

1-1-2014

Military Sexual Trauma and Mental Health Diagnoses in Female Veterans Returning from Afghanistan and Iraq: Barriers and Facilitators to Veterans Affairs Care

Kelly H. Koo

Shira Maguen

Follow this and additional works at: <https://repository.uchastings.edu/hwlj>

Recommended Citation

Kelly H. Koo and Shira Maguen, *Military Sexual Trauma and Mental Health Diagnoses in Female Veterans Returning from Afghanistan and Iraq: Barriers and Facilitators to Veterans Affairs Care*, 25 *Hastings Women's L.J.* 27 (2014).
Available at: <https://repository.uchastings.edu/hwlj/vol25/iss1/3>

This Article is brought to you for free and open access by the Law Journals at UC Hastings Scholarship Repository. It has been accepted for inclusion in *Hastings Women's Law Journal* by an authorized editor of UC Hastings Scholarship Repository. For more information, please contact wangangela@uchastings.edu.

Military Sexual Trauma and Mental Health Diagnoses in Female Veterans Returning from Afghanistan and Iraq: Barriers and Facilitators to Veterans Affairs Care

Kelly H. Koo and Shira Maguen***

I. INTRODUCTION: FEMALE VETERANS AND MILITARY SEXUAL TRAUMA

Currently, there are approximately two million female veterans, and the number of women separating from military service has doubled in the past twenty years.¹ According to the United States Department of Defense

*Kelly H. Koo, Ph.D., is a postdoctoral research fellow in women's mental health at the San Francisco VA Medical Center (SFVAMC) and Department of Psychiatry, UCSF School of Medicine. Dr. Koo completed her predoctoral internship at the VA Palo Alto Health Care System and her doctoral training in clinical psychology at the University of Washington, Seattle. Overall, her research focuses on understanding the influences of culture and gender on mental health, especially among racially diverse and female veterans with PTSD. She recently completed a NIH NIAAA predoctoral research grant examining cultural contexts of alcohol-involved rape disclosure among diverse college women. She is also clinically treating female veterans for PTSD and other anxiety and mood disorders with evidence-based treatments in the women's health clinic at the SFVAMC. Dr. Koo also provides multicultural and bias awareness trainings to develop cultural humility in the service of providing culturally competent care to diverse populations.

**Shira Maguen, Ph.D., is an Associate Professor in the Department of Psychiatry, UCSF School of Medicine and a Staff Psychologist on the Posttraumatic Stress Disorder Clinical Team at the San Francisco VA Medical Center. Her research interests fall under the umbrella of PTSD and include risk and resilience factors in veterans, with a particular focus on female veterans. Dr. Maguen is the recipient of a VA Health Services Research and Development Grant that examines the impact of killing in veterans of war. She has three additional grants that examine mild TBI and PTSD in OIF/OEF veterans, a novel treatment for veterans who have killed in war, and trauma-related eating problems in female veterans. She has recently completed a grant that examines PTSD and co-morbid conditions in OIF/OEF female veterans. Dr. Maguen is the author of numerous peer-reviewed publications, most of which focus on veteran mental health. She also works in a clinical capacity, treating veterans with evidence-based treatments for PTSD and working within the context of an OEF/OIF Integrated Care Clinic.

1. LORY MANNING, *WOMEN IN THE MILITARY: WHERE THEY STAND* 32–33 (WREI, 8th ed. 2013).

(DOD), women represented over 205,000 of active duty military personnel in 2010.² Women represent 15% of active duty, 17% of National Guard/Reserve personnel, and 20% of new recruits, and comprise 12% of the total number of personnel who served in Iraq and Afghanistan.³ About 17% of female veterans use the United States Department of Veterans Affairs (VA) services and more than 50% of these women have a service-connected disability. While women currently comprise only 5.9% of all VA health care users, the number of female veterans using VA care has increased 83%, from 159,630 in 2000 to 292,921 in 2009, while male veterans using VA care increased by only 50%.⁴ The percentage of female veterans is expected to double from 2010 to 2040.⁵

Given the growing number of women in the military who are accessing VA care, it is important to understand the unique stressors that female veterans experience to best prepare for their care. Military sexual trauma (MST) is one such stressor that will be the focus of this paper. More so than men, women who serve in the military are at increased risk for MST⁶ and MST is linked to various mental and physical health sequelae that require treatment and care. VA can provide this care, but in order to best serve this rising population of female veterans, all professionals who interact with this group would benefit from recognizing and increasing their awareness of prevalence rates and the effects of MST, VA resources and eligibility to receive VA care, and barriers and facilitators of this care.

