of healthcare
  - c. Primary care providers can apply Exposure Therapy techniques to treat MST survivors in the primary care setting
  - d. Men often do not seek help if not asked about sexual trauma
2. Which of the following symptoms are **NOT** documented to be more frequent among women with sexual trauma histories?
  - a. Low back pain
  - b. Swallowing difficulties
  - c. Pelvic pain
  - d. Rash
3. Which of the following statements is true?
  - a. Sexual trauma is associated with increased use of medical services.
  - b. Women with sexual trauma histories are more likely to use mental health services than medical services.
  - c. Combat trauma is more likely to lead to PTSD than sexual trauma.
  - d. As long as your patient is getting mental health treatment, you do not need to know about a history of MST.
4. Which of the following procedures **are least likely** to increase PTSD symptoms for individuals with a history of MST?
  - a. Colonoscopies
  - b. Pelvic exams
  - c. Blood pressure checks
  - d. Dental procedures
5. When VA primary care clinicians screen men and women for MST, they find that:
  - a. About half who screen positive are women; half who screen positive are men
  - b. Most individuals who screen positive for MST are women
  - c. Most individuals who screen positive for MST are men
  - d. About 50% of male VA patients have a history of MST

6. When screening a patient for MST, VA primary care clinicians should:
  - a. Screen only patients who have PTSD or another psychiatric condition
  - b. Use specific words like "rape" or "sexual assault"
  - c. Avoid negative questioning techniques
  - d. Assure that only female clinicians screen female patients
7. If a patient screens positive for MST, the primary care provider should:
  - a. Write a report of contact
  - b. Offer the patient a mental health referral
  - c. Contact a mental health provider urgently
  - d. Encourage the patient to provide lots of specific details about what happened during the traumatic experience
8. Provider boundaries in providing health care to patients can best be defined as:
  - a. The scope of professional practice
  - b. The expected and accepted psychological and social distance between providers and their patients
  - c. Communicating personal information to the patient
  - d. Being available to patients with MST after working hours
9. Which of the following is **NOT** a characteristic of many men who have experienced MST?
  - a. Shame about not fending off the attack
  - b. Feels threatened in a VA setting
  - c. Doubts own masculinity
  - d. Greater reliance upon the assistance of others
10. Which of the following types of therapy does **NOT** have strong empirical support for its effectiveness as a treatment for PTSD?
  - a. Cognitive-behavioral therapy
  - b. Exposure therapy
  - c. Hypnosis
  - d. Paroxetine
11. Which of the following statements is **NOT** true about the importance of service-connection for veterans?
  - a. Service-connection increases impoverished veterans' odds of accessing and using VA medical services.
  - b. Service-connection compensation accounts for a substantial proportion of disabled veterans' total family income.
  - c. Service-connection carries symbolic meaning for some veterans, including validation of past service, trials and tribulations while in the service, and resulting disablement.
  - d. Service-connection is sufficiently important to veterans that the majority will exaggerate or even invent symptoms in order to obtain it.



12. Which of the following statements about the consequences of applying for VA disability benefits on the basis of military sexual trauma is **NOT** true?
- a. Veterans' existing medical or psychiatric illnesses might be exacerbated by going through the C&P process.
  - b. Veterans may have to disclose the details of their military sexual trauma in a stressful, non-therapeutic environment.
  - c. Veterans may feel betrayed, invalidated, or disbelieved if they do not receive service-connection.
  - d. Veterans will receive more money over the course of their lifetime if they delay the filing of their disability claims.
13. Which of the following is **NOT** an appropriate action for a primary care provider when managing the care of a veteran with military sexual trauma?
- a. Discussing the pros and cons of applying for VA disability benefits and helping the veteran reach an informed decision in this regard
  - b. Persuading an indecisive veteran to file a claim as soon as possible so that s/he will get more compensation
  - c. Documenting in the medical record information about diagnoses and symptoms that might plausibly be related to military sexual trauma
  - d. Supporting the veteran through the stress of the C&P process by arranging a mental health referral
14. Which of the following statements is **NOT** true about the consequences of revictimization?
- a. Interpersonal difficulties associated with sexual trauma tend to be more severe in people who have experienced repeated victimization.
  - b. Sexually revictimized women are more likely to have a lifetime diagnosis of PTSD than women victimized once.
  - c. Sexually revictimized individuals develop psychological resiliency so that they are better able to cope with subsequent assaults.
  - d. Sexually revictimized individuals are more likely to engage in high-risk sexual behavior than individuals who have been assaulted once.

