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A Systems Thinking Approach to Formulating the Problem of Military Sexual Trauma Among Black Female Veterans

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A SYSTEMS THINKING APPROACH TO FORMULATING THE PROBLEM OF MILITARY SEXUAL TRAUMA AMONG BLACK FEMALE VETERANS

by

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ABSTRACT

Minority veterans are one of the fastest growing veteran populations (Department of Veterans Affairs, 2020b). Research over the last fifty years has documented that minority veterans, especially Black female veterans, are at a disproportionate risk for many problems, such as suicide and military sexual trauma (MST) (Department of Veterans Affairs, 2020b). In order to adequately address problems faced by the Black female veteran population, I argue that the problem must first be adequately formulated by the veteran community and veteran leadership. In this dissertation, I review the current body of literature on military sexual trauma with a systems view, using Daniel Kim's (1999) iceberg model as a template. After developing a deeper understanding of the current reality from literature, I adopted Dave Snowden and Mary Boone's (2007) Cynefin framework to include the sensing and probing by Black female veterans in order for military and veteran leadership to make sense of and respond to complex problems that Black female veterans experience. I conclude that the Black female veterans must be incorporated as decision-makers, advisors, participants, and resources in order to more adequately formulate and address the problems they experience, such as suicide and military sexual trauma.

DEDICATION

"Wisdom is the principal thing; Therefore, get wisdom. And in all thy getting; get understanding" Proverbs 4:7

This dissertation is dedicated to the memory of my parents, Edith and Robert Benson. They stressed the importance of academic excellence as far back as I can remember. Without them, there would not have been this relentless pursuit of knowledge, wisdom, and understanding. To my wife, Aronda Smith-Benson, thank you for the love, support, and expertise in organizational development that ultimately led me to discover this amazing world of systems thinking—I love you more than butterflies. Last, I dedicate this dissertation to all of the African American female veterans who endured and survived military sexual trauma.

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To my son Chandler Jacobs, my daughter Kendall Reynolds and my granddaughter, Mckenzee Anne Maria Jackson, and a host of family and friends: There are no words that will ever be able to express what I feel in my heart for each of you.

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CHAPTER 1: INTRODUCTION

Minority veterans are one of the fastest growing veteran populations (Department of Veterans Affairs, 2020b). Currently, there are approximately 291,000 Black female veterans (Department of Veterans Affairs, 2020b, p. 52). Research over the last fifty years has documented that minority veterans, especially Black female veterans, are at a disproportionate risk for many problems, such as military sexual trauma (Department of Veterans Affairs, 2020b) and suicide (Kimerling et al., 2015; Kimerling et al., 2016).

Defining Military Sexual Trauma (MST)

Within the Department of Veterans Affairs (VA), military sexual trauma is defined as "psychological trauma . . . result[ing] from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training" (Department of Veterans Affairs, 2011, para. 1). An event or situation is traumatic if "it is extremely upsetting, at least temporarily overwhelms the individual's internal resources, and produces lasting psychological symptoms" (Briere & Scott, 2015, p. 5).

Research suggests that up to "81%–93% of female veterans have been exposed to trauma that includes childhood abuse and neglect, domestic violence, MST, and combat-related stress" (Kelly et al., 2014, p. 414). MST includes any sexual activity where the service member was involved against his or her will (Zinzow, Grubaugh, Monnier, Suffoletta-Maierle, & Frueh, 2007). This includes having been pressured with threats of negative consequences or implied better treatment, or unable to consent (such as when intoxicated, asleep, or unconscious), or physically forced into sexual activities (Schmid, 2020). In addition, Schmid (2020) notes that "[t]he identity or characteristics of the perpetrator, whether the service member was on or off duty at the time,

and whether he or she was on or off base at the time, do not matter. If these experiences occurred while [in the military], they are considered by VA to be MST" (p. 6).

Importantly, when defining MST, the DOD and VA make the distinction between sexual assault and sexual harassment. While acknowledging that there is a clear relationship between the two manifestations of MST, they note that "behaviors that constitute sexual harassment do not always rise to the level of criminal misconduct" (Schmid, 2020, p. 5), and it "requires a different response than the crime of sexual assault" (Schmid, 2020, p. 5). Sexual assault refers to "intentional sexual contact characterized by use of force, threats, intimidation, or abuse of authority or when the victim does not or cannot consent" (Department of Defense, 2014b, p. 109). Sexual harassment, however, is defined as "a form of sex discrimination that involves unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature" (Department of Defense, 2014b, p. 1). Finally, the VA also emphasizes that "MST is an experience, not a diagnosis" (Schmid, 2020, p. 6).

Operational Definitions

Key terminologies in this dissertation are Black, female and women, and veteran. Each is operationally defined below:

Black or African American - "Black or African American" refers to a person having origins in any of the Black racial groups of Africa. The Black racial category includes people who marked the 'Black, African American, or Negro' checkbox. It also includes respondents who reported entries such as African American; Sub-Saharan African entries, such as Kenyan and Nigerian; and Afro-Caribbean entries, such as Haitian and Jamaican. Sub-Saharan African entries are classified as Black or African American with the exception of Sudanese and Cape Verdean because of their

complex, historical heritage" (Rastogi, Johnson, Hoeffel, & Drewery, 2011, p. 2). The terms "Black" and "Black or African American" are used interchangeably in this dissertation.

Female and *Women* – refers to a person who identifies as being a female or women, either by sex or by gender, with sex being biological and gender being socially defined (Archer & Lloyd, 2002). Despite the difference, the terms "female" and "women" are used interchangeably in literature referring to female or women veterans. In some instances, however, LGBTQ+-conscious researchers have incorporated more fluidity when selecting these categories to include cis gender, transgender, non-binary, and other identities (Kerbal, 2019).

Veteran – is defined as "a person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable discharge" (Department of Veterans Affairs, 2019b, para. 3).

Formulating Problems

The Department of Veterans Affairs, the largest healthcare delivery system of integrated healthcare for veterans and a national leader in preventing veteran suicide in the United States (Department of Veterans Affairs, 2020b), is tasked with the challenge of serving this diverse population. To adequately serve the veteran population, including minority veterans, the problems that veterans experience need to be adequately understood, formulated, and addressed.

Wicked Problems

I argue that problems, such as suicide and military sexual trauma, can be classified as wicked problems. According to Tom Ritchey (2013), wicked problems are "ill-defined, ambiguous and associated with strong moral, political and professional issues" (p. 3) that are stakeholder-dependent, have "little consensus about what the problem is, let alone how to deal with it" (p. 3), and "[a]bove all, wicked problems . . . are sets of complex, interacting issues evolving in a dynamic

social context" (p. 3). Wicked problems "are 'wicked' not in the sense of being 'evil' but in that they are seriously devious and can have (nasty) unintended consequences for the planners who try to do something about them" (Ritchey, 2013, p. 3). Also, "wicked problems are not actually 'problems' in the sense of having well defined and stable problem statements, as they are too chaotic for this (Ritchey, 2013, para. 4). Because of complex interdependencies, the effort to solve one aspect of a wicked problem may reveal or create other problems. For this reason, they have also been called social messes (Horn, 2001) and unstructured reality (Ackoff, 1974). Characteristics and descriptions of wicked problems are presented in Table 1.

Table 1. Characteristics of Wicked Problems according to Starr (2020, p. 16)

1. "This kind of problem is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize"
2. "There is no definitive formulation of the problem because due to interdependencies the problem is not understood until after the formulation of a solution"
3. "Solutions are not right or wrong or true-or-false, but better or worse"
4. "Solutions are emergent; there are no experts who can solve this type of problem"
5. "Every complex, wicked or messy problem is essentially novel and unique"
6. "Every solution is a 'one shot operation'"
7. "This type of problem has no given alternative solutions"

MST as a Wicked Problem

Military sexual trauma (MST) exhibits all of Starr's (2020) characteristics of wicked problems. MST does not have a single predictable or preventable cause, making it difficult or impossible to solve (Department of Defense, 2019; Kimerling et al., 2015; Starr, 2020) (characteristic 1). There is also no definite formulation to adequately represent the cause of MST, as there are many interdependencies that are not well understood, such as rape culture, perpetrator behavior, and the views of men towards women (Department of Defense, 2019; Goodcase, Love, & Ladson, 2015; Starr, 2020) (characteristic 2). Decreasing the MST rate does not require right or

wrong answers, but just better answers, which might be emergent and not at the discretion of experts (Kimerling et al., 2015; Starr, 2020) (characteristics 3 and 4). Finally, each case of MST has interdependent circumstances that are essentially novel and unique (Department of Defense, 2019; Kimerling et al., 2015; Starr, 2020) (characteristic 5). Attempts to decrease MST rates require one-shot operations, as there are no given alternative solutions and only possible ones (Kimerling et al., 2015; Starr, 2020 (characteristics 6, and 7).

A wicked problem related to MST is suicide. Suicide is the act of ending one's own life. Research has shown that female veterans who have experienced MST have an increased risk for suicide (Blais & Monteith, 2018; Kimerling et al., 2015). Experiencing MST also increases risk of suicide for Black female veterans (Kimerling et al., 2015; Moye, 2020).

I argue that suicide in the veteran population also adheres to all of the characteristics described by Starr (2020). Veteran suicide is a wicked problem, because the act of suicide does not have a single predictable or preventable cause making it difficult or impossible to solve (Kimerling et al., 2015; Starr, 2020) (characteristic 1). There is also no definite formulation to adequately represent the cause of suicide, as there are many interdependencies that are not well understood, such as pre-military, in-military, and post-military trauma (Department of Defense, 2019; Kunkel & Guthrie, 2016; Starr, 2020) (characteristic 2). Decreasing the veteran suicide rate or stopping a suicide does not require right or wrong answers, but just better answers, which might be emergent and not at the discretion of experts (Department of Defense, 2019; Kunkel & Guthrie, 2016; Starr, 2020) (characteristics 3 and 4). Finally, each veteran suicide is essentially novel and unique and requires one-shot operations, as there are no given alternative solutions and only possible ones that emerge when handling a suicide or preventing suicide on a larger scale (Kimerling et al., 2015; Starr, 2020) (characteristics 5, 6, and 7).

Example of the Problem

In a recent attempt to solve the wicked problem of suicide among veterans in the military, the *Executive Order on National Roadmap to Empower Veterans and to End Suicide* (mentioned hereafter as the "national strategy") was issued on March 5, 2018 (Trump, 2018). The same year, the *National Strategy for Preventing Veteran Suicide (2018-2028)* was created (Department of Veterans Affairs, 2018). This document stated that "[s]uicide is a complex problem, and it requires coordinated evidence-based solutions that reach beyond the traditional medical model of prevention" (Department of Veterans Affairs, 2018, p.1). Not once was MST, a major risk factor for suicide in the Black female veteran population, and the disproportionate effect of race ever mentioned (Kimerling et al., 2015; Kimerling et al. 2016).

Two years into presenting this strategy, President Trump (2020) signed the *Executive Order on Race and Sex Stereotyping* that barred teaching and researching using critical race theory, and thereby is intended to inhibit the in-military discussion and conduction of Department of Veterans Affairs (VA) research on the race and sex dimension of suicide among Black female veterans following MST. The overlapping nature of these dimensions is nowhere to be found in a strategy purportedly aimed to "provide protective factors at the individual, community, and societal levels" (Department of Veterans Affairs, 2018, p. 6).

Most recently, President Biden (2021) signed the *Executive Order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government* that revokes Trump's previous executive order and thereby provides an indication of limited protection at the federal level of government.

The way suicide and MST are being handled by the United States Government is just one of many instances of their misunderstanding of complexity and failure to adequately formulate this

problem as it pertains to Black female veterans with a history of MST. How can the United States Government end suicide among all veterans if they are not considering the needs of this at-risk population (Kimerling et al., 2015; Kimerling et al., 2016)?

Given that there are roughly 291,000 (Department of Veterans Affairs, 2020b) Black female veterans and 3 per 100,000 black female veterans die by suicide annually (Czekalinski, 2012), 9 would die by suicide per year, and 72 would die by suicide before the end of the national strategy. While suicide rates for Black female veterans are lowest among all populations (Czekalinski, 2012), there is less disparity in suicide rates between veteran women (28.7 per 100,000 lives) and veteran men (32.1 per 100,000 lives) (Kimerling et al., 2016). Therefore, although Black female veterans have a high risk for suicide, few die by suicide. The low rate is believed to be associated with Afri-cultural coping mechanisms, such as spiritual and collective coping in religious or group-focused activities that evolved through coping with their historical trauma of slavery, prejudice, discrimination, and systemic injustices (Kimerling et al., 2016; Myers et al., 2015; Utsey, Bolden, Lanier, & Williams, 2007). Kimerling et al. (2016) also argue that Black women are more likely to condemn suicide because it is against their value system. The rates of suicides, however, may increase if the coping strategies are disrupted, such as with the COVID-19 pandemic and social distancing policies, and may thus increase to a level comparable to white women (Kimerling et al., 2016; Yancy, 2020).

Description of the Problem

Properly formulating this wicked problem is a pre-requisite to improving the situation. In

the example above, veteran leadership did not formulate the problem of suicide in Black female veterans as completely as they should have.

I argue that the crux of their problem formulation is the mindset of military leadership. Mindset is defined as "a fixed mental attitude or disposition that predetermines a person's responses to and interpretations of situations . . . an inclination or a habit" (Collins English Dictionary, 2013, p. 1). Mindset is important because it can affect the way a leader sees the world.

The military mindset, methods of problem formulation, and the way military leadership see the world have contributed to their misconceptualization of the nature of the problem of suicide among veterans and how they decide to act toward decreasing the problem. I suggest that the misconceptualization resulted because of how they see the world and their method of problem solving; misidentifying the domain of the problem by not acknowledging the complexity associated with the problem; and failing to recognize that the context is volatile, uncertain, complex, and ambiguous (VUCA).

How veteran leadership knows the world and their approach to solving the problem.

The way in which veteran leadership knows the world and their approach to solving problems has worked against them in the case of formulating veteran suicide. This concept can be described as with epistemology, which Starr (2018) defined as "the theory of knowledge [that] describes how people separate belief, what they hold to be true, from opinion, their view or judgment not necessarily based on knowledge or fact (p. 3). The following characteristics (described by Starr's (2018) Epistemology Framework) may be aspects of the mindset of veteran leadership, which include (1) leveraging their authority and power and using heuristics, (2) embracing of the evidence-based approaches and root-cause analysis, and (3) relying on reductionism (Starr, 2018).

Authority and power approach with heuristics.

Military and veteran leadership are in a position of authority and power that historically implies the need for concise and direct decision-making. Heuristics is one means used by veteran leadership to make decisions in a concise and direct manner.

A heuristic "is a strategy that ignores part of the information, with the goal of making decisions more quickly, frugally, and/or accurately than more complex methods" (Gigerenzer & Gaissmaier, 2011, p. 454). Examples of heuristics include trial and error, a rule of thumb, and an educated guess. Policies, such as the aforementioned executive order and national strategy, that veteran leadership are attempting to use to avoid or willfully ignore addressing the wicked problem of suicide in the Black female veteran population are also examples of heuristics (Hoppe, 2013).

Decision makers use heuristics to save time and effort through faster cognition and estimated guesses (Gigerenzer & Gaissmaier, 2011). In the military, heuristics is a primary framework for decision-making, and leaders often embrace the idea that they can command and control their way to problem resolution. In this command-and-control environment, decision-makers use their authority and power to release policies, which, like other trusted authoritative documents like the Bible, set rules and guidelines for all subordinates to follow (Blair, 2010; Hoppe, 2013). They are ultimately using these trusted documents to make authoritative choices.

The strategic plan and the executive order themselves are heuristics, and parts of the plan are also heuristics too. For example, by indicating broadly that there are "[v]eterans with increased suicide risk, gender and ethnic differences, social and economic factors, [and] genetic contributions" (Department of Veterans Affairs, 2018, p. 31), the specific Black female veteran population was overlooked. I suspect the exclusion to be more than just for sake of brevity, marketing, and copywriting fundamentals. The Black female veteran population was left out by

this rule-of-thumb approach, because they are not part of the rule of thumb. This heuristic also appears in government data, given that "[g]overnment data for suicide deaths among military personnel is not available by race" (Czekalinski, 2012, para 4.).

Heuristics can be problematic when used to solve problems that are more complicated than routine problems. In the military, misapplied heuristics can contribute to incompletely addressing the problem. In healthcare, heuristics can pose a similar challenge; due to the medical community's having quickly adopted the heuristics-and-biases view, leaving the use of heuristics mainly unrevised as of today (Elstein, 1999). As a result, these "mental shortcut[s] . . . can lead to faulty reasoning or conclusions" (Elstein, 1999, p. 791). The overuse of heuristics and its popularity (as exemplified by the policy) has contributed to a misconceptualization and lack of adequately formulating of this wicked problem, because Black female veterans, who were not part of their rule of thumb, were overlooked. This will be discussed in more depth later.

Veteran leadership as well as healthcare professionals are involved in the problem of veteran suicide. Healthcare professionals also embrace evidence-based, rule-of-thumb heuristics when making decisions for patients at the VA. Evidence-based approaches and how they factor into the way veteran leadership sees the world is discussed next.

Evidence-based approaches.

While heuristics are a primary approach used by veteran leadership to make decisions quickly, veteran leadership also embrace evidence-based approaches. Although these approaches are more precise than rule-of-thumb heuristics, in the case of veteran suicide, evidence-based approaches can also lead decision-makers to inadequately address the problem.

Evidence-based medicine is the "conscientious, explicit, judicious and reasonable use of modern, best evidence in making decisions about the care of individual patients" (Masic,

Miokovic, & Muhamedagic, 2008, p. 219). The national strategy noted that "suicide . . . requires coordinated, evidence-based solutions that reach beyond the traditional medical model of prevention" (Department of Veterans Affairs, 2018, p. 1). While the national strategy states that these evidence-based solutions are "not sufficient on [their] own" (Department of Veterans Affairs, 2018, p. 1) and merely "part of a broader solution" (Department of Veterans Affairs, 2018, p. 1), the fact that they used the term "evidence-based" suggests that they believe that there is a causal relationship between multiple factors and veteran suicide, that there is an answer to veteran suicide, and that suicide can be solved.

However, as described earlier, veteran suicide is a wicked problem, in which there is no specific causality. Once again, in the case of wicked problems, there is no right or wrong answer, only better or worse answers. The factors that correlate with wicked problems can also be explained in numerous ways, which may not necessarily be based on the past, due to the ever-changing environment in which the wicked problem exists.