Because the focus of this paper is on female veterans, we will use the pronoun “she” throughout, but it is critical to note that both men and women can experience MST.

A. MST DEFINITIONS AND PREVALENCE ESTIMATES

Military sexual trauma (MST) is the term used by VA and the DOD to refer to either sexual assault or repeated unwanted threatening sexual harassment that occurred during a veteran's military service. MST includes any sexual activity in which someone is involved against her will. She may have been pressured or physically forced into sexual activities or unable to consent. For example, she may have been pressured into sexual activities

2. U.S. Census Bureau, *Statistical Abstract of the United States: 2012—Table 510 Department of Defense Personnel: 1960 to 2010*, http://www.census.gov/compendia/statab/cats/national_security_veterans_affairs/military_personnel_and_expenditures.html (last visited Oct. 3, 2013).

3. MANNING, *supra* note 1, at 32.

4. Dept. of Veterans Affairs & National Center for Veterans Analysis and Statistics, *America's Women Veterans: Military Service History and VA Benefit Utilization Statistics* vi (2011), http://www.va.gov/vetdata/docs/SpecialReports/Final_Womens_Report_3_2_12_v_7.pdf.

5. Office of the Actuary, *Veteran Population Projections: FY2010 to FY2040* (2013), http://www.va.gov/vetdata/docs/QuickFacts/Population_slideshow.pdf.

6. Amy E. Street et al., *A New Generation of Women Veterans: Stressors Faced by Women Deployed to Iraq and Afghanistan*, 29 *CLINICAL PSYCHOL. REV.* 685–94 (2009).

with threats of negative consequences for refusing to be sexually cooperative or with implied better treatment in exchange for sex. An example of lack of consent to sexual activity can be an inability to provide consent while intoxicated. Sexual activities include unwanted sexual touching or grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse. Other experiences that fall into the category of MST include threatening, offensive remarks about a person's body or sexual activities, and threatening and unwelcome sexual advances. The identity or characteristics of the perpetrator, whether the service member was on or off duty at the time, and whether she was on or off base at the time do not matter. If these experiences occurred while an individual was on active duty or active duty for training, they are considered to be MST.

Rates of MST have been reported based on different samples. According to data collected from the DOD that were reported in 2011, there were 3,192 reports of sexual assault, an increase from 2010 when 3,158 sexual assaults were reported.⁷ Despite the increase in reports, this number is still likely to be a gross underestimate as there have been an estimated 19,000 reports of assaults per year. Fifty-six percent of surveyed active duty military personnel reported at least one experience of sexual harassment, sexual assault, and/or challenges to sexual identity against gender roles.⁸ Among reservist samples, at any time during military service, sexual harassment rates were 60% among women and 27% among men; physical sexual harassment/sexual assault rates were 23% among women and 3% among men.⁹ Among VA samples, 55% of female veterans reported sexual harassment at any time during military service,¹⁰ and 3% of women and 1% of men reported sexual assault at any time during their service.¹¹

B. MST AND OEF/OIF/OND VETERANS

With a recent influx of veterans returning from Iraq and Afghanistan who served during Operation Enduring Freedom (OEF; predominantly in Afghanistan), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND; both predominantly in Iraq), MST rates and associated risk factors

7. U.S. Department of Defense, *Fact Sheet on Department of Defense Annual Report on Sexual Assault in the Military for Fiscal 2011* 1 (2012), <http://www.defense.gov/news/sexualassaultannualreportfactsheet.pdf>.

8. Maureen Murdoch et al., *The Association Between Military Sexual Stressors and Psychiatric Symptoms after Controlling for Other Stressors*, 44 J. PSYCHIATRIC RES. 1129 (2010).

