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Victims of military sexual trauma—you see them, too

Sexual assault while serving in the military is not uncommon, and the effects linger long after veterans are home—and seeing civilian physicians like you.

PRACTICE RECOMMENDATIONS

› *Routinely question veterans about physical and sexual assault.* (C)

› *Suspect a history of military sexual trauma (MST) in veterans who present with multiple physical symptoms.* (B)

› *Screen patients with a history of MST for posttraumatic stress disorder and other psychiatric comorbidities.* (B)

Strength of recommendation (SOR)

(A) Good-quality patient-oriented evidence

(B) Inconsistent or limited-quality patient-oriented evidence

(C) Consensus, usual practice, opinion, disease-oriented evidence, case series

CASE ▶ A 29-year-old veteran (whom we'll call Jane Doe) served as a medical corpsman in Iraq and has been pursuing a nursing degree since her honorable discharge a year ago. She comes in for a visit and reports a 3-month history of depression without suicidal ideation. In addition, Ms. Doe says, she has had abdominal pain that waxes and wanes for the past month. The pain is diffuse and nonfocal and appears to be unaffected by eating or bowel movements. She is unable to identify a particular pattern.

The patient has no significant medical or psychiatric history, and a physical examination is unremarkable. You advise her to follow a simplified dietary regimen, avoiding spicy foods and limiting dairy intake, and schedule a follow-up visit in 2 weeks.

Since 2002, some 2.4 million US troops have served in Iraq and Afghanistan,[1] creating a new generation of veterans who need broad-based support to recover from the physical and psychological wounds of war. All too often, those wounds include sexual assault or harassment, collectively known as military sexual trauma (MST).

MST is a growing concern for the Veterans Administration (VA) for a number of reasons—an increase in women on the front lines and greater media coverage of patterns of sexual assault in the military among them.[2] The official lifting of the ban on women in combat announced by the Pentagon in January brought the issue to the forefront, as well.[3]

In fact, MST should be a concern not only for clinicians within the VA, but also for civilian physicians. There are nearly 22 million American veterans, and the vast majority (>95%) get at least some of their medical care outside of the VA system[4]—often in outpatient facilities like yours.[5] Family physicians need to be aware of the problem and able to give veterans who have suffered from sexual trauma the sensitive care they require.

The scope of the problem? No one is sure

How widespread is MST? That question is not easily answered. The prevalence rate among female service members is 20% to 43%,[6] according to internal reports, while studies outside the military have reported rates that range from 3% to as high as 71%.[5] In a recent anonymous survey of women in combat zones, led by a VA researcher—widely reported but still undergoing final review—half of those surveyed reported sexual harassment and nearly one in 4 reported sexual assault.[7]

There are far less data on rates of MST among male service members. The documented prevalence rate for men is 1.1%, with a range of 0.03% to 12.4%, but these figures are based on internal reports of sexual harassment and assault.[8]

Military culture and personal history are key factors

While the rate at which MST is reported has increased over the past 30 years,[8] many reasons for not reporting it—stigma, fear of blame, accusations of homosexuality or promiscuity, and the threat of charges of fraternization among them—still remain.[8,9] Military culture is still male-dominated, with an emphasis on self-sufficiency that often leaves victims of MST feeling as though they have nowhere to turn.

There are also circumstances military members face that can aggravate the effects of sexual trauma. Soldiers on deployment are typically isolated from their normal support systems, under significant pressure, and unable to leave their post, which often means they have ongoing exposure to the abuser.

A history of childhood sexual abuse (CSA). As many as 50% of female service members (and about 17% of military men) have reported CSA,[10] compared with 25% to 27% of women and 16% of men outside of the military.[5,11] That finding may be partially explained by data showing that nearly half of women in the military cited escaping from their home environment as a primary reason for enlisting.[12]

Women in the military who have a history of CSA, however, face a significantly higher risk for MST than servicewomen who were not sexually assaulted as children.[8] Among female Navy recruits, for example, those who reported CSA were 4.8 times more likely to be raped than those who had no history of CSA.[13]

Combat-related trauma further complicates the picture. Evidence suggests that exposure to childhood physical and sexual abuse was associated with increased risk for combat-related posttraumatic stress disorder (PTSD) among men who served in Vietnam[14] and women who served in Operation Desert Storm.[15]

Broaching the subject should be routine

Primary care physicians can play an important role in helping veterans transition back to their civilian lives and local communities, starting with a holistic medical assessment. When you see a patient whose return is relatively recent, inquire about his or her experiences during deployment. It is important to ask specifically about traumatic experiences, and to routinely screen for MST.