Rittel and Webber (1973) indicate that "[t]he search for scientific bases for confronting problems of social policy is bound to fail, because of the nature of these problems" (p. 155). Policy problems "are 'wicked' problems, whereas science has developed to deal with 'tame' problems" (Rittel & Webber, 1973, p. 155). A policy, even supported by evidence, is therefore inefficient for adequately addressing a wicked problem.

Veteran leadership and veteran healthcare practitioners alike have a proclivity to over-rely on analysis of evidence-based results, based on what has happened in the past, in order to understand the current reality. Analysis is the process of breaking a complex topic or substance into smaller parts in order to gain a better understanding of it (Beaney, 2012).

More particularly, a military-condoned approach used by veteran leadership is root-cause analysis. Root-cause analysis "is a method of problem solving used for identifying the root causes of faults or problems" (Wilson, 1993, p. 8). The national strategy calls for a "zero-suicides strategy [that] requires health systems to conduct a root cause analysis of suicide attempts and deaths and to use findings to improve service quality by focusing on systemic issues rather than individual blame" (Department of Veterans Affairs, 2018, p. 26). Because there is no root cause to a wicked problem, veteran suicide is, in fact, a wicked problem, the veteran leadership, by using root-cause analysis, is again missing the opportunity to more fully understand and address the problem.

Reductionism.

Not only do veteran leadership over-rely on heuristics and believe wicked problems can be solved through evidence-based means or root-cause analysis, they also believe veteran suicide can be reduced down and understood through reductionism. Reductionism "is based on the assumption that any complex system can be decomposed into a set of indivisible components that operate independently of each other" (Clymer, 1994, p. 300).

The "reductionist mindset seeks to understand the world as a collection of separable and thus independent units and assumes linear cause-and-effect relationships between these units and that these relationships are reversible" (Rogers et al., 2013, p. 31). When using reductionism, one "sees the parts as paramount and seeks to identify the parts, understand the parts and work up from an understanding of the parts to an understanding of the whole" (Jackson, 2003, p. 3). A "system and its parts are, therefore, assumed to have an ultimately knowable structure and behavior" (Rogers et al., 2013, p. 31).

The national strategy notes that the Department of Veterans Affairs has adopted a systematic, four-step public health approach, used by the Centers for Disease Control, in

preventing suicide (Department of Veterans Affairs, 2018). The national strategy has reduced the solution down to a single approach and simple steps, such as defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption (Department of Veterans Affairs, 2018). While these steps can in fact be "one part of a broader solution, but not sufficient on [their] own" (Department of Veterans Affairs, 2018, p. 1), they do not provide alternative solutions that embody more elements of the diverse veteran population and their ever-changing environment. Their single approach and simple steps also start with evidence-based reductionism, and it is also likely that veteran leadership and healthcare practitioners will stick to what is comfortable and familiar to them, applying the four-step process to this wicked problem.

Reductionism and "[r]eductive thinking has dominated Western thought patterns for at least three centuries and can be traced back to Aristotle's 'logic' and then Descartes 'Rules for the Direction of the Mind'" (Rogers et al., 2013, p. 31), and has since "become such a societal habit that it is seldom questioned by the general populace and even many scientists" (Rogers et al., 2013, p. 31). Rogers et al. (2013) noted how "Descartes proposed that the only sound thinking practice was to isolate phenomena from each other and their environment and apply a process of reduction, simplification, and clarification based on a disjunctive logic of 'either/or,' which he borrowed from Aristotle" (p. 31). Rogers et al. (2013) continued that the "reductive thinking pattern, which rejects any form of integration, ambiguity, or paradox, became cemented in the Western way of life first by Newton and then by the industrial revolution" (p. 31).

Reductionism is an element of the scientific method developed by Sir Isaac Newton, which calls for "using experiments to break systems down into their simplest components, or building blocks, in order to understand them" (Rogers et al., 2013, p. 31). Rogers et al. (2013) indicated

that "[t]he belief that a system, and ultimately reality, is identifiable and knowable has very important implications for decision-making because it supports and legitimizes the notions that we can both 'get it right' and, if something goes wrong, 'reverse it'" (p. 31).

By taking a reductionist approach, veteran leadership make the assumption that "experts who can, given the right conditions, objectively provide decision-makers with knowable and, by implication, certain facts and answers" (Rogers et al., 2013, p. 31). In other words, veteran leadership assume that they can directly or indirectly solve the problem of veteran suicide by reducing it down to a root cause and using a four-step process to solve it. Even the notion that there is a "national roadmap" or a "national strategy" assumes that "our social–bio–physical reality is ultimately knowable and that paths into the future are mappable" (Rogers et al., 2013, p. 31).

Ironically, the executive order called for the development of "a comprehensive national public health roadmap for preventing suicide among our Nation's veterans, with the aspiration of ending veteran suicide once and for all [which] . . . must be holistic and encompass the overall health and well-being of our Nation's veterans" (Trump, 2018, p. 1). However, instead of holism, an opposing approach and mindset, the national strategy prescribed reductionism.

Jackson (2003) points out that holism "date[s] back thousands of years to Vedic sages of India who believed the world was an integrated whole, [hence] the concept of holism has been around for comparatively as long as reductionism" (p. 4). In contrast to reductionism, holism—a term coined by a South African statesman, military leader, and philosopher named Jan Smuts in 1926—considers that "[t]he whole emerges from the interactions between the parts, which affect each other through complex networks of relationships . . . [and] considers systems to be more than the sum of their parts" (Jackson, 2003, p. 4). Jackson (2003) also emphasizes that reductionism, unlike holism, "fails to cope with problems of complexity, diversity and change in complex

systems" (Jackson, 2003, p. 4). The fact that the veteran leadership prefer reductionism over holism suggests that their way of problem formulation is susceptible to a domain problem, which will be discussed next.

The domain problem.

The second factor that contributed to the veteran leadership's misformulation of veteran suicide is that they did not understand the domain of the wicked problem. Before discussing the domain problem, background needs to be provided in order to offer a deeper understanding of the contextual elements of the wicked problem. These include complex evolving systems, mess formulations, situational awareness and analysis, and sensemaking.

Complex evolving systems.

Veteran suicide is a wicked problem within a complex evolving system. Complex evolving systems "create novelty, self-organize, evolve, and adapt to a changing environment, usually generating more complexity in the process" (Heylighen, 1997, p. 31). The study of complex evolving systems "investigates the processes by which systems consisting of many interacting components change their own structure in response to external or internal pressures" (Heylighen, 1997, p. 31).

Systems, such as the Department of Veterans Affairs and the veteran's environment, can be ordered and unordered simultaneously. For example, the Department of Veterans Affairs can have a formal, ordered management hierarchy, but their decisions are driven, at least in part, by an informal influencing network, which is unordered. *Ordered* parts are elements within a system which have a formal structure that is organized, whereas *unorde*red parts describe elements of a system which are neither systematically ordered, nor completely disordered, but exhibit patterns or, sometimes, novel emergent entities and properties.

Mess formulation.

Within unordered elements of this complex evolving system, there could arise messes like wicked problems, which need to be adequately formulated in order to be more fully understood and addressed. A mess "is a system of interrelated threats and opportunities" (Ackoff, Gharajedaghi, & Finnel, 1984, p. 21). Formulating a mess "consists of identifying . . . current and future threats and opportunities and their interactions" (Ackoff, Gharajedaghi, & Finnel, 1984, p. 21). In an organizational context, leaders formulate messes in "order to close the gaps between where an organization is and where it wants to be" (Ackoff, 1999, p. 64). According to Ackoff (1999), leaders must know where the organization is, where the leadership wants it to be, where it is heading without behavioral changes, and what the internal and external obstructions are to organizational change.

Situational awareness and analysis.

To formulate a mess properly, leaders must understand the situation of the presenting problem(s) or mess(es). Within a military context, "good situational awareness equates to accurate perception of environmental elements key to mission success, the ability to quickly assess the meaning of these elements, and the ability to make quick and accurate projections about what is likely to occur in the immediate future" (Matthews et al., 2001, p. 351).

Situational analysis is important to acquiring a situational awareness. Situation analysis "requires relatively complete knowledge and understanding of the current state of the (problem) organization and its environment" (Ackoff, 1999, p. 63) and "requires identifying sources, seeking them out, soliciting and collecting their knowledge and understanding, and compiling it into a comprehensible form" (Ackoff, 1999, p. 63).

Part of situational awareness is projecting futures based on the factors of or measurements of the current situation. Ackoff (1999) referred to this as a reference projection. According to Ackoff (1999), a reference projection "consists of projection of the future of the organization based on two false assumptions: That there will be no change in corporate behavior and that the relevant future currently predicted by the organization is complete and correct" (Ackoff, 1999, p. 70).

According to a report published by the United States Department of Veterans Affairs (2016), which analyzed 55 million veterans' records from 1979 to 2014, an average of 20 veterans die from suicide per day (Department of Veterans Affairs, 2016). Considering that the national strategy covers from 2018 to 2028, and today (for estimate sakes) is January 1st, 2021, there would be 58,420 deaths by suicide from now until 2028.

The inadequate problem formulation of veteran suicide in the national strategy and executive order, which excluded mention of Black female veterans experiencing MST as a risk factor, suggests that the veteran leadership have either lack of understanding of the current reality of veteran suicide or are willfully disregarding parts of that reality. Through my research, I discovered that "[g]overnment data for suicide deaths among military personnel is not available by race" (Czekalinski, 2012, para. 4). It is difficult, then, to provide a future projection without population-level data.

In the absence of government data, I have used data from non-government sources. Czekalinski (2012) estimated that fewer than 3 per 100,000 Black women veterans will die annually by suicide, despite their increased risk of suicide (Kimerling et al., 2015). Given that there are roughly 291,000 (Department of Veterans Affairs, 2020b) Black female veterans, 9 would die by suicide per year and 72 would die by suicide before the end of the national strategy. This, however, does not mean their quality of life is satisfactory, as they are still at high risk of

suicide. More on why these numbers are comparatively low is discussed later. First, however, sensemaking theories require an introduction, so that the domain problem can be discussed.

Sensemaking.

In order to help make decisions about messes once they are formulated to one extent or another, decision-makers use sense-making theories and frameworks to help them react to the current conditions in their environment. Sensemaking, "a term introduced by Karl Weick, refers to how we structure the unknown so as to be able to act in it" (Ancona, 2012, p. 1). In the last fifty years, there have been many sense-making theories developed, such as those of Brenda Dervin (1983), Karl Weick (Weick & Sutcliffe, 2007), and Gary Klein (Klein, Moon & Hoffman, 2006). However, for the purpose of detailing the domain problem that veteran leadership seem to be experiencing, I have selected the sense-making conceptual framework of Dave Snowden (Snowden & Boone, 2007; Snowden et al., 2021) called the Cynefin framework.

The Cynefin framework.

Conceptual frameworks, such as the Cynefin framework, can be used to understand and make decisions about messes, elements, and conditions within ordered and unordered systems. A conceptual framework is a network of linked concepts, theories, and presumptions that can be used to help understand the elements of a phenomenon, phenomena, or a system.

Snowden and Boone's (2007) Cynefin framework recognizes that reality is unstructured and offers an approach that aids leaders in "shift[ing] their decision-making styles to match changing business environments" (p. 73). The Cynefin framework "allows executives to see things from new viewpoints, assimilate complex concepts, and address real-world problems and opportunities" (Snowden & Boone, 2007, p. 70). The Cynefin framework is "a protocol to help

leaders diagnose a situation by level of complexity, that is, a degree of unpredictability in a social system in which many individuals or groups interact" (Benjamin & Komlos, 2019, p. 5).

In the Cynefin framework, there are five contexts into which a situation can fall: simple, complicated, complex, chaotic, and disorder:

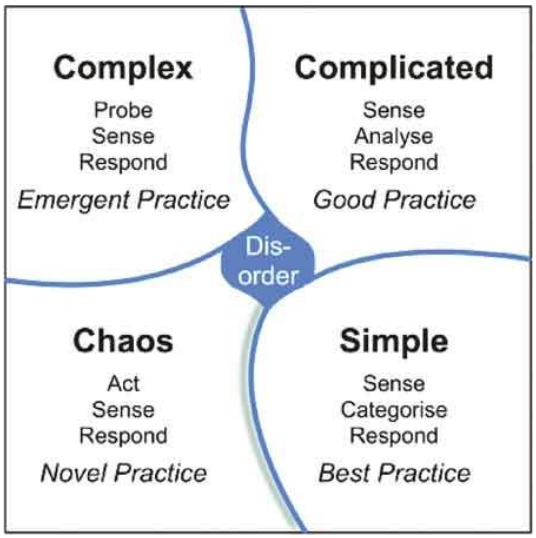

Figure 1: Cynefin Framework

Simple problems are occurrences in which cause-and-effect relationships are evident to everyone and are appropriate for repeating patterns and consistent events. The leader's job is to ensure proper processes are in place, communicate effectively, and delegate (Snowden & Boone, 2007).

Complicated problems are occurrences in which cause-and-effect relationships are made evident by experts, and there may be more than one answer. The leader's job is to create a panel of experts and listen to conflicting advice (Snowden & Boone, 2007).

Complex problems are occurrences in which there is unpredictability, no right answers, emergent patterns, many competing ideas, and a need for creative and innovative approaches (Snowden & Boone, 2007).

Chaotic problems are occurrences in which there is high turbulence, many decisions, no time to think, high tension, and no clear cause-and-effect relationships (Snowden & Boone, 2007).

Disorder is a state in which a leader does not recognize the occurrences or situation as one of the abovementioned levels of complexity (Snowden & Boone, 2007).

Veteran leadership apparently did not engage in effective situation awareness. They appear to be unaware of their contextual domain based on their language, heuristics, and authoritarian approach. The heuristic, evidence-based, and reductionistic language in the national strategy suggests that veteran leadership believe the complex, wicked problem of veteran suicide is definable and solvable by experts, that a linear relationship between cause and effect exists, and that best practice, analytics, and reductionism are required to discover the relationships. Veteran leadership seem to default habitually to methods of solving simple or complicated problems when they encounter a complex situation. As a result, their approaches do not align with the appropriate approaches for problems in the complex domain. Veteran leadership are either in disorder, or at best, believe they are in a complicated domain.

Despite their confusion with the domain of the wicked problem of veteran suicide, the military community is familiar with the Cynefin framework, but has just not applied it to the topic of veteran suicide. The Cynefin framework has been implemented as a tool within the governmental and military domains, such as the Department of Homeland Security (Department of Homeland Security, 2015) and by military strategists in the Department of Defense and Armed Forces (Marcella, 2010).

The domain of the problem of veteran suicide is complex, based on its unpredictability and there being no right answers, emergent patterns, and many competing ideas (Snowden & Boone, 2007). Therefore, the problem must be thought about with awareness of the complex and

sometimes chaotic nature of the problem in order to more adequately address the problem. Later, the Cynefin will be used in more detail to discuss the wicked problem of military sexual trauma in the Black female veteran population.

A VUCA environment.

Although the veteran leadership missed the complexity and confused the domain of the problem, the military is certainly familiar with complexity, as the acronym VUCA (volatility, uncertainty, complexity, and ambiguity) originated in the United States War College (Gerras, 2010; Whiteman, 1998). In the 21st century, the emergence of technology, globalization, and multiple complex, interdependent variables have created a complex and rapidly evolving VUCA environment. In today's environment, the entire globe experienced the essence of VUCA with the emergence of COVID-19.

In an organizational context, VUCA can be defined as

Volatile: "Exponentially accelerated change with record levels of market volatility . . ., [r]apid advances in computing power and catalyzing bio, nano, robotics and infotech growth to record levels, . . . unprecedented access to knowledge, 24hr news, viral stories, and ever expanding social networks and media" (Ramsey, 2013, pp. 6-7)

Uncertain: "Inability to know everything and the lack of predictability and the increasing likelihood of 'surprise' events" (Ramsey, 2013, p. 9)

Complex: "The multiples of forces, the chaos and confusion that surround an organization or an environment" (Ramsey, 2013, p. 10)

Ambiguous: "Differences in interpretation when contextual clues are insufficient to clarify meaning" (Ramsey, 2013, p. 11)

In the military, VUCA is a way to describe the changing environment. For instance, following the attack on the World Trade Center on September 11, 2001, VUCA was used to describe the chaotic, turbulent, and rapidly changing business environment, which was also referred to as the "new normal" (Ramsey, 2013, p. 5).

In the case of veteran suicide, the executive order and national strategy talk about veteran suicide as if it is a complex problem within an ordered and stable system. However, ultimately, with the volatile, uncertain, complex, and ambiguous reality that is faced by veteran leadership, they must improve their thinking and formation of this wicked problem in order to adequately understand and address it.

Type III Error: The Result of Inadequately Formulating the Wicked Problem

The veteran leadership has not adequately formulated the wicked problem of veteran suicide. What the veteran leadership have committed by misformulating the wicked problem of veteran suicide in the three ways mentioned above is what is known as a type III error. In 1974, Ian Mitroff and Tom Featheringham defined type III errors as either (1) "the error . . . of having solved the wrong problem . . . when one should have solved the right problem" (p. 383) or (2) "the error . . . [of] choosing the wrong problem representation . . . when one should have . . . chosen the right problem representation" (p. 383). Mitroff and Featheringham (1974) argued that in order to determine a problem's solution properly, the problem needs to be represented or formulated adequately in the first place.

Because the problem of veteran suicide is a case of a wicked problem, which is not within a simple, solvable or knowable domain in terms of the Cynefin framework, the first definition of "type III error" is irrelevant. I believe military and veteran leadership did not attempt to solve the

wrong problem but instead attempted to solve the problem of veteran suicide with an inadequate problem formulation.

Thus, the second definition of the type III error bears much relevance to the example from the nation strategy and executive order. By not changing the way they approach and think about problems, missing the VUCA nature of the problem, and selecting the wrong domain in terms of the Cynefin framework, veteran and military leadership "choos[e] the wrong problem representation" (Mitroff & Featheringham, 1974, p. 383). A type III error was committed as a result of the multiple attempts to solve the wicked problem without formulating the problem in an appropriate way, taking into account all of the elements of the system, thinking of the problem as a system, recognizing marginalized populations, and considering the changing contexts.

Next, to transition to another wicked problem that pertains to a demographic that was left out of the executive order and national strategy, which is also at an increased risk for suicide (Kimerling et al., 2015). That wicked problem is military sexual trauma in the Black female veteran population.

Military Sexual Trauma (MST)

Within the Department of Veterans Affairs (VA), military sexual trauma is defined as "psychological trauma . . . result(ing) from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training" (Department of Veterans Affairs, 2011, para. 1). While the problem of veteran suicide provides a good introduction to concepts that will be discussed moving forward, another wicked problem, Black female veterans with a history of military sexual trauma, is a problem faced by a population that was overlooked in the executive order and national strategy.