9. Amy E. Street et al., *Sexual Harassment and Assault Experienced by Reservists During Military Service: Prevalence and Health Correlates*, 45 J. REHABILITATION RES. DEV. 414 (2008).

10. Katherine M. Skinner et al., *The Prevalence of Military Sexual Assault Among Female Veterans' Administration Outpatients*, 15 J. INTERPERSONAL VIOLENCE 298 (2000).

11. Rachel Kimerling et al., *The Veterans Health Administration and Military Sexual Trauma*, 97 AM. J. PUB. HEALTH 2160 (2007) [hereinafter Kimerling 2007].

are important to note. In OEF/OIF/OND veterans seeking VA care, 15% of women and less than 1% of men reported a history of MST.¹² Among women, a history of MST was significantly associated with younger age, Hispanic ethnicity, higher education levels, middle income level, high utilization of VHA in the past year, service connection, fair/poor health status, no Medicare coverage or health insurance, and a mental health clinic visit.¹³

Among OEF/OIF/OND veterans with PTSD who were seeking VA care, gender differences in MST and comorbid mental health diagnoses have been reported.¹⁴ Thirty-one percent of female and 1% male OEF/OIF/OND veterans with PTSD reported MST.¹⁵ MST was associated with being over four times as likely to have a PTSD diagnosis for women and nearly three times as likely for men.¹⁶ MST was also associated with higher rates of comorbid mental health diagnoses in these nearly returning veterans.¹⁷ Female veterans with PTSD and MST were more likely to have comorbid depression (75% of women were diagnosed with PTSD and depression), anxiety (42%), and eating disorders (4%) than their male counterparts, while men with PTSD and MST were more likely than their female counterparts to have alcohol use disorder (27% of men).¹⁸ Among these OEF/OIF/OND female veterans with PTSD, when comparing those with and without MST, MST was associated with comorbid depression, substance use, anxiety, alcohol use and eating disorders.¹⁹ These findings are significant given that comorbid disorders results in poorer mental health outcomes²⁰ and increased healthcare utilization among the general population²¹ and veterans from OEF/OIF/OND.²²

12. Rachel Kimerling et al., *Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning from Afghanistan and Iraq*, 100 AM. J. PUB. HEALTH 1409 (August 2010) [hereinafter Kimerling 2010].

13. Rachel Kimerling et al., *Military Sexual Trauma and Patient Perceptions of Veteran Health Administration Health Care Quality*, 21 WOMEN'S HEALTH ISSUES J. S. 147 (2011) [hereinafter Kimerling 2011].

14. See generally Shira Maguen et al., *Gender Differences in Military Sexual Trauma and Mental Health Diagnoses Among Iraq and Afghanistan Veterans With Posttraumatic Stress Disorder*, 22 WOMEN'S HEALTH ISSUES e61–e66 (2012).

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. *Id.*

20. See Gerardo Gonzalez & Robert A. Rosenheck, *Outcomes and Service Use Among Homeless Persons with Serious Mental Illness and Substance Abuse*, 53 PSYCHIATRIC SERVICES 437 (2002).

21. Chung-Hsuen Wu et al., *Mental Health Resource Utilization and Health Care Costs Associated with Race and Comorbid Anxiety Among Medicaid Enrollees with Major Depressive Disorder*, 104 J. OF THE NAT'L MED. ASS'N 86 (2012).

22. Shira Maguen et al., *Gender Differences in Health Service Utilization Among Iraq and Afghanistan Veterans with Posttraumatic Stress Disorder*, 21 J. WOMEN'S HEALTH 671–72 (2012).

