

Military Sexual Trauma and Sexual Health: Practice and Future Research for Mental Health Professionals

Ryan Holliday, MA; Stacy Bonds, MS; and Rush Williams, PhD

Mental health professionals should assess for risk of sexually transmitted infections in both male and female patients who have experienced military sexual trauma.

About 24% of women and 1% of men will experience military sexual trauma (MST) during their service.¹ Despite the higher percentage of women reporting MST, the estimated number of men (55,491) and women (72,497) who endorse MST is relatively similar. Military sexual trauma is associated with negative psychosocial (eg, decreased quality of life) and psychiatric (eg, posttraumatic stress disorder [PTSD], depression) sequelae. Surís and colleagues provided a full review of sequelae, with PTSD being the most discussed consequence of MST.² However, sexually transmitted infections (STIs) during or after MST are a consequence of growing concern.

SEXUALLY TRANSMITTED INFECTIONS

The link between sexual trauma and increased incidence of STIs is well established. Survivors of rape are at a

higher risk of exposure to STIs due to unprotected sexual contact that may occur during the assault(s).³ Numerous studies have demonstrated that sexual trauma is directly related to greater engagement in risky sexual behaviors (eg, more sexual partners, unprotected sex, and “sex trading”).^{2,4}

This relationship is particularly concerning given that individuals in the military tend to report sexual trauma with greater propensity than that reported in civilian populations.⁴ Additionally, military personnel and veteran populations tend to engage in high-risk behaviors (eg, alcohol and drug use) more often than their civilian counterparts, increasing their potential susceptibility to predatory sexual trauma(s) and victimization.^{2,5} Taken in aggregate, military personnel and veterans may be at increased risk for STIs compared with the civilian population due to the increased incidence of risky sexual behavior and sexual traumatization during

military service.

Sexually transmitted infections potentially lead to immediate-term (eg, physical discomfort, sexual dysfunction) and long-term (eg, cancer, infertility) adverse health consequences.⁶ Early detection is crucial in the treatment of STIs because it can aid in preventing STI transmission and allow for early intervention. See Table for a list of common STIs and their prevalence, testing method, method of sexual transmission, and treatment. Early detection is also important because many STIs may be asymptomatic (eg, HIV, human papillomavirus [HPV]), which decreases the likelihood of seeking testing or treatment as well as increases the likelihood of transmission.⁷

Current Research

To date, only 1 study has explicitly examined the relationship between MST and STIs. In 2011, researchers analyzed a large national database of 420,725 male and female Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans.⁶ In the study, both male and female OEF/OIF veterans who endorsed MST

Mr. Holliday is a clinical psychology doctoral candidate at University of Texas Southwestern Medical Center and a PTSD research coordinator at VA North Texas Health Care System, both in Dallas. **Ms. Bonds** is a counseling psychology doctoral candidate at the University of North Texas in Denton. **Dr. Williams** is a clinical psychologist at the Counseling and Psychological Services at Columbia Health-Columbia University in New York City.

Table. Most Common Sexually Transmitted Infections^a

Sexually Transmitted Infection	Annual Prevalence	Testing	Transmission	Treatment
HPV ^b	14 million ^c	No current testing method, can screen for HPV-related cancers	Vaginal, anal, oral sex; skin-to-skin contact	No current treatment, focus on managing and removing visible warts, body's immune system clears HPV naturally in 90% of cases, vaccine protects against some but not all strands
Chlamydia	3 million	Testing body fluid or urine	Vaginal, anal, oral sex	Antibiotics
Trichomoniasis	> 1 million	Physical exam; may include wet prep, culture, or molecular testing	Genital sex; uncommon to infect hands, mouth, or anus	Antibiotics
Gonorrhea	> 800,000	Testing body fluid or urine	Genital, oral, or anal sex	Antibiotics
Genital herpes ^d	800,000	Blood test, viral culture	Genital, oral, or anal sex	No cure, current medications focus on preventing and shortening outbreaks as well as decreasing likelihood of spreading infection
Syphilis	55,000	Blood test, direct visual inspection using microscopy	Direct contact with syphilis sore during vaginal, anal, or oral sex	Antibiotics
HIV	41,000	Blood or oral fluid test	Vaginal, anal, or oral sex	No cure, antiviral therapy slows progression to AIDS, medications also exist that decrease likelihood of transmission

Abbreviation: HPV, human papillomavirus.