While it may seem ironic for a systems thinker to employ reductionism by selecting to explore military sexual trauma in only the Black female veteran population, I argue that reductionism is important for focus (Cherry, 2020). Reductionism is appropriate where it is done intentionally and purposefully, with acknowledgement of its limitations, and not purely out of habit. Without focus, this dissertation would become an infinitesimal, unstructured encyclopedia. Reductionism is also important to identify a gap in the literature and to address it. I reduced the research population from *women* to *female veterans* to *Black female veterans* to *Black female veterans with a history of MST* in order to focus on a forgotten population. In essence, reductionism and holism are not mutually exclusive; they both serve a purpose. A point must be selected to expand from. One cannot expand from nothing.

Numerically, suicide is not highly prevalent for Black female veterans despite their increased risk (Kimerling et al., 2015). Today, of approximately 2 million service members of the total Department of Defense Force, African-Americans comprise 16.8 % (n = 352,519) (Department of Defense, 2018), of which about 0.7% are Black women (Reeves & Nzau, 2020), which equates to about 90,000 Black servicewomen. While there are 90,000 Black servicewomen in the military today, there are about 291,000 Black female veterans. Based on the past, Czekalinski (2012) estimated that fewer than 3 per 100,000 Black women veterans die by suicide annually. Therefore, with a Black female veteran population of approximately 291,000, about 9 Black female veterans would die per year by suicide. By contrast, according to Ellison (2011) and Czekalinski (2012), 1 in 4 black female veterans experience sexual trauma while in the military. Therefore, approximately 22,500 would report experiencing rape, sexual harassment, or both by the end of the national strategy (2018-2028). Thus, military sexual trauma has a much greater prevalence in the black female population than veteran suicide.

Yet, there was no specific mention of Black female veterans and military sexual trauma in either the executive order or national strategy. Because military and veteran leadership did not mention military sexual trauma in their policies, they seem to imply that military sexual trauma is not important or that Black individuals and women are not important. However, more thoroughly understanding Black female veterans has implications also for the white male majority who die by suicide at a rate of 32.1 per 100,000 lives (Kimerling et al., 2016). It has been suggested that studying Black women can help researchers understand protective factors against suicide, since Black female veterans have a high risk for suicide but the lowest suicide attempt and completion rate of all demographics (Czekalinski, 2012; Price, 2018). From an economic perspective, veteran leadership may opt to focus on the white majority who are at a high risk of suicide completion despite the idea that Black women can be a resource for the majority.

While this is a compelling argument, it is not the reason that I am pursuing the topic. My *raison d'etre*, or the most important reason for bringing this work into existence, has experiential and professional roots.

Purpose of the Study: *Raison d'être*

As a Black female veteran with a history of MST, I have a personal purpose for selecting the topic of Black female veterans with a history of MST. Following twenty years of military service as a Nurse Corps officer, I served as CEO of the Women Veteran's Command Center (WVCC). Founded in August 2017, this Philadelphia-based non-profit served approximately 130 women veterans per quarter, providing them with strength-based coaching in order to assist them in living more fulfilling personal and professional lives. I heard many accounts of MST. Although the statistics suggest that 1 in 4 black female veterans experience military sexual trauma (Czekalinski, 2012; Ellison, 2011), my experience of the incidence was quite different. I found

that approximately 90% of Black female veterans who utilized the WVCC had, in fact, experienced military sexual trauma. One example is provided below. Through this story, I provide context for my argument in the next chapter that MST is larger and more complex than the sole event.

Case Report

Imagine an inpatient psychiatric unit in an urban VA Hospital in northeastern United States. The inpatient unit is characterized by patients with mental health diagnoses, substance use disorders or co-occurring conditions. Due to staffing and budget constraints, there are few resources for specialized race- and gender-specific services. The staff on the inpatient psychiatric unit are tasked to meet the race- and gender-specific needs of its female patients, but there are no special programs, technologies, or support staff to accomplish this task.

In an effort to meet the needs of all of the patients, unit staff is augmented by chaplains who are assigned to each unit to meet the spiritual needs of all inpatients. While most patients are only on the unit for short term stabilization, the chaplains make every effort to visit patients prior to discharge. This is challenging at times because of the quick transition to outpatient care. Here is one veteran's reported experience on the unit.

> "There is nothing else we can do for you. We have exhausted all of our evidence-based approaches, and your symptoms are resistant to the medications," said the VA healthcare physician.
>
> Suicide was the first thought that crossed the patient's mind. Preceding this moment was her history: Childhood sexual abuse from when she was 9 (latently remembered 25 years later), the military sexual assault, and intimate partner violence, along with a worrisome neurological symptom—dissociation—that had been misdiagnosed as advanced syphilis by the VA. What followed were PTSD and

major depressive disorder symptoms—insomnia, hypervigilance, nightmares, depression, increased appetite, and 100 pounds of weight gain. Group counseling, individual counseling, and medications could not help her through the damage done. Not only was she betrayed as a child, but she was also betrayed by her military family, her ex-husband, and the veterans' healthcare system.

Following her suicidal ideation (with a plan to take her own life), she immediately drove herself to an emergency department for help. The next thing she knew, she was locked in a psychiatric unit at the Philadelphia VA Medical Center. Depressed and in despair, she pondered:

'I was homeless months ago, parenting a child diagnosed with autism, and now I'm here. I do not want to go back to my violent husband. Why am I broken beyond repair? Am I still experiencing prolonged grief for my mother who passed away six years before? Or is it neurological damage from the meningitis and 105 degree fever around the time of my mother's death?'

Her soul had been wounded by the assaults of her past and the turbulence of the present, and she was tormented by the uncertainty of the future. This was her state until a paradigm shift occurred shortly after this time.

During that hospital stay, two very important events happened. First, a psychiatrist sat down after reviewing her records and explained that she was actually experiencing *complex trauma,* a normal response to the cumulative, horrific, and iterative events in her life. Now, she felt seen. Second, a chaplain came to see her, listened to her story, and discovered another revelation: She had a deep psycho-spiritual injury as a result of moral injury. Now, she felt heard.

> Following these revealing moments, she left that inpatient stay knowing that she mattered. This experience reshaped her world by allowing her to take her power back after releasing hurt, shame, and pain. Knowing she had nothing to lose but her own life, she found Soldier's Heart, a national organization that helped her to heal through strength-based approaches focused on soul repair and posttraumatic growth. From here on, she would go on to learn, grow, and develop, carrying books, not burdens."

As exemplified in this story, other situations can correlate and intersect with MST in ways the definitions of MST do not detail. This story, however, barely scrapes the surface of the numerous complexities associated with Black female veterans.

As a Black female researcher, I use a Black feminist epistemology, a field of knowledge that is focused on the perspectives of historical and present experiences of Black women (Crenshaw, 1989; Collins, 1990). In this work, Black feminist epistemology offers a systemic view of Black women in the military. This view is adopted for discussing the current reality of Black female veterans with a history of MST.

Organization of the Dissertation

This dissertation focuses on formulating the problem of military sexual trauma and making decisions based on the formulation of the problem. A complex problem needs proper formulation before it should be addressed.

There has been a pattern of simple, reductionist, and evidence-based solutions being repeatedly proposed to solve the complex problems among Black female veterans with a history of military sexual trauma (MST). Simply signing another policy will not solve the problem. Therefore, in this dissertation, I am seeking to

1. Use Daniel Kim's iceberg model (1999) to frame the literature review through a systems lens and to provide a deeper understanding of the current reality of black female veterans with a history of MST.
2. Recommend the Cynefin framework to military and veteran leadership, decision-makers, and stakeholders to assist them in making sense of the current reality of black female veterans with a history of MST.
3. Provide recommendations for veteran stakeholders based on implications of applying the Cynefin framework.

Discussing these topics will help to address the following research question:

> *How should leaders and stakeholders understand and make decisions with regards to the current reality of Black female veterans with a history of MST?*

In answering this research question, I hope to provide a deeper understanding of their current reality. This understanding will inform frameworks and tools that can be applied to improve the system in which Black female veterans exist.

CHAPTER 2: LITERATURE REVIEW

Chapter 1 introduced the concept of Military Sexual Trauma (MST) in the Black female veteran population as a wicked problem that needs to be formulated adequately to be understood and addressed. Like veteran suicide, MST in the Black female veteran population is a complex challenge within a complex evolving organizational system.

I argue that the leadership of the Department of Defense (DOD) and Department of Veterans Affairs (VA) do not understand the entirety of the MST problem for the Black female veteran population. The misunderstanding is in part due to the paucity of research with this population and the degree of complexity of problems faced by Black female veterans with a history of MST. A reason why there is a paucity of research on particular groups is that the "military may promote color-evasion, a domain of colorblind racial ideology that denies racial differences by

emphasizing sameness to its service members through slogans such as ‘we are all green’” (Carlson et al., 2018, p. 749).

I also believe that the lack of knowledge about MST involves epistemic injustice, which is injustice related to knowledge (Fricker, 2007). According to Fricker (2007), there are two types of epistemic injustice: testimonial injustice and hermeneutical injustice. Testimonial injustice is unfairness related to trusting the testimony or word of another person (Fricker, 2007). As will be discussed in more detail in this section, women in the military are met with disbelief when they describe their experience of MST (Baechtold & De Sawal, 2009; Hamrick & Rumann, 2012), which is a case of testimonial injustice. Hermeneutical injustice is injustice related to how people understand and interpret their own lives and the lives of others (Fricker, 2007). Hermeneutical injustice, which occurs when someone’s experiences are not well understood—by themselves or by others—because these experiences do not fit any concepts known to them (Fricker, 2007), is also experienced by women veterans. Black female veterans in particular have experiences that are often complex, ineffable, and intelligible, which are difficult for white male military leaders to conceptualize. Their historical barriers to participate in journalism, publishing, academia, law, and other institutions (owing to racism and sexism) has further elucidated their experience from a more visceral understanding. Thus, there is a need for this problem to be formulated to work against the status quo of epistemic injustice.

Who believes this is a problem?

The Department of Defense (2009, 2013, 2014a, 2019), Department of Veterans Affairs (2011), and community-based nonprofits (Ramchand, Harrell, & Lauck, 2020) have all acknowledged that MST is a problem for both male and female servicemembers. While the Department of Defense and Department of Veterans Affairs perceive MST as a problem in the

entire veteran population, Moye (2020) acknowledged that it is also a problem faced by Black female veterans. To my knowledge, Moye (2020) is the only researcher to focus on black female veterans with a history of MST.

Who is tasked with solving the problem?

The military and veteran communities, and especially the Department of Defense and Department of Veterans Affairs are tasked with handling the wicked problem of MST. Significant to this study, the VA is the largest "national health care system and is unique in that it preferentially enrolls the most complex patients into its healthcare plan" (Heyworth et al., 2020, p. 2) and is the only healthcare organization that specializes in MST-related trauma.

Currently, "the VA Healthcare System operates facilities in every state (as well as the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa) and essentially every major metropolitan area of the country" (Heyworth et al., 2020, p. 2). These facilities include "170 VA medical centers, 1,061 community-based outpatient clinics, 134 community living centers (nursing homes), 300 outpatient readjustment counseling centers, and many residential rehabilitation programs" (Heyworth et al., 2020, p. 2). In addition, the VA manages a $230 billion per year health insurance program for over 9 million enrolled veterans who also may receive care by private providers (Heyworth et al., 2020). With this $230 billion per year funding, the VA has become "the nation's largest provider of graduate medical education and other health professional training and manages a $2 billion per year research portfolio" (Heyworth et al., 2020, p. 2). Disability claims for women veterans can cost over $500,000 per victim over the course of a lifetime (Associated Press Staff, 2013).

In addition to the DOD and VA, community organizations, such as my Women Veterans Command Center, also play an important role in the veteran community. In comparison to the VA,

community-based nonprofits are much smaller and have far fewer resources. For instance, the Council of Nonprofits (2020) found that 88% of community-based American veteran nonprofits spend less than $500,000 annually, some of which operate on an annual budget of $25,000 a year or less.

While the Department of Defense is largely tasked with preventing MST, the Department of Veterans Affairs in conjunction with community organizations are tasked with helping those affected by MST. At the end of each subsection, I will discuss what is being done about aspects related to MST.

About the literature review

The literature details current conceptualizations of the problem in three groups: by military and veteran leadership, policymakers, and clinical researchers. As the literature on Black women veterans with a history of MST is weak and scarce, included in this review are problems facing this community before, during, and after leaving the military. In examining the literature from multiple disciplines including military history, gender studies, African American studies, Black feminist epistemologies, and military tactical and operational works, I was careful to differentiate information that pertains to all women, Black female civilians, and Black female veterans in particular. While Black female civilians and veterans share a culture, military service makes the current reality of Black female veterans particularly unique.

I would also like to point out the importance of a strength-based lens when viewing the literature. The problems we discuss are not representative of all women veterans or all Black female veterans with a history of MST. The literature only details trends and patterns of participants who identify as Black in samples on studies intended to identify problems. Therefore,

we must not view Black female veterans for only their problems. This would result in failure to completely understand their successes in spite of their unfavorable reality.

Literature can sometimes be biased toward problems and deficit views based on low-points in their participants' lives. Many Black female veterans with a history of MST, like the author herself, go on to lead fulfilling personal and professional lives (Smith-Benson, 2020). Thus, as we review this literature, we must keep in mind their strengths despite the many possible problems they may experience being Black, being female, and being a veteran with a history of MST.

Using the iceberg model to template the literature review

In order to help gather a preliminary understanding of the available knowledge on military sexual trauma in the Black female veteran population, I will explore literature on (1) women, (2) women in the military, (3) Black women, (4) Black women in the military, (5) female veterans, (6) Black female veterans, and (7) black female veterans with a history of MST. The iceberg model (Kim, 1999; Social in Silico, 2017) will serve as a template for organizing, evaluating, and understanding the information in the literature review from a systems perspective.

The information in the literature review represents parts of the complex evolving system(s) in which Black female veterans reside. As discussed in Chapter 1, complex evolving systems "create novelty, self-organize, evolve, and adapt to a changing environment, usually generating more complexity in the process" (Heylighen, 1997, p. 31).

I use systems thinking to achieve a deeper understanding of their current reality within the complex evolving system(s), which encompass their historical, collective, pre-military, in-military, and post-military experiences. Systems thinking is a way of critically thinking about complex evolving systems (Kasser, 2018). It involves perceiving situations from many perspectives, which can be used to understand a situation holistically, assess possibilities, weigh

decisions, and select or create solutions (Kasser, 2018). Systems thinkers such as Russell Ackoff (1999) and Kasser (2018), are opposed to binary black-and-white thinking or yes-no answers, are intentional when they select options, and are skeptical of decisions selected merely by habit or routine.

The iceberg model of Daniel Kim (1999) is a framework and metaphor to help aid systems thinkers, or those who use systems thinking, in seeing the world. The iceberg model is a bottom-up model that consists of four levels, with the tip representing situations that are visible to the naked eye and the under-water levels representing aspects of situations that can be difficult to assess by looking only at the top of the structure or "tip of the iceberg." Broo and Törngren (2018) define the four levels as follows:

> *Events* "[r]epresent the manifest components and actions observable to us." At this level, one can make observations about a situation" (p. 6). The important question at this stage is "what just happened?"
>
> *Patterns* are "[b]ehavioral patterns or trends over time" (p. 6). Once an event is selected, at the patterns level, one focuses on repeated events and tries to notice patterns by asking the question "what trends have there been over time?"
>
> *Underlying structures* "describe how the parts are interrelated to influence the patterns" (p. 6). Here, one identifies underlying systems by asking "what has influenced the patterns?" and "what are the relationships between the parts?"
>
> *Mental models* "[s]upport everything else in the system through a set of beliefs, values, and assumptions which shape stakeholders' perceptions" (p. 6). At this level, one seeks to answer the questions "what assumptions, beliefs, and values do people hold about the system?" and "what beliefs keep the system in place?"

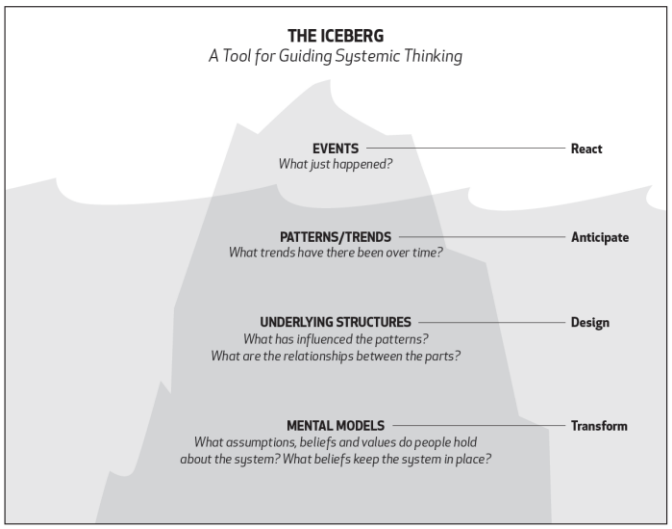

Figure 2: Iceberg Model of Daniel Kim (1999) from Social in Silico (2017)

Like an iceberg, many things are hidden from our view, and in order to better understand the world and adequately formulate the problem of MST among Black female veterans, one must go below the surface of the event and forge his or her way to deeper levels of understanding. Doing this can assist one in making sense of the world and adequately formulating its problems.

I have adapted the iceberg model above to template the literature review from a systems perspective. I understand that factors influencing the event of MST exist in the containing systems, which are below the tip of the iceberg (Ackoff, 1999). The following definitions, then, will parallel each level in this adapted form:

(1) Mental models are ways the veteran leadership view the world.

(2) Systemic factors represent structural and systemic elements experienced by (1) women, women in the military, (3) Black women, (4) Black women in the military, and (5) Black civilians.

(3) Patterns are collateral damage associated with MST.

(4) Event(s) represents literature on the event of MST.

Mental models.

At this depth of the iceberg model, there are mental models. Mental models "[s]upport everything else in the system through a set of beliefs, values, and assumptions which shape stakeholders' perceptions" (Broo & Törngren, 2018, p. 6). At this level, one seeks to answer the questions "what assumptions, beliefs, and values do people hold about the system?" and "what beliefs keep the system in place?"