Overall, MST has been found to be associated with poorer physical health such as obesity, weight loss, and hypothyroidism for women,²³ readjustment problems after discharge, e.g., difficulties finding work, alcohol and drug problems,²⁴ greater incidence of not working due to mental health problems, disrupted relationships with family and friends,²⁵ and greater healthcare utilization.²⁶ Treating MST-related conditions is critical for the overall health of female OEF/OIF/OND veterans, particularly since recent research has demonstrated that when female veterans and service members are effectively treated for PTSD, they reported improvements in work-related quality of life.²⁷

II. RECEIVING MST-RELATED CARE AT VA

The U.S. Department of Veterans Affairs (VA) oversees care and benefits for those who served in the military. In more recent years, VA has passed laws and procedures specific to MST in order to ensure that appropriate care was provided for the mental and physical sequelae of MST. Starting in 1992, U.S. Congress passed a series of laws mandating that VA monitor MST screening and treatment for sequelae of MST,²⁸ provide free care for conditions related to MST, and provide staff with training on MST-related issues.²⁹ Additionally, VAs can provide evidence-based treatments for mental health conditions resulting from MST and also have providers who specialize in women's healthcare and/or comprehensive women's clinics that specialize in providing gender-separate care.

The first step to receiving VA care for sequelae of MST is the veteran must either disclose/report the incident or screen positive to questions behaviorally describing MST. Mandated universal screening for MST began in 2000³⁰ using the following two-item screener: "While you were in

23. Kimerling 2007, *supra* note 11, at 2164.

24. Lori S. Katz et al., *Women Who Served in Iraq Seeking Mental Health Services: Relationships Between Military Sexual Trauma, Symptoms, and Readjustment*, 4 PSYCHOL. SERVICES 239–249 (2007).

25. Kristin M. Mattocks et al., *Women at War: Understanding How Women Veterans Cope with Combat and Military Sexual Trauma*, 74 SOC. SCI. & MED. 543 (2012).

26. Rachel Kimerling et al., *Evaluation of Universal Screening for Military-Related Sexual Trauma*, 59 PSYCHIATRY SERVICES 638 (2008).

27. Paula P. Schnurr & Carole A. Lunney, *Work-Related Outcomes Among Female Veterans and Service Members After Treatment of Posttraumatic Stress Disorder*, 63 PSYCHIATRIC SERVICES 1072–79 (2012).

28. A. M. Suris et al., *A Survey of Sexual Trauma Treatment Provided by VA Medical Centers*, 49 PSYCHIATRIC SERVICES 382–84 (1998).

29. Susan J. McCutcheon & Joanne Pavao, *Resources for Military Sexual Trauma (MST) Survivors* (2011), <http://www.va.gov/WOMENVET/2011Summit/Breakout-ResourcesforMSTSurvivors2011.pdf>.

30. Jessica A. Turchik et al., *Utilization and Intensity of Outpatient Care Related to Military Sexual Trauma for Veterans from Afghanistan and Iraq*, 39 J. BEHAV. HEALTH SERVICES & RES. 221 (2012).

the military: (1) Did you receive unwanted sexual attention, such as touching, cornering, pressure for sexual favors or verbal remarks? (2) Did someone ever use force or threats of force or punishment to have sexual contact with you when you did not want to?" A veteran must then be diagnosed with a mental health condition related to the MST. Afterward, she is referred to an appropriate program to treat the condition. There are no requirements to have reported the incident(s) or to have any documentation of the MST. In other words, veterans who disclose or screen positive for MST are not required to "prove" that it occurred.

There are additional resources that may apply to certain cases. Every VA facility has a designated MST Coordinator who is responsible for facilitating veterans' access to MST-related care and serves as a point person for MST issues at that facility. There are also resources available that exist outside VA. Within the DOD, there is the Sexual Assault Prevention and Response Office (SAPRO), but SAPRO does not handle sexual harassment and thus not all MST. SAPRO differentiates types of sexual assault reporting, including unrestricted (which results in an investigation as well as treatment and services) and restricted reporting (which allows for services and increased confidentiality around the reporting without investigation).³¹ Another resource available to veterans with MST is Vet Centers, which also provide evidence-based treatments for sequelae of MST. Vet Centers are affiliated with VA but do not share its records with VA nor with the DOD. The confidentiality of records protects against the potential barrier of harmful consequences against their careers that some veterans fear when receiving mental health care.³²