^aInformation based on CDC estimates and recommendations; other STIs that may occur but are less common include chancroid, lymphogranuloma venereum, mycoplasma genitalium, pubic lice, and scabies. (For further information, including symptoms associated with each STI, please refer to <http://www.cdc.gov/std>.)

^bMultiple types of HPV, information is based on the most common strands.

^cMost common STI, estimated that nearly all sexually active men and women will have HPV during their life.

^dTwo types of genital herpes viruses.

were significantly more likely than those who did not endorse MST to have a STI diagnosis. The researchers noted that this finding underscored the necessity for sexual health assessment in survivors of MST, to facilitate early detection and treatment.

STI Risk Assessment

Because military personnel and veterans often initially disclose their MST to a mental health provider (MHP), these providers operate in a unique circumstance where they may be the individual's first point of contact for determining STI risk. In these circumstances, the MHP should consider the

utility of briefly assessing the patient's sexual health and making subsequent medical referrals as necessary.

To accurately assess a patient's STI risk, the MHP should gather information regarding both current/acute risk (eg, "Have you had unprotected sexual contact, for instance, genital contact without a condom or oral sex without a dental dam, in the past month?") as well as longer standing (eg, "Have you had unprotected sexual contact... in the past year?") STI risk. Providers also should consider oral, anal, and genital modes of sexual contact as well as common STI symptoms (eg, warts, sores, geni-

tal discharge, and/or pain or burning sensation when peeing or during sex). Additionally, psychoeducation should be provided, especially information regarding the asymptomatic nature of certain STIs, such as HIV and HPV, and the risk of transmission in all forms of sexual contact, including nongenital anal contact. Appropriate referrals to sexual health education, including safe sex practices, also should be considered in order to minimize risk of future STI transmission.

Mental health providers also should determine the date of patient's most recent STI test. Not all

STIs can be detected via a blood test or routine yearly Papanicolaou (Pap test) physicals. Additionally, MHPs should be aware that risky practices, including substance misuse, are more common in survivors of MST and that there is an association between substance misuse and STIs.^{2,6} If testing has not occurred recently, MHPs should strongly encourage the individual to access STI testing and provide resources as necessary, such as access to low-cost STI testing. Further, if the MHP has reason to suspect the presence of an STI after the brief assessment (eg, individual endorses unprotected sexual contact or risky behaviors, including substance misuse, sex trading, and STI symptomatology; a positive STI test but the patient has not accessed treatment), an appropriate sexual health referral should be made.

During the assessment and psychoeducation processes, terminology and language plays an integral role. If a MHP assumes an individual has sexual contact only with opposite sex partners (eg, asking a male “How many women have you had sexual contact with in the past 30 days?” vs “How many partners have you had sexual contact with in the past 30 days?”), the MHP will not accurately assess the individual’s level of current risk. Additionally, it is important to remember that sexual behavior does not always align with sexual identity: A man who identifies as heterosexual may still have sexual contact with men. Due to the sensitive nature of sexual health, MHPs should be careful to use nonjudgmental language, such as using the term *sex work* rather than the more pejorative term *prostitution*, to avoid offending patients and to increase their likelihood to disclose sexual health information.

Nonjudgmental language is es-

pecially relevant when working with gender-minority veterans (eg, transgender, gender nonconforming, gender transitioning), because this clinical population has a higher risk of victimization and lower rates of help-seeking health behavior.⁷ In particular, a sizable portion of individuals who identify as transgender do not seek services out of fear that they will be discriminated against, humiliated, or misunderstood.⁷ To assuage these concerns, MHPs should ensure they refer to the veteran with the veteran’s preferred pronouns. For example, a MHP could ask “I would like to be respectful, how would you like to be addressed?” or “What name and pronoun would you like me/us to use?” Providers also should consider nonbinary pronouns when appropriate (eg, singular: ze/hir/hirs; plural: they/them/theirs). Providers also should recognize that making a mistake is not uncommon, and they should apologize to maintain rapport and maximize the patient’s comfort during this distressing process. Further, MHPs should consider additional training, education, and/or consultation if they feel uncomfortable or ill prepared when working with gender-minority veterans.