Using Starr's (2018) Epistemology Framework, I provided mental models used by the military and veteran leadership in Chapter 1. The mental models were (1) leveraging their authority and power and using heuristics, (2) embracing evidence-based approaches and root-cause analysis, and (3) relying on reductionism (Starr, 2018). These mental models contribute to how veteran leadership see, understand, and address problems. These mental models also permeate both military and veteran leadership culture, which "represents the value structure that guides conduct in the military and promotes expressions of collective identity" (Wilson, 2008, p. 12).

Throughout the literature review, I note instances where authority and power approaches, evidence-based approaches, and reductionism failed to adequately address a problem. According to Mitroff & Featheringham (1974), a problem must be adequately formulated in order to be addressed. Similar to how I discussed that veteran leadership committed a type III error in the first chapter, I will note instances of the type III error throughout this literature review. For instance, the type III error will occur when one group is left out because the rule of thumb did not include them, and it will also be committed when an approach shown to work in one population is assumed by researchers or clinicians to work in another population. Such instances can appear in evidence, interventions, and policies throughout the remainder of the literature review.

Underlying structures: Systemic factors.

The next level of the iceberg model is the underlying structures. Underlying structures "describe how the parts are interrelated to influence the patterns" (Broo & Törngren, 2018, p. 6). At this level, one identifies underlying systems by asking "what has influenced the patterns?" and "what are the relationships between the parts?"

While I discussed the *ways* veteran and military leadership think in mental models, I will discuss here *what* some of them believe that contribute to problems related to sex and race. This level consists of structural and systemic elements experienced by (1) women, (2) women in the military, (3) Black women, (4) Black women in the military, (5) female veterans, and (6) Black female veterans.

History of Servicewomen.

Understanding the unique history of servicewomen and their experience within the American system helps answer the question of how the underlying structures influence the patterns. Historically, both Black and white women have played heroic, brave, and critical roles in the history of the American military. Women have "carried arms or engaged the enemy in virtually every conflict ever fought by the United States, including and beginning with the War for Independence" (Murdoch et al., 2006, p. 8). During the Civil War, female nurses "pioneered the strategy of bringing treatment to wounded soldiers on the battlefield (instead of evacuating them first)" (Murdoch et al., 2006, p. 6). During World War I, women in the Navy (Yeomanettes), Marine Corps Reserves (Marinettes), and Army Signal Corps filled clerical, radio, draftsmen, translator, and bilingual interpreter roles, and released men for more dangerous overseas duties (Holm, 1982; Murdoch et al., 2006); in World War II, women served as airplane pilots and mechanics, control tower operators, truck drivers, aerial gunnery teachers, logistics chiefs, cryptographers, and intelligence officers (Murdoch et al., 2006). However, as the Korean Conflict

neared, women were increasingly restricted back into clerical and nursing duties like their counterparts in the Civil War.

Murdoch et al. (2006) noted that women encounter danger while in service that is on par with many of their male counterparts. Murdoch et al. (2006) argued that "[e]ven so-called 'noncombatants,' such as nurses, water couriers, and messengers have risked death or maiming every time they stepped onto the battlefield because smoke, dust, blood, and noise often precluded easy identification of friends or foes" (Murdoch et al., 2006, p. 5). Also, because nurses are frequently deployed near front lines (Skelton & Skelton, 1995), they face risks of being engulfed during shifting battles (Skelton, 1999; Wilson, 1996). This "perhaps explain[s] why [nurses] have historically accounted for the majority of female prisoners of war" (Murdoch et al., 2006, p. 5).

A turning point for women's rights and opportunities in the military did not occur until near the end of the Vietnam conflict when "Congress finally authorized a new expansion in women's roles in 1968[,] Public Law 90-130, [which] . . . . removed restrictions on rank attainment by women, eliminated the 2% cap on female troops, and slightly increased the allowable numbers of female mid-level Officers" (Murdoch et al., 2006, p. 6). When conscription ended in 1973, goals to increase the number of women by 170% (Holm, 1982) "were met and quickly exceeded" (Murdoch et al., 2006, p. 6). Over the decade that followed, "[w]omen's selection criteria, previously more stringent than men's, were equalized . . . . [T]heir training and promotion lists were integrated with men's . . . [and] [p]regnancy, marriage, or dependent children were no longer grounds for military discharge" (Murdoch et al., 2006, p. 6).

By the Gulf War's start in 1991, "women comprised almost 11% of all active-duty personnel, with fewer than half in administrative or medical specialties. Many worked beside men, accepting equal hardships and risks. Over 33,000 women served in key combat support functions,

driving trucks, flying planes and helicopters, running POW facilities, directing artillery, and serving in port security and construction battalions (Murdoch et al., 2006).

By Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), "approximately 10% of troops stationed in Afghanistan (OEF) and Iraq (OIF) were women" (Murdoch et al., 2006, p. 7), and women accounted for as many as 1 in 5 enlisted troops in some service branches (Murdoch et al., 2006). Today, of approximately 2 million service members of the total Department of Defense Force, Black men and women comprise 16.8 % (352,519) (Department of Defense, 2018), and about 0.7% of them are Black women (Reeves & Nzau, 2020), which equates to about 90,000 Black female service members.

Systemic factor: Sexism.

Despite the gradual change in the view of servicewomen's contributions and progress in their rights and numbers (Harrell & Miller, 1997), sexism, which encompasses gender discrimination, sexual harassment, and sexual assault against women by brothers in arms, far outstrips casualties incurred by enemy actions (Frayne et al., 1999; Sadler et al., 2001; Sadler, Booth, Cook, & Doebbeling, 2003).

Sexism is a systemic condition that creates an environment in which rape and sexual harassment are viewed "acceptable" and "forgivable" behavior. Sexism, as it pertains to women, includes prejudice, stereotyping, and discrimination on the basis of sex (Morral, Gore, & Schell, 2015). In the military, sexism is also coupled with sexual harassment and sexual assault. In Fitzgerald et al.'s (1999) model of sexual harassment, they define four types of sexual harassment that a woman may experience. Street, Gradus, Stafford, and Kelly (2007, pp. 466-467) define each below:

> (a) sexist hostility (i.e., a form of gender-based harassment involving behaviors or attitudes that are not aimed at sexual cooperation but are discriminatory based on the individual's gender), (b) sexual hostility (i.e., a form of gender-based harassment involving offensive behaviors or attitudes that are not aimed at sexual cooperation but are overtly sexual and insulting in nature), (c) unwanted sexual attention (i.e., offensive nonverbal or verbal behaviors of a sexual nature that are unwanted and unreciprocated and aimed at sexual cooperation), and (d) sexual coercion (i.e., extortionist quid pro quo behaviors). (pp. 466-467)

Sexism and gender-based harassment create a hostile workplace with the unwanted and uninvited actions of men against women. These include "sexual teasing, jokes, remarks, or questions, pressure for dates, sexually suggestive looks, gestures, letters, or other sexual attention, including unwanted sexual contact" (Sadler, Booth, Cook, & Doebbeling, 2003). Because these actions put the women in the position of the outsider, the suffering that sexual assaults and harassment in the military sexual can be even more damaging than in civilian women assaulted and harassed in other occupations (Pryor & Whalen, 1995).

Feminist scholars have examined the patriarchal society and the inequalities it creates. An action that displays sexism is sexual harassment.

MacKinnon (1979) "conceptualized sexual harassment as an expression of a patriarchal society and a mechanism for perpetuating beliefs, attitudes, and actions that devalue women because of their sex and enforce male dominance" (Street, Gradus, Stafford, & Kelly, 2007, p. 471). Through MacKinnon's lens, sexual harassment is conceptualized as something that men do to women in order to maintain patriarchal dominance (MacKinnon, 1979; Street, Gradus, Stafford, & Kelly, 2007).

However, nearly two decades after MacKinnon's publication, Franke (1997) suggested the sociocultural dynamics of men and women are more complex. She believed that harassment is about the enforcement of gender norms for men as well as women, and that harassment is "a means of regulating and policing a particular view of how women and men 'should be,' punishing women who deviate from their prescribed feminine gender role and men who deviate from their prescribed masculine gender role" (Street, Gradus, Stafford, & Kelly, 2007, p. 471).

Neither MacKinnon nor Franke addressed sexual harassment in the military. Both were also white women who studied primarily white feminism. However, their contributions serve as a good introduction to feminist thought, although the degree of sexual harassment and assault in the military is much more intensified than in the civilian culture that they studied.

An early case study of military sexism occurred following a slander campaign in 1943. First thought to be an "act of enemy saboteurs, the President, First Lady, and Secretary of War launched FBI and Army Intelligence investigations, only to find that United States general officers and enlisted men were responsible" (Murdoch et al., 2006, p. 7). The campaign involved dirty jokes, snide remarks, obscenities, and cartoons against servicewomen, and it almost derailed the women's WWII recruitment effort (Holm, 1982). Not only did this slander campaign impede recruitment efforts for Black females in World War II, pre-1948 racial quotas and caps also had discouraged Black women from reenlisting after WWII. While approximately 6,500 Black women served in the Women's Army Corps (WAC) during World War II (Hagen, 2019), when hostilities in the Korean Conflict ended in 1950, of 22,000 women in uniform, 4 officers and 121 enlisted women were Black (Sheldon, 2004). Recruitment did not increase for black servicewomen until the Vietnam Conflict in which there were 27,250 Black servicewomen (Haynes, 1997).

Despite numerous accomplishments and efforts of women since the slander campaign, "the legacy of 1943's 'scandal campaign' lingers, and many women report being stigmatized as 'whores' or 'lesbians' as a result of their service" (Murdoch et al., 2006, p. 7). This campaign reinforced gender norms by creating trope and long-standing jokes regarding sex and race.

In the military today, the elements of slander campaign and other emergent elements of sexism still appear. Cornelius and Monk-Turner (2019) identified four themes pertaining to sexism in the military. These themes are "military women as second-class citizens and/or not belonging in the military; military women (or female spouses) deserving of violence; the myth of the scorned gentleman soldier and the "dependapotomus"; and military women as source of entertainment" (Cornelius & Monk-Turner, p. 233).

The first theme, that of second-class citizenship, describes a denial of the historic role of women that was mentioned in the paragraphs above. Male culture in the military denies this role in order to assert male dominance and justify their manliness in using the presumed femininity of women to build contrast. Even when women exit the military, fellow male veterans may not view her veteran status as authentic because they believe women might have not experienced war in the same way men have.

The second theme, that of deserving violence, also shares a negative sentiment towards women. Street, Gradus, Stafford, and Kelly (2007) noted that the military can be characterized by an environment that promotes hypermasculinity, "a rigid male sex-role stereotyped identity, characterized by calloused sexual views toward women and a belief that violence is manly" (p. 467)**.** Sexual and gender harassment are also ways in which men can punish women for occupying roles that challenge the successful exhibition of stereotypical male traits by women (Berdahl, 2007;

Buchanan, Settles, & Woods, 2008). Violence toward women, then, proves to other men and women that they are manly and more dominant than other males.

The third theme, the scorned gentleman soldier and the dependapotamus, is not widely discussed in literature, but is common in contemporary military culture. Cornelius and Monk-Turner (2019) defined dependapotamus as follows:

> Dependapotamus: (noun) A shallow, heartless land mammal; preys upon enlisted military males; its natural habitat: the bars and nightclubs near military bases; its diet: government benefits, vodka and Doritos; its preferred transportation is a convertible adorned with military support stickers; its predominant predatory tactic is pre-emptive pregnancy and possessing your 1st Sgt's digits on speed dial. (p. 235)

This description of a *certain type of woman* is a compilation of negative human dispositions (using someone, unhealthy eating habits, and infidelity) mixed with other tropes of women in hypermasculine military and civilian culture. This belief is internalized, however, and is extrapolated out and applied, to some degree, to every woman in order to reinforce female inferiority.

Last, the fourth theme, military women as source of entertainment, is a belief that coincides with the idea that sexual assault and harassment are acceptable, normal, and expected. Pershing (2003) also noted how some men believe that women join the military to become "fuck chick[s]" (p. 6). If a woman denies being "a fuck chick" (p. 6), she is assumed to be a dyke. For many presumed "fuck chicks," also known as MST survivors, what follows their harassment or assault is being socially isolated, bullied, and called a "sexual harassment Nazi . . . or crybaby" (Pershing, 2003, pp. 6-7) if she were to report the incident or incidents. Importantly, Burkhart and Hogan

(2015) found that in "comparison to the actual traumatic event [of MST], the blaming, skepticism, targeting them as promiscuous by male peers and superiors was even more traumatic" (p. 122).

Collectively, Cornelius and Monk-Turner's (2019) themes exemplify the manifestation of the slander campaigns in the contemporary military community. Left unaddressed, cultural myths about women in both American and military culture will continue to reinforce beliefs and behaviors inconsistent with the realities of sexual assault (Department of Defense, 2009).

As these themes suggest, additional literature describes that the military is a gendered institution. From the time a woman begins basic training, the process of "depersonalization and deindividuation [starts], in which the military, in the form of drill sergeants, must strip the individual of all previous self-definition . . . [and redefine and manage femaleness]" (Herbert, 2000, p. 9). During basic training, women are repeatedly exposed to misogynistic, sexist, and homophobic slurs from drill instructors during call-and-response rhymes that are chanted or sung in unison during marches and runs (Baechtold & De Sawal, 2009). Not only does this reinforce the previously held belief of males in civilian culture, but it also makes female "recruits feel pressured to act either more feminine, more masculine, or both" (Baechtold & De Sawal, 2009, p. 39).

Following basic training, women report feeling the need to constantly monitor their expressions of stereotypical feminine characteristics (emotional, weak, shy, and submissive) and masculine characteristics (rugged, strong, confident, and dominant) (Baechtold & De Sawal, 2009; Herbert, 2000). Herbert (2000) noted that women tend to overly display their femininity (wearing makeup) or may suppress it by engaging in typical male behavior (swearing and drinking alcohol). If she chooses to be too feminine, she risks being viewed as weak, but if she is too masculine (e.g. acting overconfident and denying help from others in lifting heavy objects), she may be seen as

competition, or called a dyke by male comrades, and risk harassment (Herbert, 2000). From the basic training until her transition out of the military, women are embedded in a system ridden with misogyny and hypermasculinity.

Unfortunately, however, it does not end with departure from the military as misogyny and hypermasculinity still exist, to a lesser degree, in civilian culture, especially towards women who encounter male veterans at the VA, other veteran facilities, or veteran events who still may believe she is not "woman enough . . . [or] veteran enough" (Hirudayaraj & Clay, 2019, p. 1). During encounter with male veterans, the male veterans may express skepticism or disbelief during discussions with civilians and other male veterans about the traumatic nature of a woman's deployment (Baechtold & De Sawal, 2009; Hamrick & Rumann, 2012). Fellow veterans and civilians within American culture at large—perhaps due to media depictions of only or mostly males (Hamrick & Rumann, 2012)—may also not recognize women as combatants (Baechtold & De Sawal, 2009). Thus, even after her departure from the military, a woman may not identify as a veteran (Herbert, 2000). Fortunately, this perception is gradually changing with more women being featured in the military and in civilian media (Gipson, 2019).

What is being done about sexism?

Based on the current understanding that sexism is a part of both civilian and military culture, the community at large, not necessarily the military or veteran community in particular, has been seeking an end to sexism. Without decreasing sexism in both the military and civilian cultures, there is a concern that ideologies from one culture will contribute to more sexism in the other culture.

Interventions for sexism include:

(1) Passing laws that seek to bar discrimination of the basis of sex, such as the Fair Employment Act of 1941, Civil Rights Act of 1957 (race, color, religion, sex, national origin, and sexual orientation discrimination), Voting Rights Act of 1965, Employment Non-Discrimination Act, Equal Pay Act of 1963, the creation of the White House Council of Women and Girls in 2009, the Matthew Shepard and Byrd, Jr, Hate Crimes Prevention Act of 2009, and the Don't Ask, Don't Tell Repeal Act of 2010.

(2) Forming movements to end sexism and acts of sexism, such as rape, including the #metoo movement, Time's Up, and All Rise, to inspire and empower millions of survivors to speak out against a culture of systemic sexual violence and silence (Drake & Burgess-Mundwiller, 2019).

(3) Providing platforms in media (including news media, YouTube channels, podcasts, talk shows, social media, and written publications) for survivors of sexual assault in the military to tell their story in order in order to both empower them and promote cultural change toward the reduction of sexual violence towards women in the military as well as civilian society (Azoulay, 2008).

(4) Evolving rape narratives on platforms from the problematic confessional ("I was raped"), which "assumes secrecy, prohibition, sin, desecration, trespass, transgression, besmirchment of value as a sexual object, a morally pure women, and the patriarchal views of masculinity" (Azoulay, 2008) to the unedited exact script that allows the full story to be told (without producers sensationalizing and dramatizing by isolating parts featuring suffering), and further to an empowerment narrative that seeks to transform the perception of gender and sexual assault and harassment survivors (Azoulay, 2008).

(5) Providing more opportunities for Black women and women from other minority groups to tell their stories in order to provide a narrative that is unique to them (Varsanyi, 2019), which is important because white women have had more opportunities historically to tell their stories.

Appendix A lists many more interventions that are being done to reduce the amount of sexism in both the civilian and military cultures collectively.

Systemic factor: Racism.

I argue that a systemic factor that continues to permeate every aspect of the pre-military, military, and post-military experience is slavery. Slavery has contributed to racism, race discrimination, and oppression throughout the American social, healthcare, legal, and economic systems. This complex historical trauma is shared by approximately 90,000 Black servicewomen (Department of Defense, 2018; Reeves & Nzau, 2020) and 290,000 Black female veterans (Department of Veterans Affairs, 2020b).

I explored literature on Black feminist epistemology to provide a deeper understanding of black women. Black feminist epistemology, also known as Black feminist thought, is a field of knowledge that encompasses the perspectives and experiences of Black women (King, 1988). Black feminists discuss topics such as sexism, racism, and class discrimination as they pertain to Black women in order to conceptualize these forces of oppression and fight against them (Carson, 1981; Morris, 1984).

Black feminist epistemologies presume “an image of Black women as powerful, independent subjects” (King, 1988, p. 72). Historically, Black women held foundational and powerful leadership roles in the Black community and within the politics of liberation (Davis, 1998a; Davis, 1998b; King, 1988). Renowned Black women in history include “Harriet Tubman

[who] led slaves to freedom on the underground railroad; Ida Wells Barnett [who] led the crusade against lynching; Fannie Lou Hamer and Ella Baker [who] were guiding political spirits of the southern Black efforts that gave birth to SNCC [Student Nonviolent Coordinating Committee] and the Mississippi Freedom Democratic Party; the 'simple' act of Rosa Parks that catapulted Martin Luther King to national prominence" (King, 1988, p. 54).