While these resources and policies were put in place to facilitate veterans' care for sequelae of MST, disclosure of MST is necessary in order to receive this care. Unfortunately, many veterans do not initially arrive to treatment ready to disclose their MST, even when screened. Highly relevant to veterans, sexual assault victims who have a higher risk of negative psychological outcomes (such as those with childhood sexual trauma and complex trauma histories) and those who were raped by someone they knew are more likely to delay disclosure of sexual assault experiences.³³ Anecdotally, we find this to be true among veterans who can

31. Sexual Assault Prevention and Response Office, *Department of Defense Sexual Assault Prevention and Response Program Overview and Initiatives* 1, 2 (2013), <http://www.defense.gov/news/DoDSexualAssaultPreventionandResponseInitiatives.pdf>.

32. Gina P. Owens et al., *A Preliminary Investigation of Mental Health Needs and Barriers to Mental Health Care for Female Veterans of Iraq and Afghanistan*, 15 *TRAUMATOLOGY* 32–33, 35, 36 (2009); Dawne Vogt, *Mental Health-Related Beliefs as a Barrier to Service Use for Military Personnel and Veterans: A Review*, 62 *PSYCHIATRIC SERVICES* 136, 137 (2011).

33. Barbara Duffy Stewart et al., *The Aftermath of Rape: Profiles of Immediate and Delayed Treatment Seekers*, 175 *J. NERVOUS & MENTAL DISEASE* 93 (1987); Sarah E. Ullman, *Social Support and Recovery from Sexual Assault: A Review*, 4 *AGGRESSION & VIOLENT BEHAV.* 343–58 (1999).

wait weeks, months, or even years to disclose their MST, only after developing a strong enough rapport with their providers.³⁴ Thus, it is not uncommon for a veteran with an MST history to initially be treated for a mental health condition that, unbeknownst to the provider, may seem unrelated to MST, and only later does her MST history emerge.

A. BARRIERS TO CARE

There is evidence to suggest that some veterans with MST are utilizing VA care. In 2012, 896,947 health care outpatient visits were designated as MST-related, and every VA facility provided at least one instance of MST-related care.³⁵ However, despite efforts to improve accessibility to MST-related care, barriers to care persist.

Independent of military involvement, for all victims of sexual trauma, barriers to care lie in a tendency to not report nor seek help. The majority of sexual assault survivors do not report the incident to formal systems.³⁶ Disclosure of any sexual trauma is challenging for several reasons including shame, embarrassment, guilt, fear of not being believed, fear of others' judgments and blame, and distrust of the criminal justice system.³⁷

Although there is sparse literature that addresses general barriers to health care for veterans, little research specifically addresses barriers to treatment of MST-related mental health conditions for female veterans and even less focuses on veterans from OEF/OIF/OND. In a review on barriers to general mental health care for veterans and military personnel, public stigma and personal beliefs about general mental health treatment were consistently reported as barriers to service utilization,³⁸ particularly for OEF/OIF/OND veterans.³⁹ Presumably then, barriers to MST-related care may be even more challenging, given that a label of sexual trauma is additionally stigmatizing.⁴⁰ In an empirical study on stigma and help-seeking attitudes among veterans with PTSD diagnoses, greater concerns

34. E-mail from Nancy E. Herzoff, MST Coordinator, San Francisco VA Medical Center, to authors (Oct. 17, 2012, 14:44 PST) (on file with authors).

35. Department of Veterans Affairs, Military Sexual Trauma Support Team, *Summary of Military Sexual Trauma-Related Outpatient Care*, Fiscal Year 2012 (2013).

36. U.S. Department of Justice, Office of Justice Programs et al., *Reporting of Sexual Violence Incidents*, <http://www.nij.gov/topics/crime/rape-sexual-violence/rape-notification.htm> (last visited Oct. 3, 2013); U.S. Department of Justice, Office of Community Oriented Policing Services, *Acquaintance Rape of College Students* 1, 4 (Aug. 2003), available at <http://www.cops.usdoj.gov/pdf/e03021472.pdf>.

37. Janice Du Mont et al., *The Role of "Real Rape" and "Real Victim" Stereotypes in the Police Reporting Practices of Sexually Assaulted Women*, 9 VIOLENCE AGAINST WOMEN 468 (2003).