FUTURE RESEARCH

Research has attempted to understand the consequences of MST on sexual health; however, despite these efforts, more research is necessary. The majority of published studies have focused on females even though a similar number of males have reported MST.² This dearth of published studies likely is due to hesitation by male active-duty personnel and veterans to disclose or seek treatment for MST and because the percentage of females reporting MST is much higher. Males are less likely to report or seek treatment for MST

because of stigma-based concerns (eg, shame, self-blame, privacy concerns).^{8,9} Therefore, it is difficult to acquire a sizable research sample to study. As previously noted, a single study has specifically examined MST and STI risk. Although this study included a sizable population of male OEF/OIF veterans, results have yet to be replicated in other clinical populations of interest, such as male military personnel and male veterans of other service eras.

Research is even more limited regarding lesbian, gay, bisexual, transgender, and other gender-minority military personnel and veterans. Although researchers propose that these populations may experience a similar, or even heightened, likelihood of MST during their service, no empirical research yet exists to fully examine this hypothesis.^{10,11} It is important to note that the paucity of research attention may be related to the Don’t Ask, Don’t Tell (DADT) policy, which obstructed the open discussion and empirical examination of sexual and gender minorities within military populations.¹¹ The DADT policy led to limited awareness and greater stigmatization among sexual- and gender-minority personnel, resulting in poorer sexual health outcomes in these populations.^{10,11} With the end of DADT in 2011, it is now imperative for future research to examine the prevalence and associated consequences of MST in sexual- and gender-minority military personnel and veterans.

CONCLUSION

The DoD and VA should be commended for their continued focus on understanding the health consequences of MST. These efforts have yielded substantial information regarding the negative effects of MST on sexual health; in particular, increased

risk for STIs. These findings suggest that MHPs may, at times, be the first point of contact for MST-related sexual health concerns. These providers should be aware of their ability to assess for STI risk and make appropriate referrals to facilitate early detection and access to treatment. Despite the presence of MST-related sexual health research, continued research remains necessary. In particular, a broader focus that includes other genders (eg, male, transgender) and sexual minorities would further inform research and clinical practice. ●

Author disclosures

The authors report no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of Federal Practitioner, Frontline Medical Communications Inc., the U.S. Government, or any of its agencies.

REFERENCES

1. Military Sexual Trauma Support Team. *Military sexual trauma (MST) screening report fiscal year 2012*. Washington DC: U.S. Department of Veterans Affairs, Office of Patient Care Services, Mental Health Services; 2013.
2. Suris A, Holliday R, Weitlauf JC, North CS; the Veteran Safety Initiative Writing Collaborative. Military sexual trauma in the context of veterans' life experiences. *Fed Pract*. 2013;30(suppl 3):16S-20S.
3. Jenny C, Hooton TM, Bowers A, et al. Sexually transmitted diseases in victims of rape. *N Eng J Med*. 1990;322(11):713-716.
4. Senn TE, Carey MP, Venable PA, Coury-Doniger P, Urban MA. Childhood sexual abuse and sexual risk behavior among men and women attending a sexually transmitted disease clinic. *J Consult Clin Psychol*. 2006;74(4):720-731.
5. Schultz JR, Bell KM, Naugle AE, Polusny MA. Child sexual abuse and adult sexual assault among military veteran and civilian women. *Mil Med*. 2006;171(8):723-728.
6. Turchik JA, Pavao J, Nazarian D, Iqbal S, McLean C, Kimerling R. Sexually transmitted infections and sexual dysfunctions among newly returned veterans with and without military sexual trauma. *Int J Sex Health*. 2012;24(1):45-59.
7. National LGBT Health Education Center. Affirmative care for transgender and gender non-conforming people: best practices for front-line health care staff. <https://www.lgbthealtheducation.org/wp-content/uploads/2016/12/Affirmative-Care-for-Transgender-and-Gender-Non-conforming-People-Best-Practices-for-Frontline-Health-Care-Staff.pdf>. Published 2016. Accessed February 16, 2017.
8. Morris EE, Smith JC, Farooqui SY, Suris AM. Unseen battles: the recognition, assessment, and treatment issues of men with military sexual trauma (MST). *Trauma Violence Abuse*. 2014;15(2):94-101.
9. Turchik JA, Edwards KM. Myths about male rape: a literature review. *Psychol Men Masc*. 2012;13(2):211-226.
10. Mattocks KM, Kauth MR, Sandfort T, Matza AR, Sullivan JC, Shipherd J. Understanding health-care needs of sexual and gender minority veterans: how targeted research and policy can improve health. *LGBT Health*. 2014;1(1):50-57.
11. Burks DJ. Lesbian, gay, and bisexual victimization in the military: an unintended consequence of "Don't Ask, Don't Tell"? *Am Psychol*. 2011;66(7):604-613.