In their communities, Black women "founded schools, operated social welfare services, sustained churches, organized collective work groups and unions, and even established banks and commercial enterprises" (King, 1988, p. 54). Even though many were "rural, poorly educated, and economically disadvantaged" (King, 1988, p. 56), Black women created the Black southern strategy of the 1950s and 1960s during the civil rights movement (Carson, 1981; Morris, 1984). King (1988) saw this powerful, historical progress as the legacy and "affirmation of the strength of seemingly powerless people, and particularly of the Black women who were among the principal organizers and supporters" (p. 56).

The literature reveals that individuals in Black communities see Black women as authorities and leaders. Because the father figure has been stereotypically removed from the family, Polise (2017) noted that "Black women are usually perceived as the natural leaders within a predominantly matriarchal system, and, therefore, held accountable for many problems within the Black community" (p. 231).

Thus, by concentrating on both their strengths in spite of their multiple oppressions, King (1988) noted the importance of "discover[ing] and appreciate[ing] the ways in which Black women are not victims" (p. 72). In this dissertation, I seek to do the same.

Intersectionality.

Another element influencing the concept of Black feminist thought is intersectionality, yet another concept not addressed in the national strategy and the executive order. First coined by Kimberlé Crenshaw (1989), intersectionality is an analytical framework that enables examining the intersection of multiple identities and axes of subordination (Byrd, 2014; Carbado, 2013). The multiple domains and axes of subordination include identity, discrimination, and social problems such as racism, sexism, genderism, ageism, classism, and homophobia (Carbado, 2013; Cooper, 2015). Individually and collectively, "Black women experience marginalization at the intersections of various identity markers including race, gender, sexuality, class, religion, nationality, citizenship status, and ability" (Patterson et al., 2016, pp. 55-56).

Intersectionality can help "captur[e] the complexity and multiplicity" (Lewis, 2009, p. 207) of Black female veterans. As such, intersectionality is useful in examining how discriminatory practices "in one sector reinforce parallel practices in other sectors, creating interconnected systems that embed inequities in laws and policies" (Egede & Walker, 2020, p. 1).

When interpreting through an intersectional lens, it is important to recognize the scope of intersectionality. Pedulla (2014) provides crucial insight for understanding intersectionality:

> Theories of 'intersectionality' do not necessitate that disadvantaged social categories will combine in this additive, negative manner. One of the insights of 'intersectionality' theory is that social categories may combine in complex, non-additive ways. In other words, the combination of social categories is more complex than the sum of its parts. (p. 79)

Through this lens, adding racism into the equation does not necessarily mean that racism makes every aspect of the situation worse (additive, negative); it just adds a layer of complexity (non-additive, complex). While racism might exacerbate the damage of trauma (Carlson et al.,

2018), racism might have also helped Black women develop posttraumatic resilience through africultural coping traditions (Myers et al., 2015; Utsey, Bolden, Lanier, & Williams, 2007).

In practice, the Black women of #BlackLivesMatter use the concept of intersectionality "to seek the inclusion of all types of oppressed Black subjectivities [and] broade[n] the scope of the movement to other stigmatized groups such as homosexuals, transgenders and gender non-conforming people, whose exclusion from a hegemonic ideology has left them exposed to the scrutiny of society itself" (Polise, 2017, p. 231). Consequently, the study of intersections aids in understanding how inequalities in education, employment, housing, credit markets, health care, and the justice system (Bailey et al., 2017; Paradies et al., 2015) "mutually reinforce practices that allow or encourage discriminatory beliefs, stereotypes, and unequal distribution of resources" (Egede & Walker, 2020, p. 1).

Intersectionality, however, does not go without criticism and critique. One must recognize its criticisms in order to avoid incorrect usages and applications of the lens. An ontological criticism of intersectionality is that it "promises almost everything: to provide complexity, overcome divisions and to serve as a critical tool. However, the expansion of the scope of intersectionality has created a consensus that conceals the fruitful and necessary conflicts within feminism" (Carbin & Edenheim, 2013, p. 233). In other words, intersectionality has become so ontologically multivalent and multidisciplinary that it does not represent a single scope or premise. It is, therefore, difficult to define.

In response to Carbin and Edenheim (2013), Mckibbin et al. (2015) proposed that "intersectionality has shifted from being a metaphor grounded in structuralist ontology to being an overarching feminist theory which makes explicit an ontology of neither the subject nor power" (Mckibbin et al., 2015, p. 100). Intersectionality "is no longer defined as a metaphor for the way

in which intersecting systems of oppression impact on women's "subjectivities" (Mckibbin et al., 2015, p. 100) as used by early scholars such as Crenshaw (1989), "but is referred to in the literature as a methodology, a tool for data analysis, a nodal point in feminist theory, a feminist project or platform, and a framework for social policy development (Mckibbin et al., 2015, p. 100). Such variability in scholarship equated intersectionality with "signifier, a metaphor, a theory, a project, a discourse and a field" (Mckibbin et al., 2015, p. 100). Members of the #BlackLivesMatter movement, to one degree or another, see their application of intersectionality to encompass all these meanings. Intersectionality is a key concept in BlackLivesMatter projects and often serves as a metaphor for the way marginalized individuals experience life in America (Polise, 2017).

However, Villeseche and Śliwa (2018) noted that the social media hashtag #intersectionalfeminism shares ontological divergence between actual feminist scholars and a virtue-signaling, activist fad that strips it of all fundamental tenets: "many voices denounce the depoliticized, de-contextualized heralding of intersectionality or intersectional feminism" (p. 2), and "[s]uch hashtagging trends could be seen as idiosyncratic, symptomatic of a postfeminist era in which theories and concepts can be used ad hoc as buzzwords or temporary signifiers before moving on to the next fleeting wave of (online) 'activism'" (Villeseche & Śliwa, 2018, p. 2).

On September 22, 2020, President Donald Trump (2020) signed the *Executive Order on Combating Race and Sex Stereotyping* in response to Black feminism, critical race theory, and any intersectional discussion of race and oppressive force in American society. While this executive order pertained to critical race theory, a study intended to critically examine the law as it intersects with issues of race and challenge approaches to racial justice, intersectionality is a vein that runs throughout all of Black feminism and is thus a part of this criticism.

According to Trump's executive order, instead of sharing the story of America that emphasizes the positives and progress of valiant Americans in recognition of the Constitution as national creed, such as in the changes that America's Independence, the abolishment of slavery, women's suffrage movement, and Dr. Martin Luther King inspired, "[t]oday . . . many people are pushing a different vision of America that is grounded in hierarchies based on collective social and political identities rather than in the inherent and equal dignity of every person as an individual (para. 5). The executive order continues that this "anti-American . . . . ideology is rooted in the pernicious and false belief that America is an irredeemably racist and sexist country; that some people, simply on account of their race or sex, are oppressors; and that racial and sexual identities are more important than our common status as human beings and Americans" (para. 5).

Taught by instructors and materials in diversity training across America, this destructive ideology, the executive order claims, "misrepresent[s] . . . our country's history and its role in the world" (Trump, 2020, para. 6) and "threatens the core institutions of our country" (para. 6). This "destructive ideology" (para. 5) also teaches that "our government 'was made on the white basis,' 'by white men, for the benefit of white men,'" (para. 5), and that "virtually all white people, regardless of how 'woke' they are, contribute to racism" (para. 6). The executive order also states that critical race theory suggests that racism "is interwoven into every fabric of America" (para. 7) and that "[o]bjective, rational linear thinking" (para. 9), the idea that "[h]ard work [is] the key to success" (para. 9), the "nuclear family" (para. 9), and belief in a single god are "aspects and assumptions of whiteness" (para. 9).

Viewing this executive order in light of the 2020 environment, the perceived anti-American connotations embedded in this criticism stems from the divided political landscape of contemporary America. Criticisms typically coming from individuals on the political right,

perhaps due to the frequent juxtaposition of a Marxist lens and feminist teachings within a Capitalism-embracing economy demonstrate fear that these teachings are a form of reverse oppression of the white male designed to establish Black or female supremacy.

In 2020 America, there was a vivid intersection of politics and law because of the emergence of COVID-19, civil unrest sparked by police shootings of several Black Americans, and the #BlackLivesMatter movement. Boyd, Lindo, Weeks, and McLemore (2020) describe this current reality:

> In the wake of the police killings of Elijah McClain, Breonna Taylor, Tony McDade, and Rayshard Brooks, the heart-wrenching public murders of Ahmaud Arbery and George Floyd, and the premature and disproportionate deaths of tens of thousands of African Americans from COVID-19, our national racism bleeds anew, into the open, exposing the intersecting forms of violence that continue to threaten Black lives. (para. 2)

Edege and Walker (2020) note that current protests throughout the United States are highlighting "the history of marginalization of and discrimination against Black Americans, including 250 years of slavery, 100 years of Jim Crow laws, high rates of incarceration, and unanswered calls for action after police shootings of unarmed Black Americans" (p. 1).

The emergence of COVID-19 has reminded us of the extant systemic inequities, racism, and discrimination and their complex intersection with other phenomena and systemic entities. In particular, COVID-19 illuminates inequalities in the healthcare system, economic system, and the workplace inequalities (Edege & Walker, 2020). Ironically, COVID-19 has also disrupted protests that seek to end underlying structural racism (Edege & Walker, 2020).

Intersections between racism and sexism.

In the literature, the history of sexualizing Black women in the United States is dissimilar, not only in the time of slavery era, but also in the post-slavery era to the sexualization of white women. The difference lies in the intersection of historical gender norms of women relative to the gender norms of men. In comparison to the 19th century's elite white woman, "whose alleged natural sphere of activity was the house and whose primary role was that of the obedient wife and devoted mother" (Polise, 2017, p. 229), Black women were "forced to toil in the fields, contradicting any notion of women's frailty, but their unions with male slaves were not officially sanctioned, making them sexually impure by definition" (Polise, 2017, p. 229). From slavery until the 1920s (Pascale, 2001), "Black women's primary employment was either as field and industrial workers (jobs which were undesirable and often required the physical strength typically expected of men) or domestic workers as maids and cooks" (Buchanan, Settles, & Woods, 2008, p. 348).

In contrast with the more stereotypically feminine white women (Santamarina, 2006), "Black women have been visible as workers, deemed physically suited for traditionally male jobs, and expected to maintain employment, regardless of their caretaking responsibilities within their own families (Buchanan, Settles, & Woods, 2008, p. 349). While slaves, Black women workers "suffered the same demanding physical labor and brutal punishments as Black men" (King, 1988, p. 47), "consist[ing] of floggings and mutilation . . . as well as raped" (Davis, 1981, p. 7). At the same time, Black women were used for their "reproductive and child-rearing activities . . . to enhance the quantity and quality of the 'capital' of a slave economy" (King, 1988, p. 47), "depriving them of the most sacred woman's role at the time" (Polise, 2017, p. 229).

Furthermore, unlike white women, during slavery, "the rape of a Black woman was not considered a crime and, if prosecuted, the rape was litigated as a property crime with her owners presented as the victims" (Buchanan, Settles, & Woods, 2008, p. 349). King (1988) noted that the

institutionalized exploitation of Black women "as the concubines, mistresses, and sexual slaves of white males distinguished our experience from that of white females' sexual oppression because it could only have existed in relation to racist and classist forms of domination" (King, 1988, p. 47).

Due to the pseudo-legality of rape, Black women were "easily stigmatized as sexually loose beasts, which represented a means for slaveholders to justify rape, and constituted a defiance to the rhetoric of the virtuous woman who must be subjected and confined to the household" (Polise, 2017, p. 229). Complexly, the notion that these "sexually loose" women have partners who are "'Black male beast[s]' . . .represents them as less feminine and vulnerable, failing to live up to the standards of the American cult of the true woman" (Polise, 2017, p. 229) while also being the casualty of both Black male and white male patriarchy.

From the post-slavery era to 2020, many stereotypes emerged of Black females (Bell, 2004; King, 1988). A pervasive sexualized stereotype of Black women is the biblical Jezebel image (Campbell, Dworkin, & Cabral, 2009; Collins, 1990; West, 2004a). According to Britannica (2021), Jezebel was

> the wife of King Ahab, who ruled the kingdom of Israel. By interfering with the exclusive worship of the Hebrew God, Yahweh, by disregarding the rights of the common people, and by defying the great prophets Elijah and Elisha, she provoked the internecine strife that enfeebled Israel for decades. She has come to be known as an archetype of the wicked woman. (para. 1)

The archetype of Jezebel shifted the original meaning away from a violation of religious customs and laws to a depiction of Black women as "sexually insatiable, promiscuous, and morally corrupt (Bell, 2004; Buchanan, Settles, & Woods, 2008; West, 2004a). The Jezebel archetype was

used to justify the sexual exploitation of Black women during and after slavery (Buchanan, Settles, & Woods, 2008; Collins, 1990; West, 2004a).

Over the last century, this archetype is present in the depiction of Black women in many forms of popular culture, such as television, film, advertisements, and the news (Bryant-Davis, 2005; Poran, 2006). Such representations may contribute to individuals viewing Black women in a sexualized manner (Bell, 2004; Buchanan, Settles, & Woods, 2008; Collins, 1990; Settles, 2006; West, 2004a).

The Jezebel archetype intersects with many other stereotypes of Black individuals. While stereotypes of Black men since the 1980s depict them as drug dealers, crack victims, the underclass, the homeless, and subway muggers (Drummond, 1990). Black women are contemporarily stereotyped as Democratic welfare queens, who are immoral, promiscuous, unclean, lazy, and mannerless, or as angry Black women who are loud, aggressive, demanding, and uncivilized (Corbin, Smith, & Garcia, 2018; Harris-Perry, 2011). Other stereotypes of Black women include growing, selling, and eating watermelon (Sheet, 2012; Wade, 2012); viciously devouring buckets of fried chicken (Demby, 2013); the inherently weak connotation of the "strong Black woman" (Corbin, Smith, & Garcia, 2018); and the narcissistic "independent Black woman" (Moody, 2012).

Individually and collectively, these narratives are deployed to maintain a position of power over Black women and have "become, over time, part of the cultural iconography that slowly turns into introjected, implicit truths" (Jordan-Zachery 2009, p. 35), "a process explaining why the life of African American women is still affected today by pervasive models of Black womanhood rooted in the post-slavery era" (Polise, 2017, p. 230).

Historically however, it is not only a white male and Black female problem. Black men are simultaneously embracing narratives to maintain dominance over Black women. Giuseppe Polise (2017) admits that Black men are part of the equation as well. Giuseppe Polise (2017) articulated this well when noting the conundrum of being part of the patriarchy, yet part of the marginalized Black demographic:

> We love Black women as ornaments to our masculinity. We hate to engage the intellectual and emotional complexity of Black women and the art they create because it reminds us that even as Black boys and men trying not to be crushed by oppression, we are mighty fine crushers ourselves. (p. 230)

In contemporary society, the stereotypes of Black women from the post-slavery era, especially the Jezebel archetype, intersect with law and the justice system, and in 2020, particularly in police brutality. Taylor (2016) notes that

> the perpetuation of deeply ingrained stereotypes of African Americans as particularly dangerous, impervious to pain and suffering, careless and carefree, and exempt from empathy, solidarity or basic humanity is what allows police to kill Black people with no threat of punishment. (p. 3)

In response to the trends in police violence against unarmed Black men and women, the #BlackLivesMatter movement was born.

Founded by Patrisse Cullors, Opal Tometi and Alicia Garza (Garza 2014), #BlackLivesMatter was conceived with a specific purpose: "it was a call to arms, a cry to galvanize concrete action in a world where 'Black lives are systematically and intentionally targeted for demise'" (Polise, 2017, p. 227). The emergence of smartphone technology has "erased the lag between when an incident happens and when the public is made aware of it" (Polise, 2017, p. 228)

and has "given people the possibility to record such events and share them so that their occurrence on a daily basis could not be ascribed to fortuitous glitches in police procedures, but inevitably constituted a trend" (Polise, 2017, p. 228).

The news media can no longer simply downplay an event or rule it an isolated incident non-indicative of a large trend that reflects racist ideologies of both police and general society. The public's novel access to information has forced traditional news outlets and their audience to see and acknowledge the pernicious nature of racism and white patriarchal supremacist ideology in the United States. This increase in public awareness has been "painstakingly drawing attention to the many cases of inhumanity occurring in a presumed color-blind, post-racial America" (Polise, 2017, p. 228).

The literature suggests that police violence is not only a Black male problem, but also a Black female problem (Polise, 2017). The accounts of police violence against Black females are underrepresented in media. What has been the focus is that Black males "between 15 and 34 . . . are nine times more likely to be killed by (white) police than any other demographic" (Polise, 2017, p. 229). Male victims of police brutality, such as Trayvon Martin in 2013 and Mike Brown in 2014, received far more media attention and were, as a result, more likely to spark protests and riots. In spite of the lack of media coverage, Black female victims, such as Breonna Taylor, Sandra Bland, Korynn Gaines, Jessica Williams, Grey Shur, Kisha Michael and Mya Hall, comprise a large portion of statistics on police brutality and harassment with "Black women and girls account[ing] for a third of all female victims to police violence" (Polise, 2017, p. 228).

The intersection between racism, economics, and the justice system is apparent in cases of police violence against Black women. Black women generally belong to a marginalized population, have lower social status and economic class, and are, therefore, less likely to be

believed or even heard, which makes them the perfect target of abuse from police (Polise, 2017; Taylor, 2016). The result of this intersection "let police officer Daniel Holtzclaw get off lightly with the alleged rape of thirteen Black women in Tulsa, Oklahoma, while on duty" (Polise, 2017, p. 229). Thus, the silence that occurs after Black women are victims of police brutality "shows how racism . . . also intersects with sexism" (Polise, 2017, p. 229).

Racism and COVID-19.

The COVID-19 pandemic can affect Black females' ability to maintain adequate mental and physical health (Egede & Walker, 2020). Before the emergence of COVID-19, a meta-analysis of 293 studies revealed that racism is significantly associated with poorer mental and physical health (Paradies et al., 2015). These intersections of inequality affect health through social deprivation, such as reduced access to employment, housing, and education; increased environmental exposures; targeted marketing of unhealthy substances; inadequate access to health care; physical injury; psychological trauma resulting from state-sanctioned violence such as police brutality; and chronic exposure to discrimination (Bailey et al., 2017; Paradies et al., 2015). Collectively, these systemic stressors can lead to "diminished participation in healthy behaviors or increased participation in unhealthy behaviors as coping mechanisms" (Egede & Walker, 2020, p. 1). In addition, although the Black race in the United States is made up of a multitude of genetic ancestries; this group as a whole has seen racial discrimination and seclusion into neighborhoods with poor housing, high crime, air and water pollution, and low access to healthy foods which have significant effects on health outcomes (Anthopolos, Kaufman, Messer, & Miranda, 2014; Greer, Kramer, Cook-Smith, & Casper, 2014; Poulson et al., 2020).