38. Vogt, *supra* note 32, at 137.

39. Charles W. Hoge et al., *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care*, 351 NEW ENG. J. MED. 16, 20–21 (2004); Tracy Stecker et al., *An Assessment of Beliefs About Mental Health Care Among Veterans Who Served in Iraq*, 58 PSYCHIATRIC SERVICES 1358, 1360 (2007).

40. Du Mont et al., *supra* note 37.

with stigma were related to initiating counseling at VA Vet Centers and unrelated to initiating psychotherapy for PTSD at VA outpatient clinics⁴¹ indicating that stigma did not serve as a barrier. These authors suggested that because they also found that few participants received eight or more sessions of psychotherapy, stigma may have affected continuing treatment rather than initiating treatment. Although significant findings, they did not consider MST status. More research on the relationship between mental health stigma and use of treatment is needed,⁴² particularly with female veterans with MST from OEF/OIF/OND. Additional barriers to VA care use for both male and female veterans are difficulty navigating the system⁴³ and longer wait times and paperwork.⁴⁴

For female veterans, perceptions of lack of availability of services predicted decreased use of mental health care,⁴⁵ and female veterans also expressed greater concerns about fitting in at VA which may serve as another potential barrier to VA care.⁴⁶ However, both of these did not specifically consider MST status, again indicating that more research focusing on barriers to VA care for female veterans with MST is needed.

Although not extensively reviewed here, it is important to note that culturally-specific barriers to care for minority veterans from all war eras have also been studied.⁴⁷ Despite increased research efforts to understand this pattern, this work has not yet focused on MST status among diverse female OEF/OIF/OND veterans. This is a significant research gap considering beliefs around sexuality and attitudes toward rape and sexual assault vary by culture.⁴⁸

For individuals who were actively serving when assaulted, military culture may decrease the likelihood of a military sexual trauma being reported. The military has large power differentials with distinct

41. Craig S. Rosen et al., *Stigma, Help-Seeking Attitudes, and Use of Psychotherapy in Veterans With Diagnoses of Posttraumatic Stress Disorder*, 199 J. NERVOUS & MENTAL DISEASE 879–85 (2011).

42. Vogt, *supra* note 32.

43. Mark S. Bauer et al., *Perceived Barriers to Health Care Access in a Treated Population*, 35 INT'L J. PSYCHIATRY IN MED. 23 (2005).

44. JoAnn Damron-Rodriguez et al., *Accessibility and Acceptability of the Department of Veteran Affairs Health Care: Diverse Veterans' Perspectives*, 169 MILITARY MED. 245 (2004); Joseph Westermeyer et al., *Perceived Barriers to VA Mental Health Care Among Upper Midwest American Indian Veterans*, 40 MED. CARE I–66 (2002).

45. Dawne Vogt et al., *Barriers to Veterans Health Administration Care in a Nationally Representative Sample of Women Veterans*, 21 J. GEN. INTERNAL MED. 21 (2006).

46. Paige Ouimette et al., *Perceived Barriers to Care Among Veterans Health Administration Patients with Posttraumatic Stress Disorder*, 8 PSYCHOL. SERVICES 212, 216, 217 (2011).

47. Damron-Rodriguez et al., *supra* note 44, at 249; see Westermeyer et al., *supra* note 44 at I-66-I-69.

48. Leah E. Adams-Curtis & Gordon B. Forbes, *College Women's Experiences of Sexual Coercion: A Review of Cultural, Perpetrator, Victim, and Situational Variables*, 5 TRAUMA, VIOLENCE, & ABUSE 91–92 (2004).

hierarchies⁴⁹ and is a traditionally male-dominated system. Thus, it is particularly challenging for a woman in the military to report a male perpetrator, particularly if he is a superior. Among female civilians, there is evidence to suggest that disclosure of sexual assault is even less likely when a negative reaction is expected,⁵⁰ and when loyalty to her unit is valued, it may be that she believes reporting a perpetrator within her unit may be discouraged by her peers.