15. Which of the following statements is **NOT** true about why some individuals remain in physically abusive relationships?
- The longer the duration of the relationship, the more committed individuals tend to be to staying in relationships even when abuse occurs.
  - Individuals often remain in physically abusive relationship because they lack the financial and housing resources needed to help them to leave.
  - Individuals frequently remain in physically abusive relationships because they were abused as children, and psychologically have a need to repeat these prior trauma experiences.
  - Individuals remain in physically abusive relationships because they believe their perpetrator's promises to change and they believe that the violence will cease.
16. People who have experienced abuse...
- almost always disclose this information spontaneously
  - are **NOT** likely to disclose this information spontaneously
  - usually do **NOT** want to be asked about this
  - usually will **NOT** disclose this information if asked
17. Which is the best way to ask about intimate partner violence?
- Ask the patient's partner: "are you hurting or have you threatened your partner?"
  - Ask the patient: "you're not being hurt or threatened, are you?"
  - Ask the patient: "are you in a relationship with a person who physically hurts or threatens you?"
  - Ask the patient: "are you experiencing domestic violence?"
18. Immediately after a patient states that she has experienced MST, an appropriate initial response by the clinician might be:
- "Were you drunk at the time?"
  - "I'm sorry that happened to you."
  - "People like you often do have such experiences."
  - "Do you have any proof that it happened?"
19. Which of the following mental health consequences is **NOT** commonly associated with sexual assault?
- PTSD
  - Anxiety
  - Malingering
  - Depression
20. Which of the following is **NOT** part of the management of acute rape?
- Suicide assessment
  - Counseling about sexually transmitted disease risks
  - Immediate reporting to local authorities of all rape cases
  - Identifying where definitive management and evidence collection will occur

21. Which of the following is **NOT** a potential consequence of ignoring signs of burnout?
- Increased risk of physical ailments
  - Increased effectiveness at work
  - Work dissatisfaction
  - Psychological distress
22. Enthusiastic urging of a reluctant patient with MST to accept a mental health referral:
- Will facilitate the patient's resolution of his or her ambivalence about the referral
  - Will increase the likelihood of a positive outcome even if the patient only goes along with the referral to please the provider
  - Will decrease the likelihood of an open discussion about the patient's reservations
  - Will definitely cause irreparable damage to the patient
23. Which strategy is most helpful in responding to a patient's fears about mental health referral?
- Minimize the patient's fear by reassuring the patient that there is nothing to be afraid of.
  - Recognize that the patient's fears are the result of distortions and therefore, avoid talking about them.
  - Drop the subject as soon as the patient expresses concern about a mental health referral.
  - Explore reasons for the patient's concerns and address any misconceptions.
24. Which of the following is **NOT** a potential boundary violation?
- Providing the patient with educational materials about MST
  - Spending more time with the patient than is customary
  - Self-disclosure about the clinician's own family situation
  - Consenting to the patient's request for treatments outside the clinician's scope of practice
25. What can be done to help minimize difficult interpersonal interactions in the care of survivors of MST?
- Clinicians should show patients they care by accommodating the patient's request for after-hours appointments
  - When a patient resists a treatment recommendation, the clinician should recommend the treatment more emphatically
  - To prevent angry outbursts, it often helps to assure that patients have as much control over the clinical encounter as possible
  - Clinicians should avoid mental health referral, which might further alienate the patient

26. What should a primary care clinician do if a patient dissociates while the clinician is examining her breast?
- Reach out and hold the patient's hand until she calms down
  - Call her name loudly into her ear
  - Stop the exam and attempt to reorient the patient
  - Call for a stat mental health consult
27. Which of the following is **NOT** a clinical clue that a patient may be experiencing a PTSD flare caused by medical interventions?
- Withdrawn affect
  - Irritability
  - Anxiety
  - Delusions of grandeur
28. VA's MST Counseling & Treatment benefit, which is based upon Public Laws 102-585, 103-452, and 106-117:
- assures that, if a VA clinician determines that the veteran's current symptoms are related to or consequences of MST, the veteran can receive MST counseling in VA without co-payment obligation
  - requires that the veteran successfully prove to the Compensation & Pension Board that he/she experienced MST
  - requires that the veteran provide military records to the clinician proving that an MST took place
  - applies only to female MST survivors
29. Which of the following is **NOT** a potential mechanism for the association between MST and physical illness?
- Chronic neuroendocrine dysregulation following trauma
  - Increased health risk behaviors following trauma
  - Injuries sustained during the assault
  - Lower rates of somatization disorders in sexual trauma survivors
30. Which of the following is a recommended strategy when screening for MST?
- Arrange to have the clerk ask all patients about a history of MST
  - Leave the door open while interviewing the patient
  - Introduce the line of questioning with a general statement, such as, "Violence is common in our society, so I ask all my patients about this."
  - Inform the patient that he should have reported the military sexual assault immediately to his supervisor