Before the pandemic, the Black females in the United States experienced the lowest veteran unemployment rate in a decade (Department of Labor, 2020). However, with the emergence of

COVID-19, employment rates have drastically declined, and other factors associated with racist disparities have become more apparent, as many layers of racial disparity were brought to the surface. Americans saw the headlines of the #BlackLivesMatter movement across social media, which served as a reaction not only to police brutality but also to the inequalities that have been made apparent due to the COVID-19 crisis. With the COVID-19 pandemic, Americans witnessed the vivid intersection between racism, sexism, economics, justice system, and the healthcare system, and began to truly understand how this intersection has created inequalities for the Black population as a whole. Junker (2020) articulated this intersection well:

> The profound inequality that is inflicted by white supremacy, neocolonialism, capitalist extractivism and exploitation, cishet patriarchy is exacerbated today within the nexus of this pandemic zones of terror where Black, Indigenous, and Other People of Color (BIPOC), trans, queer, elderly, and disabled folks continue to be the most vulnerable and suffer from insecurities of all tenors. Instead of functioning as an 'opportunity' to reevaluate and mend the brokenness these injustices have caused, the virus has unmasked how countries are failing to protect their citizens while further militarizing and closing borders, allowing entrepreneurs to capitalize on global suffering, exploit the vulnerable, continue to kill, and find ways to reproduce and strengthen their powers within a pandemic zone. (pp. 117-118)

As Junker (2020) indicated, the stranglehold of bigotry and the status quo in America has systematically created inequalities and has set the system up for the marginalized to fail. This inequality is seen in the literature when numerous studies reported that COVID-19 mortality disproportionately affects the Black population in the United States (Bäcker, 2020; Egede &

Walker, 2020; Golestaneh et al., 2020; Gur et al., 2020; Price-Haywood, Burton, Fort, & Seoane, 2020). For instance, Bäcker (2020) found that "COVID-19 is killing African Americans at a rate 7% to 193% higher than the general population (p. 1). However, one study found that "there are no differences in COVID-19 deaths between Black and white patients in patients under 19, but disparities in death between Black and white Americans increases with advancing age" (Poulson et al., 2020, p. 6).

Possible explanations for why Black Americans have an increased risk of getting COVID-19 and dying from it include greater representation in the following situations. Black Americans do not have the work-at-home privilege of their many white counterparts (Williams, 2020) and are overrepresented as low-wage "essential workers" in service occupations that do not allow for adequate social distancing, such as plants, grocery stores, the plant and agriculture industries, gas stations, and the transportation industry (Bäcker, 2020; Brooks, 2020; Centers for Disease Control and Prevention, 2020; Gould & Shierholz, 2020; Hooper, 2020; Poulson et al., 2020; Rentsch et al., 2020; Tolbert, 2020; Valentino-Devries, Lu, & Dance, 2020). Black Americans "are more likely to live in areas with high housing density, high crime rates, and poor access to healthy foods" (Yancy, 2020, p. E1) and "more likely to rely on public transportation and live in impoverished environments that are not amenable to social distancing" (Williams, 2020, p. 1). Black Americans also have a greater likelihood of living in inner cities with high population density (Alderwick & Gottlieb, 2019; Price-Haywood, Burton, Fort, & Seoane, 2020), in which they may be less able to practice social distancing or limit their contact with their families in more populated, multigenerational households (Brooks, 2020; Cohn & Passel, 2018; Egede & Walker, 2020; Hooper, 2020; Poulson et al., 2020).

In addition, Black Americans experience implicit biases within the health care system (Ordaz-Johnson et al., 2020). Black Americans are overrepresented in jails, prisons, and detention centers, all of which lead to reduced capacity to implement physical distancing (Thomas et al., 2013; Bolin & Kurtz, 2018; Resnick, Galea, & Sivashanker, 2020; Hooper, Nápoles, & Pérez-Stable, 2020; Rentsch et al., 2020). Black Americans have increased risk for comorbidities such as "cardiovascular disease, diabetes, and other chronic diseases Black Americans face due to structural racism, psychosocial stress, and socioeconomic status" (Ordaz-Johnson et al., 2020, Para. 1). That Black Americans have a disproportionate lack of financial resources resulting from years of structural racism confers a host of social risks, including food insecurity, housing instability, limited access to transportation, and lack of insurance to pay for COVID-19 testing and healthcare treatments (Brooks, 2020; Hooper, 2020; Poulson et al., 2020; Williams, 2020).

Black American women who are pregnant may have "greater likelihood of having their employment negatively impacted, more concerns about a lasting economic burden, and more worries about their prenatal care, birth experience, and post-natal needs" (Gur et al., 2020, p. 1) Therefore, COVID-19 has highlighted how social determinants of health, such as economic status, education, employment, and the environment, are impacted by racism.

What is being done about racism?

In recent years, interventions and movements have emerged that are intended to combat structural racism. Interventions for racism include:

(1) Utilizing empowerment frameworks to build trust in Black communities (Ivankova, 2015; Williams, 2020), such as using Community-Based Participatory Action Research (CBPAR) when researching Black participants, an approach that involves community members in the design and implementation of research projects, and that can be used to

empower marginalized communities to take action to improve their health status (Ivankova, 2015; Williams, 2020). This not only "involves the community from project conception through dissemination" but also "seeks to change the underlying systemic issues that are critical to the community and embraces transformative strategies to effect sustained social change" (Williams, 2020, p. 1).

(2) Creating strategies to counter the effects of systemic racism through identifying ways changes can "occur within federal, state, county, and city governments; within private and nonprofit businesses and in the health care, food, housing, education, and justice arenas; and at the individual level" (Egede & Walker, 2020, p. e77).

(3) Denouncing racist beliefs and manifestation of racism system-wide with the objective being that "if everyone took a stand to stop racism and found a way to participate in sustainable change . . ., the result could be transformational" (Egede & Walker, 2020, p. e77).

(4) Recommending actions to mitigate structural racism described by Egede and Walker (2020), such as (1) "[c]hang[ing] policies that keep structural racism in place" (p. e77), (2) "break[ing] down silos and create cross-sector partnerships" (p. e77), (3) "institut[ing] policies to increase economic empowerment" (p. e77), (4) "fund[ing] community programs that enhance neighborhood stability" (p. e77), (5) "be[ing] consistent in efforts by health systems to build trust in vulnerable communities" (p. e77), and "test[ing] and deploy[ing] targeted interventions that address social risk factors" (p. e77).

(5) Embracing frameworks that adjust power dynamics in healthcare to help Black communities on the patient care level. This includes "emphasiz[ing] patient autonomy and provid[ing] tools for addressing socioeconomic or pathologic risk factors relevant to health

outcomes" (Ordaz-Johnson et al., 2020, para. 7). This is accomplished by switching the role of the doctor from being a judge or an authority of healthcare to the student and perceiving the patient not as an ignorant and uninformed person but as an expert of their own experience (Hall, 2020).

Appendix B features many more interventions general society is using to decrease the prevalence of racist beliefs and behaviors.

Conclusion of Underlying Structures: Systemic Factors

In this section regarding the iceberg model's underlying structures, I added a deeper level of understanding about Black female civilians and Black servicewomen. The underlying structures are the systemic factors of racism and sexism. The structural and systemic elements experienced by (1) women, (2) women in the military, (3) Black women, (4) Black women in the military, (5) and Black civilians shown in this section provides context for the next section, which will describe patterns associated with female veterans with a history of MST.

Patterns: Collateral damage.

The next level of the iceberg model presents *Patterns* as "[b]ehavioral patterns or trends over time" (Broo & Törngren, 2018, p. 6). At the patterns level, one focuses on repeated events and tries to notice patterns by asking the question "what trends have there been over time?" (Kim, 1999). In this section, patterns consist of trends of collateral damage faced by female veterans who have experienced MST.

The literature revealed that female veterans of all races have an increased risk for numerous collateral damages following MST, including posttraumatic stress disorder, anxiety, depression, suicidal ideation, alcohol and drug abuse, dissociative disorders, eating disorders, personality disorders, homelessness, disrupted social networks, employment difficulties, and intimate partner

violence (Bell & Reardon, 2011; Blais et al., 2017; Brownstone et al., 2018; Creech & Orchowski, 2016; Frayne et al., 1999; Himmelfarb, Yaeger, & Mintz, 2006; Surís, Lind, Kashner, & Borman, 2007; Van Berlo & Ensink, 2000). In addition to these multiple associations, from the incident(s) themselves, the victim may experience injuries to the genitals and other body surfaces as well as sexually transmitted infections or diseases, unintended pregnancy, dyspareunia, anorgasmia (female orgasmic disorder), and vaginismus (Bartoi and Kinder 1998; Centers for Disease Control and Prevention, 2017; Christensen, 2019; Goodcase, Love, & Ladson, 2015; Tambling, 2012; Van Berlo & Ensink, 2000). Furthermore, the literature revealed that female veterans with a history of MST are also at elevated risk of experiencing various physical health difficulties including liver disease, chronic pulmonary disease, obesity, weight loss, sexual dysfunction, breast cancer, heart attacks, asthma, and hypothyroidism, as well as musculoskeletal, gynecological, urological, neurological, rheumatologic, and gastrointestinal pain and difficulties (Brownstone et al., 2018; Frayne et al., 1999; Murdoch et al., 2006; O'Brien & Sher, 2013; Smith et al., 2011; Turchik et al., 2012).

Relationships between victims and others are impacted following MST. The literature suggested that victims might also "experience disruptions in important relationships, have difficulties trusting themselves or others, have difficulty identifying and setting appropriate interpersonal boundaries, and express concerns about sexual functioning and sexuality" (Bell & Reardon, 2011, p. 39). For instance, "[c]ouples where one individual has experienced MST can have a multitude of relationship issues, such as: problems in understanding the assault; difficulties in commitment; and poor communication patterns" (Goodcase, Love, & Ladson, 2015, p. 292). Also likely are social traumas, such as victim-blaming, stigmatization by peers, family, partner, or community members, which further exacerbate the posttraumatic fallout following MST (Centers

for Disease Control and Prevention, 2017; Christensen, 2019). With the long history of victim-blaming in the United States, she is also likely to blame herself for her victimization and the fallout she is experiencing (Bourke, 2007). Such victim-blaming prevents the perpetrators from being held accountable for their violations (Buchwald, Fletcher, & Roth, 2005), because survivors often internalize the victim-blaming or often believe they were at fault for the violence for "allowing" themselves to be sexually harassed or assaulted in the first place (Bell & Reardon, 2011; Christensen, 2019).

Psychological and sociological responses from MST have been reported. Brownstone et al. (2018) found that female victims with a history of MST "described being sexualized and objectified (rather than treated as equals, peers, or colleagues) [and] often described a struggle to find community, interpersonal support, and belongingness" (p. 6). Brownstone et al. (2018) also found that participants "described loss of trust as a common, immediate, and longstanding response to MST, . . . particularly with men" (p. 8). Brownstone et al. (2018) concluded that the lack of a support network in the military contributed to their "internaliz[ing] experiences of MST, objectification, trust violation, and powerlessness in terms of the attitudes and responses that they developed toward themselves, their bodies, and their femininity" (Brownstone et al., 2018, p. 8).

Patterns in maladaptive coping behaviors.

In the literature, there is a pattern of maladaptive coping behaviors in women veteran populations with a history of MST. In Brownstone et al.'s (2018) phenomenological study on women veterans with a history of MST, participants "described maladaptive coping behaviors as means of escape, [such as] . . . turn[ing] to problematic drinking and emotional (possibly binge) eating after being sexually assaulted, . . . [and] engaging in risky sexual behaviors as means of

coping with MST, like being very promiscuous and using dietary restriction, risky driving, compulsive shopping, and marijuana" (p. 10).

While these coping behaviors are intended to make the situation more manageable or deal with the pain, these maladaptive behaviors often further complicate the problems that already exist from the collateral damage of MST. Even with their attempt to cope, "it can be very hard for many veteran survivors to acknowledge that their experiences of sexual trauma in the military had a powerful impact on them" (Bell & Reardon, 2011, p. 39). Since the coping behavior itself may present as the problem and cloak the initial problems following MST, the veteran also may not see the complex interaction between the maladaptive behavior and the MST experience (Bell & Reardon, 2011).

Patterns in cumulative traumas.

Many female veterans who have experienced MST have also experienced previous trauma and are likely to have experienced additional traumas after leaving the military. After conducting clinical work with MST survivors, Northcut and Kienow (2014) coined the phrase "trauma trifecta" to describe three trends that occur with many MST survivors. The trauma trifecta includes

> [1] the simultaneous loss of personal and professional identity, [2] the occurrence of self-damaging behaviors perceived as necessary to regain control over the body, and [3] the experiences in the military culture that often retraumatised survivors as they seek help. (p. 248)

Adding to this conceptualization, Sandra Bloom (2013) described the phenomenon of sanctuary trauma, which occurs when an individual who is seeking help for trauma encounters what was expected to be a supportive and protective environment but discovers only more trauma.

There is a parallel in the work of Goodcase, Love, and Ladson (2015). In their conceptualization, they likened the experience of military sexual trauma to incest. As servicewomen prepare for deployment, they begin to emotionally detach from their families and connect to their military family. Through basic training, servicewomen are conditioned to respect their commanders, trust their fellow service members, and deindividualize themselves into the group mentality (Goodcase, Love, & Ladson, 2015). However, when a trusted service member commits sexual assault or harassment, the complexity of this trauma is difficult for the victim to process. Through this lens, the veteran had a family-like relationship with the perpetrator and the occurrence happened in a military home, which was perceived to be a safe place (Goodcase, Love, & Ladson, 2015). When this trust is shattered, she may blame herself for something leading up to the incident and have difficulty accepting the breach in trust (Goodcase, Love, & Ladson, 2015).

As in incest, many service members use defense mechanisms (e.g., denial) to cope with the emotional pain caused by the sexual abuse from the trusted individual (Goodcase, Love, & Ladson, 2015). Moreover, Goodcase, Love, and Ladson, (2015) found that the physical and psychological symptoms are also similar between survivors of MST and incest, including depression, sleep-related problems, and sexual dysfunction. In addition, the cognitive and interpersonal effects that survivors of MST and incest often have are low self-esteem, belief that they are unlovable or not worthy of love, and relationship difficulties (Goodcase, Love, & Ladson, 2015). Additional complexities associated with MST include (a) it is an interpersonal trauma perpetrated by someone in a position of trust, which creates mixed messages of acceptable and expected behavior from a trusted other and (b) the victim is often young (in early twenties) and does not have a fully developed repertoire of positive coping strategies (Bell & Reardon, 2011).

In light of Northcut and Kienow's (2014), Bloom's (2013), and Goodcase, Love, and Ladson's (2015) conceptualization, I discovered a pattern of sexual re-victimization in the literature. First, female veterans with a history of MST are likely to have been abused physically or sexually as children (Briere, Kaltman, & Green, 2008; Kelly et al., 2014; Iverson, Mercado, Carpenter, & Street, 2013). Childhood sexual abuse (CSA) often precedes MST, and intimate partner violence (IPV), another type of revictimization, frequently follows (McCauley, Yurk, Jenckes, & Ford, 1998; Murdock & Nichol, 1995). IPV can include physical violence, psychological aggression, and stalking by a significant other and can happen both in the military and as a veteran (Breiding, Basile, Smith, Black, & Mahendra, 2015; Brownstone et al., 2018). A woman is likely to experience anxiety, depression, isolation, physical injuries, and pregnancy after experiencing IPV (Jasinski, 2020; Rossi et al., 2020). Black and Merrick (2013) found that nearly 32% report having experienced physical violence, stalking, or rape from an intimate partner, and West (2004) found that Black women are also disproportionately affected by partner abuse.

IPV is associated with childhood sexual assault (Iverson, Mercado, Carpenter, & Street, 2013). While this CSA-MST-IPV relationship and mechanism is not fully understood, it is possible that the earliest incident of trauma hinders protective senses of intuition that cue for warning signs associated with abusers or characteristics of the perpetrator like alcoholism, drug addiction, and racial and misogynistic tendencies (La Flair et al., 2012; Sadler, Booth, Cook, & Doebbeling, 2003; Widom & Hiller-Sturmhöfel, 2001), or it can also be possible that reoccurring circumstances, or coincidentally similar socioeconomic or dysfunctional environments, predispose them to be victimized sexually (Lawson et al., 2017; West, 2004b).

As a result of this little-understood relationship of sexual revictimization, it is recommended that "[p]roviders working with women veterans should assess for unwanted sexual

experiences during childhood and military service given their strong associations with IPV risk among this population" (Iverson, Mercado, Carpenter, & Street, 2013, p. 771). In addition, factors affecting impact of MST include military environment and ongoing contact with a perpetrator (a feeling of being trapped, helpless, and at risk for additional sexual trauma); dissonance from military values (of loyalty, trust, selflessness, integrity, and teamwork (Department of Defense, 2009); limited social support; and limited maturity to have developed effective posttraumatic coping strategies due to age (Bell & Reardon, 2011).

This long list of associations with MST and how women veterans may cope adds another layer of complexity to the already complex presentation of MST. This further expands our understanding from the surface-level understanding of MST. As a result of the pattern of re-traumatization, the risk for cumulative trauma and likelihood of symptom complexity is increased (Bell & Reardon, 2011; Briere, Kaltman, & Green, 2008; Campbell, Dworkin, & Cabral, 2009; Christensen, 2019; Department of Defense, 2009).

Patterns in literature on PTSD and MST.

A pattern that is constant through MST literature is the relationships among sexual assault, sexual harassment, and PTSD (Kessler et al., 1995; Kilpatrick et al., 1997; Surís & Lind, 2008; Ullman & Brecklin, 2002). Symptoms of PTSD include reliving the event, avoiding places or things that remind the person of the event, a shift to more negative thoughts and feelings, feeling numb, and feeling hyper-aroused (Schmid, 2020; VA, 2016). Numerous studies have reported that women who experienced sexual assault were more likely to experience PTSD than women veterans who have experienced other types of trauma, including combat exposure (Bell & Reardon, 2011; Kang, Dalager, Mahan, & Ishii, 2005; Kessler et al., 1995). Women with MST-related PTSD

are more likely to be homeless and experience suicidal ideation, bipolar disorder, schizophrenia, comorbid depression, anxiety, and eating disorders (Maguen et al., 2012; Pavao et al., 2013).