Receiving care for health concerns related to MST requires disclosure of the MST. Requiring disclosure of sexual trauma to receive sexual trauma-related care is not a problem specific to VA or the military. However, veterans may perceive that VA health care providers are associated with the military, which may exacerbate the already low likelihood to disclose MST. Thus, it may be particularly complicated for female veterans to voluntarily disclose MST to VA health care providers, who may serve as reminders of the military.

Research on satisfaction of VA care highlighted additional potential barriers to care for veterans with a MST history.⁵¹ In a national survey of veterans receiving care at VA, overall, female veterans were generally satisfied with VA care (72.3% rated very good or excellent satisfaction);⁵² however, differences in satisfaction levels were found that may reveal barriers to continued care. For both men and women, lower overall satisfaction proportions were significantly associated with younger age, race other than White, fair/poor health status, being divorced or never married, and lack of service connection (VA disability status) or Medicare coverage.⁵³ When controlling for these and other patient characteristics, for women only, MST history was associated with lower satisfaction levels of overall coordination and education across multiple providers and with patients.⁵⁴ Thus potential barriers to continued care at VA for female veterans with MST may involve perceived poorer coordination of care between multiple providers and less communication between patient and provider. Moreover, independent of MST history, certain patient characteristics such as being an ethnic minority, single, or younger, or not having access to resources such as service connection and Medicare coverage are related to decreased satisfaction in VA care⁵⁵ and thus may point to additional barriers to care.

49. Street, Vogt & Dutra, *supra* note 9.

50. S. E. Ullman et al., *Exploring the Relationships of Women's Sexual Assault Disclosure, Social Reactions, and Problem Drinking*, 23 J. INTERPERSONAL VIOLENCE 1238, 1239 (2008).

51. Kimerling 2011, *supra* note 13, at S148.

52. Kimerling 2011, *supra* note 13, at S148.

53. Kimerling 2011, *supra* note 13, at S148.

54. Kimerling 2011, *supra* note 13, at S148.

55. Kimerling 2011, *supra* note 13, at S148.

B. FACILITATORS OF CARE

Notwithstanding potential barriers to care, there are also identified facilitators to receiving MST-related care at VA for female veterans. Female veterans are more likely than men to seek MST-related care and to have more MST-related visits in a one-year period.⁵⁶ Another facilitator of care involves policies on systematic levels. Given that civilian patients are not routinely screened for trauma history in general health care settings⁵⁷ and are unlikely to volunteer trauma histories,⁵⁸ screening for MST facilitates victims' use of resources. Certain facility policies increase the odds of patients receiving MST screening. Having mandatory universal MST screening policies was related to a nearly three-fold greater odds of being screened for MST for new female patients and new women patients at facilities with audit and feedback procedures were almost twice as likely to receive an MST screening. Among those facilities that housed a Women's Health Clinic (WHC), new and continuing patients who used a WHC had greater odds of being screened for MST compared with women who had not used a WHC.⁵⁹

Additionally, VA has implemented several policies to facilitate veteran care for sequelae of MST. One might assume a barrier to care would involve eligibility for and access to MST-related care. Independent of MST, to typically attain "veteran" status (and to receive free VA care for five years post-discharge), two years of active duty service or any deployment to a combat zone is required. However, within the VA system, all veterans with MST are eligible to receive services even if they are not eligible for other VA care. This also means that regardless of time served or combat exposure, anyone who served should be screened for MST and evaluated for sequelae of MST since they could be eligible for free VA care. All staff should be informed of these different eligibility requirements for MST-related care that are outside the scope of other VA care and to never assume someone is ineligible for care. Lack of awareness of these policies may become a barrier to care. This is also the case with other professionals as well. In other words, the more professionals, regardless of their field, who can identify MST and who are aware of

56. Turchik et al., *supra* note 30, at 228.

57. Claire Hurst et al., *Routine Questioning About Non-Consenting Sex: A Survey of Practice in Australian Sexual Health Clinics*, 14 INT'L J. STD & AIDS 330 (2003); Julie A. Pruitt & Ruth E. Kappius, *Routine Inquiry into Sexual Victimization: A Survey of Therapists' Practices*, 23 PROF. PSYCHOL.: RES. & PRAC. 475 (1992).