CASE ▶ When Ms. Doe returns. you begin by asking about her mood, using open-ended, nondirective questions. She responds by admitting that she had left important information off of the intake form she filled out on her last visit—most notably, a history of CSA. You gently ask about her experiences in the military, particularly during the year she spent in Iraq—and whether anything happened there that you should know.

Haltingly and with much emotion, the patient tells of her experience with another soldier. She worked with him every day, she says, and had grown close to him. One evening things went further than she expected. At first, it was only kissing, but then he forced himself on her sexually. She has not told anyone else about this event, Ms. Doe confides, because she wasn't sure whether she precipitated it and felt embarrassed and humiliated by her choice to trust this man.

She did not feel that her supervising officers would listen or understand, as romantic attachments are best avoided in a combat zone and daily injuries are the norm. She says that her role as a medic kept her focused on

In a recent survey of women in combat zones, half reported sexual harassment and nearly one in 4 reported sexual assault.

TABLE 1

Primary care PTSD screen (PC-PTSD)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

— Have had nightmares about it or thought about it when you did not want to?

— Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

— Were constantly on guard, watchful, or easily startled?

— Felt numb or detached from others, activities, or your surroundings?

A Yes response to any 3 questions is a positive screen, indicating a need for further investigation and possible referral to a mental health professional.

PTSD, posttraumatic stress disorder.

Source: National Center for PTSD. http://www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp.

Why does military sexual assault go unreported? Stigma, fear of blame, accusations of homosexuality or promiscuity, and the possibility of being charged with fraternization.

the pain of others and enabled her to avoid looking at her own situation.

Evidence has shown that, like Ms. Doe, most survivors of trauma do not volunteer such information, but will often respond to direct and empathic questions from their physician.[16] Routine screening of all veterans for MST, which the VA recommends, has been shown to increase their use of mental health resources.[17,18] This can be easily incorporated into a medical history or an intake questionnaire, using this simple 2-question tool:[17,18]

While you were in the military:

- Did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks?
- Did anyone ever use force or the threat of force to have sexual contact with you against your will?

Screen for PTSD, and consider other psychiatric disorders

MST has been found to confer a 9-fold risk for PTSD. Indeed, more than 4 in 10 (42%) women with a history of MST have a PTSD diagnosis.[19] Thus, if the screen for MST is positive—as indicated by a Yes answer to either question—follow up with the 4-question Primary Care PTSD screen (**TABLE 1**) is recommended.[20]

Veterans with a history of MST are twice as likely as other veterans to receive a mental health diagnosis;[17] they're also more likely to have 3 or more comorbid psychiatric conditions.[21] Women appear to be more likely than men to suffer from depression, eating disorders, substance abuse,[22] anxiety disorders,[21] dissociative disorders, and personality disorders.[17]

Research on the mental health consequences of sexual assault in men (in any setting) is limited, however, and data on male survivors of MST are particularly sparse. What is known is that men who have experienced sexual trauma have higher rates of alcohol abuse[23] and self-harm[24] than women with a history of sexual trauma, and that MST has a greater association with bipolar disorder, schizophrenia, and psychosis in men.[17]

Multiple physical symptoms are often trauma-related

Veterans with a history of MST are also more likely to report physical symptoms[25] and to have a lower health-related quality of life,[26] poorer health status, and more outpatient visits[12] than vets who were not exposed to MST. And, while pelvic pain is widely believed to be associated with female sexual abuse, survivors often present with a wide range of physical problems. The most common symptoms, similar to those affecting civilian rape survivors, include headache, gastrointestinal (GI) problems, chronic fatigue, severe menopause symptoms, and urological problems, as well as pelvic pain and sexual problems.[27] Cardiac and respiratory disorders are also common (**TABLE 2**).[17,25]

TABLE 2

Common physical symptoms reported by female MST survivors*[17,25]