Similar to the example of complex trauma in the case report from Chapter 1, the literature describes complex trauma. Herman (1992) identified three broad areas to distinguish simple PTSD from complex PTSD:

> The first is symptomatic: the symptom picture in survivors of prolonged trauma often appears to be more complex, diffuse, and tenacious than in simple PTSD. The second is characterological: survivors of prolonged abuse develop characteristic personality changes, including deformations of relatedness and identity. The third area involves the survivor's vulnerability to repeated harm, both self-inflicted and at the hands of others. (p. 379)

Herman's findings indicated that PTSD itself can have a complex symptom picture along with the broader recognized notions of complex trauma. The accumulation of multiple traumatic events and their associated collateral damage complicate the symptom picture. Unfortunately, like MST, PTSD is infrequently reported while in the military, as many fear reporting PTSD symptoms would be career-killing (Rowan & Campise, 2006).

Patterns in literature on PTSD and COVID-19.

During the COVID-19 pandemic, literature supported the fact that female veterans may experience exacerbation of PTSD symptomologies in relation to the COVID-19 environment (Ramchand, Harrell, Berglass, & Lauck, 2020). Marini, Pless-Kaiser, Smith, and Fiori (2020) indicated that the COVID-19 pandemic is reminiscent of wartime for veterans with

> the enactment of the Defense Production Act; concern about shortages of food and medical supplies; separation from family; constant references to mortality; and a

> general sense of uneasiness, powerlessness, ... uncertainty, [and] media outlets us[ing] explicit language that compares COVID-19 to a global war. (p. 217)

The COVID-19 pandemic created a perfect storm that threatens the mental health of many female veterans, particularly those with pre-existing mental health conditions, such as PTSD (Ramchand, Harrell, Berglass, & Lauck, 2020; Scarella, Roland, & Barsky, 2019).

When confronted with this emergent trauma in the COVID-19 environment, female veterans who have experienced past traumas are more likely to develop new mental health symptoms or to experience worsening PTSD symptoms (Ramchand, Harrell, Berglass, & Lauck, 2020). For women veterans with PTSD, the context of an extended pandemic can create a greater risk of anxiety, sense of helplessness, isolation, depression, substance abuse and increases in PTSD symptoms (Ramchand, Harrell, Berglass, & Lauck, 2020). In addition, quarantine has been shown to result in "increased risk of developing mental health problems, particularly when associated with inadequate supplies; boredom; frustration; and a sense of isolation, insufficient or conflicting public health information, fears about personal health or infecting others, and socioeconomic distress or loss" (Ramchand, Harrell, Berglass, & Lauck, 2020, p. 8). For women veterans with a history of MST and PTSD, exposure to the virus also creates additional potential for grief, risk of stigmatization, and rejection by others (Brooks et al., 2020; Watson, 2020).

Even worse, research has reported widespread increases in intimate partner violence (IPV) during the COVID-19 pandemic (Ramchand, Harrell, Berglass, & Lauck, 2020), which is another risk factor for PTSD and revictimization (Iverson, Mercado, Carpenter, & Street, 2013). The likelihood of IPV has been increased by stay-at-home orders (Rossi et al., 2020). With up to 60% of women veterans in relationships reporting IPV (Iverson, Vogt, Maskin, & Smith, 2017), there is considerable risk for this population during the pandemic. When both the intimate partner and

the veteran experience increased emotional, financial, occupational, and social stressors simultaneously, the risk for abuse is elevated (Marini, Pless-Kaiser, Smith, & Fiori, 2020; Rossi et al., 2020). IPV is also more likely to go unreported due to being in close proximity with a controlling, watchful, and vigilant IPV perpetrator.

Even before the pandemic, there were patient barriers including shame, denial, and fear of repercussions from abusers, lack of financial resources to get medical care and housing without the abuser's support, fear of police involvement, and fear the family will separate (McCauley, Yurk, Jenckes, & Ford, 1998). With the history of police brutality against Black men and women, one can also understand that the Black female veterans could fear police involvement if they were called. In addition, physicians reported barriers to their discussing and addressing IPV, including fear of offending the patient, a feeling of powerlessness to help the woman leave an abusive relationship, lack of continuity of patient, lack of education about detection and treatment, and disinclination to consider the possibility of abuse among women of higher socioeconomic backgrounds (McCauley, Yurk, Jenckes, & Ford, 1998).

The literature of this subsection provided a broader discussion about MST, and I was left with knowledge of how PTSD affects female veterans with a history of MST, but not necessarily Black female veterans, as they have been infrequently studied. In order to build a more nuanced understanding of the current reality, in the following section, I return to an earlier discussion of the failure to include MST in a national strategy to eliminate veteran suicide.

Patterns in literature on suicide and MST.

The *National Strategy for Preventing Veteran Suicide (2018-2028)* (Department of Veterans Affairs, 2018) failed to include MST, a known risk factor for suicide in the Black female

veteran population (Kimerling et al., 2016). I argued that the omission of MST and the Black female veteran population from the national strategy resulted in a type III error, as the military and veteran leadership did not formulate the problem of veteran suicide adequately. This subsection serves to provide a deeper understanding of the demographic and risk factor that they omitted.

Research has documented that minority veterans, especially Black female veterans, are at a disproportionate risk for suicide (Kimerling et al., 2015; Kimerling et al. 2016). However, I found that despite their high risk for suicide, Black female veterans have the lowest suicide completion rate of all ethnicities. Czekalinski (2012) estimates that fewer than 3 per 100,000 Black female veterans will die by suicide, despite their increased risk. Given that there are currently about 291,000 (Department of Veterans Affairs, 2020b) Black female veterans, 9, then, would die by suicide per year and 72 would die by suicide before the end of the national strategy in 2028.

The literature supports that suicide, in female veteran populations of all ethnicities, is a growing concern (Campbell, Dworkin, & Cabral, 2009; Kimerling et al., 2015; Kimerling et al. 2016). From 2000 to 2011, Kelly et al. (2014) found that "suicides accounted for 20% of all non-war related deaths of US service members in Iraq and Afghanistan" (p. 413), and there is concern that this suicide percentage could increase if MST rates are not more adequately decreased in the female veteran population (Kimerling et al., 2016).

> For women veterans overall, Monteith et al. (2016a) found that
>
> veterans who screen positive for military sexual trauma are also more likely to die by suicide, adjusting for age, rurality, medical morbidity, and psychiatric conditions (i.e., depression, posttraumatic stress disorder, substance use disorder, bipolar disorder, schizophrenia, and other anxiety disorders). (p. 258)

Monteith et al. (2016a) also found that "[m]ilitary sexual trauma predicted suicidal ideation when adjusting for PTSD, depressive disorders, and negative affect, suggesting that these variables do not fully explain the relationship between military sexual trauma and suicidal ideation among Veterans in VHA care" (p. 263).

For Black female veterans in particular, MST and its collateral damage may increase their risk for suicide (Kimerling et al., 2015; Kimerling et al. 2016). However, there are some studies that suggest otherwise. Although Kimerling et al. (2016) found an increased rate for suicide among Black female veterans, one study of lifetime victimization has reported White and non-White women do not differ in suicidal ideation and attempts (Ullman & Brecklin, 2002). Two decades earlier, when defining trauma as the general effect of the assault on victims' lives, Ruch and Chandler (1983) found that white women were more traumatized than racial or ethnic minority survivors.

Why do Black female veterans not die by suicide more frequently despite their high risk?

A distinguishing factor to explain these varying results may be in how much a woman from a particular ethnic background is traumatized and the efficacy of her coping behaviors. Literature suggests that there are numerous protective factors to keep Black female veterans from committing suicide despite their high risk (Kimerling et al. 2016).

Novacek et al. (2020) provided an explanation for why Black women may be equipped with coping skills that help combat suicidal ideation. They reasoned that

> Despite high levels of exposure to psychosocial stressors, including trauma and discrimination, and systemic barriers that prevent Black Americans from having their mental health needs met, . . . this group displays high levels of resilience via culturally sanctioned coping strategies (Novacek et al., 2020, p. 450)

Earlier researchers supported Novacek et al.'s (2020) explanation in suggesting that Afri-cultural coping tenets, such as spiritual and collective coping in religious or group-focused activities, help manage stress and predict quality of life in Black Americans from high-risk urban communities over and above traditional indicators of coping (Myers et al., 2015; Utsey, Bolden, Lanier, & Williams, 2007). It was postulated that these Afri-cultural coping mechanisms emerged as a result of the historical collective trauma of sexism and racism (Myers et al., 2015; Utsey, Bolden, Lanier, & Williams, 2007). Suicide among Black female veterans and their coping behaviors appear to be unique in presentation from their white counterparts.

Despite coping behaviors of Black communities, MST is sometimes associated with suicide for Black female veterans (Khan et al., 2019; Kimerling, 2016; Monteith et al., 2016a). Monteith et al. (2016b) found that sexual assault was more often associated with suicidal ideation than was sexual harassment, but noted the possibility that "ongoing sexual harassment (e.g., in the battlefield) is a proximal risk factor for suicidal ideation" (p. 753). Khan et al. (2019) added that particular military stressors, specifically, perceived life threat and military sexual assault and harassment were the strongest factors associated with suicidal ideation. Being wounded or injured, loss of someone close, and witnessing someone killed were second highest correlated with suicidal ideation, and seeing injured or dead bodies and killing others in combat were the lowest. Importantly however, "[c]ompared to those who reported the source of their PTSD symptoms as combat- or deployment-related, those who identified MST as the source were at least three times as likely to report current suicidal ideation" (Blais & Monteith, 2018, p. 1).

The literature reveals symptoms of suicidal ideation but does not differentiate by ethnicity. Warning signs of impending suicide include "personal situations, thoughts ('I am a failure'), images (flashbacks), thinking styles (having racing thoughts), mood (feeling down, anxious, and

irritable), or behavior (avoiding previously enjoyed activities, using drugs, and practicing self-isolation)" (Stanley et al., 2008, p. 4). Bell and Reardon (2011) noted that "[w]ithout effective strategies for maintaining internal homeostasis following MST, these individuals . . . may also find themselves drawing on less developmentally advanced coping strategies, such as dissociation, behavioral acting out, or cutting or other forms of self-harm (p. 43).

Unfortunately, like both MST and PTSD, suicidal ideation may not get reported until it is too late. Some may fear the consequences of reporting suicidal ideation, such as loss of second amendment rights, legal provisions, and the extra obligation to attend counseling (Bell & Reardon, 2011; Monteith et al., 2016c; Stanley et al., 2008).

Patterns in literature on suicide and COVID-19.

Suicidal ideation is also exacerbated by conditions arising following the emergence of the novel coronavirus. During the unprecedented COVID-19 pandemic, people around the world may not be able to comfort an ill family member in person, end up surviving when others are dying, and be unable to provide for one's family because of loss of employment (Haller et al., 2020). Ramchand, Harrell, Berglass, and Lauck (2020) indicated that "[t]here is also a real concern that increased mental health symptoms, coupled with a sense of isolation and lost employment or wages, can increase the veteran suicide rate, which is already elevated relative to the general population" (p. 8).

Additional studies also have shown that loneliness brought about by social distancing, quarantining, and isolating threatens psychological health (Leigh-Hunt et al., 2019) and increase risk for cardiovascular disease and an earlier death (Ramchand, Harrell, Berglass, & Lauck, 2020). Family members of COVID-19 patients have reported difficulty comforting patients dying in

isolation and assessing the risk of exposing others to the virus (Haller et al., 2020; Shanafelt, Ripp, & Trockel, 2020; Williamson, Murphy, & Greenberg, 2020).

With many Black female veterans already having suffered moral injury from childhood, MST, and the military's healthcare system (Briere, Kaltman, & Green, 2008; Kelly et al., 2014; Iverson, Mercado, Carpenter, & Street, 2013), COVID-19 can also create yet another moral injury as well as feelings of guilt and shame. The highly distressing, morally difficult, and cumulative nature of COVID-19-related stressors may be a perfect storm to trigger a guilt and shame response (although the actual prevalence will not be known for some time) (Haller et al., 2020, p. 175). Untreated guilt, shame, and moral injury are associated with posttraumatic stress disorder, depression, suicidal ideation, problematic substance use, and poorer functioning and quality of life (Browne, Trim, Myers, & Norman, 2015; Bryan, Morrow, Etienne, & Ray-Sannerud, 2013; Griffin et al., 2019; Haller et al., 2020; Kubany et al., 2004; Norman et al., 2018; Wilkins, Myers, Goldsmith, Buzzella, & Norman, 2013).

In conjunction with the loneliness and potential moral injury, literature also suggests that unplanned job or wage loss may result from factors related to the pandemic and contribute to additional mental health symptoms or suicidal ideation (Karsten & Moser, 2009; Tanielian & Jaycox, 2008; Department of Veterans Affairs, 2019a). Economic stress is also a manifestation of this current reality and a contributing factor for suicide (Blais & Monteith, 2018; Ramchand, Harrell, Berglass, & Lauck, 2020)

Finally, suicide risk is also increased during the pandemic due to the unavailability of positive coping mechanisms and the prevalence of easy-to-obtain negative coping mechanisms in the environment. Ramchand, Harrell, Berglass, and Lauck (2020) noted that

> The emergence of new symptoms or a worsening of existing symptoms can result in maladaptive coping mechanisms, like alcohol or drug misuse, or a deterioration in other areas of their health, and can eventually affect one's family and social relationships or even lead to the loss of stable housing. (p. 8)

While it is difficult to comprehend how long the COVID-19 pandemic will last and if it will increase suicide rates, what is known is that there are interventions that can help reduce the risk for suicide and help Black female veterans overcome other collateral damage.

What is being done about collateral damage?

There are many interventions for the collateral damage of MST that were based on the current understanding of many MST-related problems. Over the last three decades, many novel modalities emerged to join existing traditional interventions in the multidisciplinary toolbox used by the military, the VA, and community health providers to combat the collateral damage of MST, including an increased risk for posttraumatic stress disorder, anxiety, depression, suicidal ideation, alcohol and drug abuse, dissociative disorders, eating disorders, personality disorders, homelessness, disrupted social networks, employment difficulties, and intimate partner violence (Blais et al., 2017; Bell & Reardon, 2011; Brownstone et al., 2018; Creech & Orchowski, 2016; Frayne et al., 1999; Himmelfarb, Yaeger, & Mintz, 2006; Surı´s, Lind, Kashner, & Borman, 2007; Van Berlo & Ensink, 2000).

Because many female veterans might benefit from care coordination after mixed findings of preference and quality of care between the VA and civilian providers (Kimerling et al., 2011), the VA facilities "are partnering with civilian providers to help reach female veterans through community-based agencies" (Kimerling et al., 2011, p. 145). However, an existing problem with seeking help from a community practice is that "[h]ealth care professionals in the civilian sector

may not understand the complexity of the unique experiences and needs of female veterans" (Burkhart & Hogan, 2015, p. 124). Furthermore, "clinicians may be competent in combat trauma, but also need to have competency to address sexual harassment and sexual assault in the military" (Bell & Reardon, 2011, p. 36). There may also be a lack of understanding about military culture in some community-based nonprofits, and not being informed on military culture may lead to female veterans being retraumatized in the civilian healthcare sector as well (Bell & Reardon, 2011). Yet, it can also be argued that the VA is in somewhat of the same position, since many of the physicians at VA facilities have no military background themselves (Bell & Reardon, 2011).

Although the VA, as a whole, is very bureaucratic and slow to change in many VA facilities (Dickerson, 2013), select, progressive VA locations in cooperation with community-based non-profit organizations are fountain-heading a novel variety of tools for the veteran population (Franco, Hooyer, Ruffalo, & Fung, 2020). Going beyond the basic customer service skills and competencies of clinicians, Northcut and Kienow (2014) called for professionals who will work with veterans to

> add as many tools from the therapeutic toolbox as theoretically compatible and pragmatically possible to empower clients to draw on existing strengths and borrow the strengths and comfort of the therapist until they can reconnect with their own strengths—both physically and mentally. (p. 258)

Some of the newest additions to the toolbox of modalities are shown in Table 2.

Table 2. Interventions for Collateral Damage

1. Using theater as a treatment for posttraumatic stress disorder (Ali, Wolfert, & Homer, 2019; Ali & Wolfert, 2016; Franco, Hooyer, Ruffalo, & Fung, 2020).
2. Engaging with military veteran college students in higher education settings (Dobson et al., 2019; Franco, Hooyer, Ruffalo, & Fung, 2020; Kent & Buechner, 2019).

3. Addressing changes in veteran identity in the aftermath of moral injury and integrations between the chaplaincy and psychology (Antal et al., 2019).
4. Allowing individuals departing the military to volunteer as a reintegration strategy in civilian life (Franco, Hooyer, Ruffalo, & Fung, 2020; Matthieu et al., 2019).
5. Using music, mindfulness, yoga, and dance classes in the VA settings for MST-related PTSD (Landis-Shack, Heinz, & Bonn-Miller, 2017; Franco, Hooyer, Ruffalo, & Fung, 2020; Telles, Singh, & Balkrishna, 2012; Northcut & Kienow, 2014; Uebel, 2019).
6. Using equine-facilitated cognitive processing therapy for veterans with PTSD (Wharton, Whitworth, Macauley, & Malone, 2019).
7. Engaging veterans in advisory roles with VA health services research (Franco, Hooyer, Ruffalo, & Fung, 2020; Wendleton et al., 2019).
8. Using photovoice as a strategy to increase trust and communication between veterans larger institutions (Franco, Hooyer, Ruffalo, & Fung, 2020; True et al., 2019).
9. Performing collaborative research on veteran homelessness issues (Franco, Hooyer, Ruffalo, & Fung, 2020; Nelson et al., 2019).
10. Utilizing nature-based, wilderness, and challenge-based outward bound experience therapy, such as snowboarding, rock climbing, white-water rafting, camping, ropes courses, kayaking, canoeing, for veterans with PTSD (Dustin, Bricker, Arave, & Wall, 2011; Hyer et al., 1996).
11. Using exercise-based approaches, such as bodybuilding, mindfulness-based stretching, long-distance running, Crossfit, walking, biking, basketball, and soccer, as part of a healthy lifestyle action plan for both male and female veterans (Burgoyne-Goode, 2014; Caddick & Smith, 2017; DeLuca, 2019; Kim et al., 2013; Shivakumar et al., 2017).
12. Exploring the lived experiences of recent military veterans using psychedelics as a strategy for self-medication (Franco, Hooyer, Ruffalo, & Fung, 2020; Hooyer, 2020).
13. Using faith-based coalitions to support veteran reintegration hubs (Bennet et al., 2019).
14. Allowing for collaborative design of veteran peer support training curricula (Franco, Hooyer, Ruffalo, & Fung, 2020; Ruffalo, 2017).
15. Using strength-based approaches, like Appreciative Inquiry (Cooperrider & Whitney, 2005), with women veterans (Smith-Benson, 2020) to provide a more holistic and balanced approach. This approach is in contrast to traditional deficit-based approaches and is intended to help them lead more fulfilling personal and professional lives.