58. Kirsty Agar et al., *Identification of Abuse Histories in a Community Mental Health Centre: The Need for Policies and Training*, 11 J. MENTAL HEALTH 534 (2002); Lawrence S. Friedman et al., *Inquiry About Victimization Experiences: A Survey of Patient Preferences and Physician Practices*, 152 ARCHIVES OF INTERNAL MED. 1186-90 (1992); Jeanne McCauley et al., *Inside "Pandora's Box": Abused Women's Experiences with Clinicians and Health Services*, 13 J. GEN. INTERNAL MED. 554 (1998).

59. Jenny K. Hyun et al., *Organizational Factors Associated with Screening for Military Sexual Trauma*, 22 WOMEN'S HEALTH ISSUES E209-E215 (2012).

available resources and eligibility of care, the less barriers there are between each veteran and the care for which she is entitled.

Despite offering services for all veterans with conditions related to MST, this unfortunately does not necessarily provide a simple solution to treating these veterans' concerns. If an individual who served does not fulfill the standard requirements for "veteran" status (i.e., time served, or combat exposure, or had an other-than-honorable (OTH) discharge), in order to receive MST-related services, she must indicate she is requesting an evaluation for MST, requiring disclosure of her MST. Moreover, those with OTH discharge and who were not in combat could still be considered for MST-related care; however this would involve additional approval to attain veteran status, also requiring her acknowledgement under public law that she is requesting to be seen for MST, again necessitating MST disclosure. The challenges of disclosing *military* sexual trauma to a VA provider for a female veteran may be exacerbated by the involvement of the military, a historically male-dominated system with distinct and large power differentials, and by the involvement of the VA system, which is associated with the military. Indeed, providing care for MST-related conditions is complicated.

III. CONCLUSION AND FUTURE DIRECTIONS

With the rise in women serving in the US military and thus rise in female veterans who require care, professionals who interact with this group should be knowledgeable of the contexts of these women's experiences while serving, including MST, as well as the resources available to them. Incidence rates of MST are higher for women than men, with 15% of OEF/OIF/OND female veterans screening positive for MST,⁶⁰ and nearly one-third of OEF/OIF/OND female veterans with PTSD screening positive for MST.⁶¹ Veterans with MST are at greater risk for PTSD as well as comorbid disorders. VA has established regulations to improve access to care for the sequelae of MST, including mandating MST screenings and providing free care for all survivors of MST. However, barriers to care persist, including public stigma and personal beliefs about mental health treatment, perceived lack of coordination of care for female veterans with MST, and the need for disclosure of MST to receive care.

Future work should continue to research gender differences in barriers to care for OEF/OIF/OND veterans and gender differences in the development of mental health diagnoses among those with MST. In particular, prospective/longitudinal studies would be beneficial to understand the trajectories of mental health issues associated with MST. Moreover, studying risk and protective factors for the development of

60. Kimerling 2010, *supra* note 12, at 1410.

61. Maguen et al., *supra* note 22.

PTSD and other mental health diagnoses resulting from MST is critical. Examining other mental health and health diagnoses that female veterans are more likely to develop such as eating disorders and those relationships with PTSD and MST is also important. Investing in the development and implementation of evidence-based treatment protocols that target comorbid conditions with attention to MST is necessary to properly treat this group. It may also be fruitful to focus efforts on MST-related psychoeducation, resources, and reporting options for specific groups, given certain social risk factors of MST (such as younger age, Hispanic ethnicity, higher education levels and middle income level) are associated with a history of MST.⁶² Developing effective methods to prevent the perpetration of MST with all military personnel is crucial as well. Indeed, there are several areas where future work can be directed to address the needs of female OEF/OIF/OND veterans with MST.

Professionals in the legal field may find themselves interacting with a female veteran who discloses MST to them. With the information from this article, these legal professionals may now better understand the contexts of MST and free VA health care options for which she is likely eligible.

62. Kimerling 2011, *supra* note 13, at S147.