Reproductive/gynecological • Dysmenorrhea • Severe premenstrual symptoms • Menometrorrhagia • Chronic pelvic pain	**Pulmonary** • Sinus congestion • Allergies • Cough
GI • Indigestion • Diarrhea and constipation • Dysphagia/odynophagia • Irritable bowel syndrome	**Neurologic/rheumatologic** • Severe headache • Chronic back pain • Knee/foot pain/aching/stiffness
Other • Chronic fatigue • Vision problems • Hearing problems • Weight loss	**CVD/CVD risk factors** • HTN • Obesity • Sedentary lifestyle • Alcohol use problem • Smoking • Hysterectomy <40 y

*This is a selection of the symptoms and risk factors MST survivors present with; it is not an exhaustive list.
CVD, cardiovascular disease; GI, gastrointestinal; HTN, hypertension; MST, military sexual trauma.

Half of all female soldiers report childhood sexual abuse, and 49% cite escape from their home environment as a primary reason for enlisting.

Compared with their unaffected counterparts, women with a history of MST are more likely to be obese and sedentary, to smoke and drink, and to have had a hysterectomy before the age of 40 years.[28] They are also more than twice as likely as other female veterans to say that they were treated for a heart attack within the past year.[25] Data on the physical symptoms of male survivors of MST are extremely limited, but one study found an association with pulmonary and liver disease and human immunodeficiency virus and acquired immune deficiency syndrome.[17]

A cluster of nonspecific findings?

Patients with a history of MST often present with complex and nonspecific signs and symptoms, making it difficult for a primary care physician to arrive at a diagnosis. MST and combat-related trauma should be considered in such cases, as well as in veterans who present with complaints involving multiple organ systems.[21,25]

Refer, treat—or do both

Once you have evidence that a patient is a survivor of MST, you need to consider a mental health referral or consultation and address physical symptoms. All honorably discharged veterans are eligible to receive VA treatment for MST, regardless of their disability rating or eligibility for other services. If a veteran indicates that he or she would like to seek psychotherapy or see a specialist outside of the VA system, it will fall to you to help the patient find the most appropriate treatment. (You'll find links to VA and nonmilitary resources in the box on page 124.) Either way, patient acuity is a guide to the optimal approach.

Inpatient treatment will likely be needed for a patient who reveals thoughts of self-harm or harming others. If the patient is safe

Military sexual trauma: VA and nonmilitary resources

Department of Veterans Affairs

Military sexual trauma
www.mentalhealth.va.gov/msthome.asp

National Center for PTSD
www.ptsd.va.gov

Vet center
www.vetcenter.va.gov

Women Veterans Health Care
www.womenshealth.va.gov/womenshealth/trauma.asp

Other resources:

American Psychiatric Association
www.psych.org

American Psychological Association
www.apa.org

Give an Hour
www.giveanhour.org

National Alliance on Mental Illness Veterans Resource Center
www.nami.org/veterans

"The Invisible War," an Academy Award-nominated documentary about military sexual trauma, can be seen on DVD or at community screenings (invisiblewarmovie.com).

and stable enough for outpatient treatment, a therapist or psychiatrist with experience in treating sexual trauma is a good first step. Cognitive behavioral therapy and trauma-focused therapy have both been shown to have good outcomes in patients with sexual trauma and PTSD.[29] Depending on the individual's key presenting issues, a consultation with a substance abuse specialist, gynecologist, or other specialist may be helpful, as well.

As a family physician, you are in a position to build a long-term, trusting relationship with such a patient, which may be therapeutic in itself.[9] In building such a relationship, keep in mind that the experience of serving in the military could make a patient particularly sensitive, or resistant, to your advice; you'll need to strive for a collaborative approach.

CASE ▶ You tell Ms. Doe that the incident she described was indeed sexual violence—and specifically known as military sexual trauma. Her feelings about it are likely surfacing now due to the time away from the military—and by the fact that she's beginning to date. In addition to spending some time listening to her story, you advise Ms. Doe to start seeing a therapist. You suggest she consider VA treatment services, and direct her to its MST web site (www.mentalhealth.va.gov/msthome.asp). Before she leaves, you make it clear that you will continue to see and support her through this difficult time, and you schedule a follow-up visit. JFP

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