Appendix C features many more interventions that the VA and community-based organizations have incorporated for MST-related collateral damage.

Conclusion of patterns: Collateral damage.

This section focused on the pattern level, noting trends associated with Black female veterans with a history of MST and helped to answer the question "what trends have there been over time?" Patterns that I identified in the literature were related to maladaptive coping behaviors, cumulative traumas, PTSD and MST, PTSD and COVID-19, suicide and MST, and suicide and COVID-19. In the next section, I will explore the "tip of the iceberg," which is the event level.

The events: MST.

The tip of the iceberg is the events level. Events "[r]epresent the manifest components and actions observable to us" (Broo & Törngren, 2018, p. 6). At this level, one can make observations about a situation. The important question at this stage is "what just happened?"

The literature I focus on here deals with sexual assault, sexual harassment, and military sexual trauma (MST). Since there is a lack of studies that focus on Black female veterans with a history of MST, this level consists of literature on MST experienced by on women veterans in general.

Military sexual trauma can consist of sexual assault, sexual harassment, or both. The Department of Defense (2019) uses the phrase "sexual assault" to "refer to a range of crimes, including rape, sexual assault, forcible sodomy, aggravated sexual contact, abusive sexual contact, and attempts to commit these offense" (p. 3). In contrast, sexual harassment involves "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature" (Schmid, 2020, p. 4). Oftentimes, sexual harassment consists of "comments or physical conduct that offends service members or sexual quid pro quo incidents in which someone uses his or her power or influence within the military to attempt to coerce sexual behavior in exchange for a workplace benefit" (Morral, Gore, & Schell, 2015, p. xviii). Experiences that are considered MST include "unwanted sexual touching or grabbing, threatening, offensive remarks about a

person's body or sexual activities, and threatening and unwelcome sexual advances" (Schmid, 2020, p. 6).

Since the United States Navy Tailhook scandal of 1991, in which 83 women reported they were victims of sexual assault and harassment at a convention in Las Vegas (Department of Defense, 1992), many more women have come forward to tell their MST stories alongside the most popularly cited statistic that MST afflicts 1 in 4 women through sexual assault (Ellison, 2011) and up to 80% of women through sexual harassment (Ellison, 2011).

In the decades that followed the Tailhook scandal, the DOD and VA started taking MST more seriously with careful attention and research directed to recognize the high-stake, riveting effects of MST (Dickerson, 2013). What may have ultimately caught their attention was the cost of medical expenses as well as the estimated "$250,000,000 *a year* in lost productivity, personnel replacement costs, transfers, and absenteeism" (Hollywood, 2007, p. 152). While financial costs may have caught their attention, the costs of MST are far greater than its monetary expenses.

Statistics on MST.

Research has documented that minority veterans, especially Black female veterans, are at a disproportionate risk for many problems, such as military sexual trauma (Department of Veterans Affairs, 2020b; Kimerling et al., 2016). A recent meta-analysis of women of all races revealed that 15.7% of military personnel and veterans report MST (38.4% of women) when the measure includes both harassment and assault (Wilson, 2016, p. 9-10). This meta-analysis also found that 13.9% of military personal report MST (23.6% of women) when measuring for only sexual assault and 31.2% of military personnel report MST (52.5% of women) when measuring for only sexual harassment (Wilson, 2016).

However, statistics on MST prevalence vary greatly. For instance, Arvey and Cavanaugh (1995) indicated that "researchers use widely different definitions of sexual harassment in their survey methods" (p. 41). Variability in sample size, year of study, ethnicity, age, rank, branch, and position may also change the results (Wilson, 2016). Hence, there is great variability in statistics reported in literature. For instance, the first population-based study on MST reported by women veterans shows 40% experienced MST (Barth et al., 2016). A nationally representative sample of female reservists who were discharged prior to OEF/OIF found that 60% of women had experienced repeated or severe sexual harassment at some point during their military service, and 13.1% of women reported being sexually assaulted at least once during their service (Street, Stafford, Mahan, & Hendricks, 2008).

In spite of the variability of statistics, a study suggested that there may have been decrease in incidence throughout the last forty years. Wolff and Mills (2016) found that

> [t]hose who joined the military during integration (1979–1992) had the highest percentage of MST, with each subjected to at least one form of sexual misconduct; the majority (87.5%) experienced more than one form. Individuals who joined after 1992 had the lowest percentage (60%). (p. 843)

Along with the variability of these samples, studies have not represented the incidence of MST in the Black female veteran population, because researchers have not published statistics on MST by race. By grouping women together and not distinguishing the prevalence of the unique experiences of Black women, researchers have missed the opportunity to consider the intricacies embedded within the experiences of Black female veterans. Researchers also do not have data to assess how the prevalence of MST in Black women can be correlated with the historical and

sociological mechanisms of racism, sexism, and their intersectional manifestations. As a result, extant racial differences are obscured.

Risk factors of MST.

Literature on MST details risk factors that increase a women's chance of experiencing sexual assault or sexual harassment. For example, stalking is a considerable risk factor for MST for Black female veterans in particular (Kintzle, Schuyler, Alday-Mejia, & Castro, 2019; Schuyler et al., 2020). One study found that "veterans who were women, of a younger age, single, or nonwhite reported higher rates of stalking experiences" (Kintzle, Schuyler, Alday-Mejia, & Castro, 2019, p. 478). In addition, "women [of all ethnicities] who reported military stalking were 14 and 4 times more likely, respectively, to also report experiencing [MST]" (Kintzle, Schuyler, Alday-Mejia, & Castro, 2019, p. 479). Furthermore, the risk for stalking and assault may be higher if the Black female veteran is a part of the LGBQT+ community (Schuyler et al., 2020). This is not known for certain, however, because studies on LGBQT+ female veterans have considerably small samples "due to fear of judgement, teasing, and cruelty (even a decade after 'Don't Ask, Don't Tell' was released)" (Kerbel, 2019, p. 23).

Women veterans with disabilities are also at increased risk for MST. Campbell, Dworkin, and Cabral (2009) noted that "women with disabilities (mobility/visual/hearing impairments, mental/emotional disabilities, cognitive/developmental disabilities, and/or chemical dependency) are at disproportionately high risk for being sexually assaulted" (p. 238). This supports Elman's (2005) finding that as many as 85% of women with disabilities have been raped.

Childhood sexual trauma is a risk factor for MST. In a study of female active-duty soldiers in the United States Army,

> sexual and physical-emotional abuse during childhood were found to be predictors of unwanted sexual experiences and of acknowledged sexual harassment in the workplace. Among female soldiers, the most severe type of unwanted experience—coercion—was predicted only by childhood physical-emotional abuse. (Martin et al., 1998, p. 269)

Among military service members and veterans, Kelly et al. (2014) "reported prevalence rates of childhood sexual abuse are 25%–49% for women" (p. 414). Childhood sexual, physical, and emotional abuse are highly correlated with MST, although the mechanism for this is not well understood. For female veterans with a history of childhood sexual abuse, this prior trauma can also cause multiple symptoms related to MST, such as depression, PTSD, anxiety disorders, suicidal ideation, substance abuse, self-harm, smoking, sexual promiscuity (Felitti et al., 1998; Kelly et al., 2014).

Reporting sexual assault and harassment.

The literature asserted that many women veterans do not report experiencing sexual assault and sexual harassment. For women who experience MST, the Department of Army (2014) provides two options for filing complaints: formal and informal. Formal sexual harassment complaints "must be filed in writing within sixty days from the date of the alleged incident with the commander lowest echelon of command" (Department of Army, 2014, para. 6). In formal complaints,

> [c]ommanders will then conduct an investigation personally or appoint an investigating officer within fourteen days of receiving the complaint, implement a

> plan to protect the complainant, and consult with a judge advocate or legal advisor should a violation . . . be suspected. (Dickerson, 2013, p. 216)

In contrast, informal complaints are not filed in writing and "may be resolved directly by the individual, with the help of another unit member, the commander or other person in the complainant's chain of command" (Dickerson, 2013, p. 217). However, "[i]f uncomfortable filing within their chain of command, victims may also turn to a chaplain, provost marshal, medical personnel, and the staff judge advocate, among others" (Dickerson, 2013, p. 217). Any agency that receives an informal or formal complaint must talk with the victim and attempt to assure resolution of the complaint, but commanders are responsible for eliminating underlying causes of all complaints (Department of the Army, 2014; Dickerson, 2013). For instance, a servicewoman filing an informal complaint might go to her commander to discuss how another servicemember harassed her. The commander would then work to correct the perpetrator's behavior without conducting a formal investigation. Counseling and supportive services might also be provided.

Despite the reporting options available and well documented prevalence of MST, literature reveals that MST goes largely unreported in the military. As such, MST is sometimes called the "Silent Syndrome," as victims frequently do not report or deal with their MST directly (Herlihy, 2014). For instance, of the "20,300 estimated cases of sexual assault in fiscal year 2014, only 14% of survivors reported their assaults" (Wieskamp, 2018, p. 7). Unfortunately, if sexual assault and harassment are not reported frequently when they happen, working to address the problem at the event level can be especially challenging, as it teaches perpetrators that they can harass or assault again without consequences.

Why do women not report sexual assault and sexual harassment?

The literature includes reasons why women do not report sexual assault and sexual harassment. Barriers to submitting formal or informal complaints include (1) shame, embarrassment, and other threats to personal identity, such as self-blame or pride (Department of Defense, 2009); (2) fear of being stigmatized, gossiped about, and derogatively labeled, not believed, or being blamed (Department of Defense, 2009); and (3) fear of punishment for "collateral misconduct such as underage drinking, fraternization, adultery, or for being in an unauthorized location" (Department of Defense, 2009, p. 30). Fear of punishment is a valid concern for many as one study found that "[m]ore than a quarter of victims and over half of assailants were noted to be under the influence of drugs or alcohol at time of the rape" (Sadler, Booth, Cook, & Doebbeling, 2003, p. 272). Other studies found that women reported being too embarrassed, not knowing how to report MST, having fear of being identified, fearing it would negatively affect their career, and expressing concern that confidentiality would be compromised (Brownstone et al., 2018; Burns, Grindlay, Holt, Manski, & Grossman, 2014; Holland et al., 2015; Mengeling, Booth, Torner, & Sadler, 2014). The Department of Defense (2009) reflects these findings in noting that the victim may have "[m]istrust of the reporting, investigative, and legal processes, or concerns that 'nothing would be done'" (p. 30).

The literature also indicates that even when sexual assessment and assault are reported, the perpetrator often goes unpunished (Brownstone et al., 2018; Protect Our Defenders, 2014; Wieskamp, 2018). Of those cases where the military could take action, Protect Our Defenders (2014) found that only 19% were prosecuted and only 7% of offenders were charged with a sex offense. In addition, among women who made an official report of sexual assault, between 52% (Brownstone et al., 2018; Morral, Gore, & Schell, 2015) and 62% (Protect Our Defenders, 2014) experience some form of social or occupational retaliation. MST victims also "expressed concern

that they would be re-victimized by the process, typically because it would be so difficult to recount repeatedly what happened, especially to strangers" (Department of Defense, 2009, p. 30).

In addition, proving MST is a complex and bureaucratic undertaking. Dickerson (2013) noted that "[p]roving military sexual trauma is thus more difficult than proving other types of trauma because the military could ostensibly attribute the trauma not to incidents that occurred during military service but to pre-military sexual abuse" (p. 223). Invisible injuries or latent symptoms include self-harm, panic attacks, depression, flashbacks, substance abuse, or sleep and eating disorders, emotional numbness, ambivalence, feelings of isolation, alienation from family and friends, hopelessness, lack of motivation, emotional breakdown, humiliation, anger, mood swings, and many other mental health, physiological, economic, and interpersonal difficulties (Blais et al., 2017; Bell & Reardon, 2011; Brownstone et al., 2018; Creech & Orchowski, 2016; Dickerson, 2013 ; Frayne et al., 1999; Himmelfarb, Yaeger, & Mintz, 2006; Surís, Lind, Kashner, & Borman, 2007; Van Berlo & Ensink, 2000).

Dickerson (2013) added that, "[u]nlike burns or broken limbs, the effects of sexual assault are not always obvious, . . . [and] the rehabilitative and long-term disability costs are difficult to calculate" (p. 222). An example that Drake and Burgess-Mundwiller (2019) provide for obtaining VA benefits for female veterans with a history MST is as follows:

> In the MST context, assume a veteran is sexually assaulted while serving in the military and was victimized in a gang rape. Later, the veteran is diagnosed with PTSD and the VA grants service connection for the mental disorder based upon the MST stressor. As the years go on, the veteran develops hip issues and urinary problems and is diagnosed with Pelvic Floor Dysfunction ("PFD"). The treating physician states that it is "as likely as not" the PFD is the result of the rape. The

> veteran also suffers from sleep apnea, and her knee hurts. Advocating for a veteran who has experienced MST can be difficult. (p. 698)

Drake and Burgess-Mundwiller's (2019) example suggests that evidence must be recent and overtly connected to an MST incident for a MST survivor to qualify for VA disability benefits. It also suggests that health conditions that develop later or are less overtly related to an MST incident often do not meet the VA's qualifications. To receive disability benefits and compensation, MST victims must prove that that they have a medically diagnosed disability, submit proof that the sexual assault is causally connected to their military service, and receive a high enough VA disability percentage rating to merit receiving VA compensatory funds (Villarreal & Buckley, 2012).

Dickerson (2013) argued that this burden of proof "places a tough-to-meet evidentiary standard on the majority of victims who do not file a formal or informal report" (p. 222). Drake and Burgess-Mundwiller (2019) added that assimilating the veteran's mental health and physical symptoms into a formula for MST benefits can be frustrating. Going through the reporting process can be especially frustrating because the "veteran may be hesitant to talk about the personal details involved in both the assault and the after-effects" (Drake & Burgess-Mundwiller, 2019, p. 698).

Many women wait until they leave the military to report MST. Because many veterans wait until they depart from the military to make MST-related claims due to fear of reprisal (Banner, 2013), "victims do not receive adequate compensation because either they never report the incident while in the service or they receive help too late—only after they may have experienced retribution in addition to sexual assault" (Dickerson, 2013, p. 224). Dickerson (2013) continued that "[s]uch a result evidences a flawed system. It is time for the military to compensate its victims fairly, in a

process that considers fully the unique nature of military sexual trauma and during the time when victims most need the support" (Dickerson, 2013, p. 224).

It also does not help the situation that many servicemembers believe reports are often false. The Department of Defense (2009) found that individuals believed that false reports are common and were made only "for revenge, to protect themselves from repercussions for infidelity or other misconduct, or when they regret have engaged in consensual sex" (Department of Defense, 2009, p. 33). However, the Department of Defense (2019) asserted that false reports are rare. Overestimation of false reports may be due to the victim's recounting the incident differently throughout the investigation, having cases go to trial with insufficient evidence, and final consequences for the alleged perpetrator not being published or shared (Department of Defense, 2009). Unfortunately, due to the difficulty of distinguishing between a false report and an unsubstantiated report and the widespread assumption that the victims are lying, MST victims may see this as yet another reason not to come forward with confidence to report their traumatic experience (Department of Defense, 2009).

MST and race.

Carlson et al. (2018) indicates that the "[e]xperiences of racial/ethnic discrimination may be even more detrimental in the military, an environment where individuals work closely together and demonstrate loyalty toward one another and where interdependence is required for safety and well-being" (p. 749). However, "[t]o date, there has been inadequate attention on traumatization stemming from race-based stress, within the military or otherwise" (Carlson et al., 2018, p. 750). Veterans may experience "a ubiquity of triggers, including daily microaggressions, media coverage of violence against people of color, and incidents that evoke memories of racial discrimination experienced during service" (Carlson et al., 2018, p. 750). As mentioned

previously, the breaking of trust associated with MST along with discrimination based on sex create additional trauma for Black females in the military (Drake & Burgess-Mundwiller, 2019; Goodcase, Love, & Ladson, 2015).

The literature suggests that there is a connection between perpetrators of sexual harassment and assault (DeLisle et al., 2019), rape myth acceptance (Bell, 1980; Grigg & Manderson, 2015), and racism (Carlson et al., 2018). I found that the servicemembers who show psychopathic traits, and who also hold racist and sexist beliefs, are likely to be perpetrators of sexual assault or sexual harassment against black women (Carlson et al., 2018; DeLisle et al., 2019), and the hypermasculine, white-dominated culture of the military enables this behavior.

DeLisle et al. (2019) found that rape myth acceptance "demonstrates association with psychopathic traits, traditional gender role norms, and negative attitudes towards women" (DeLisle et al., 2019, p. 125). Psychopaths often exhibit a "calloused and manipulative interpersonal style" (DeLisle et al., 2019, p. 129) to assert dominance. This seeking of dominance, in conjunction with elevated rape myth acceptance, creates risk for sexual aggression (Burt & Albin, 1981; DeLisle et al., 2019; Edwards et al., 2011; Mouilso & Calhoun, 2013).

Therefore, dominance exhibited by men with psychopathy serves as a mediating variable between rape myth acceptance and rape proclivity (Chiroro, Bohner, Viki, & Jarvis, 2004; DeLisle et al., 2019) and is associated with hostile attitudes and overt behaviors towards women (DeLisle et al., 2019; Suarez & Gadalla, 2010). Considering that racism may also be a belief system held by the perpetrators with psychopathy, Black female veterans become ideal targets, because, through sexual assault and harassment, the perpetrator can feel both sexually and racially dominant (Bell, 1980; Grigg & Manderson, 2015).

However, while this finding represents a pattern of sexual assault occurrence on the individual level, men with low scores for psychopathy also commit sexual harassment and sexual assault in the military (DeLisle et al., 2019; Suarez & Gadalla, 2010). While mental illness is a factor on the individual level, other factors include the sexualization of Black women and the prevailing racist social pathology stemming from America's history of slavery and the post-slavery era. Nevertheless, much is still unknown about this relationship.

Studies investigating racial differences in sexual harassment frequency have shown inconsistent results (Buchanan, Settles, & Woods, 2008). For example, although the majority of studies have found that Black women report more frequent experiences of sexual harassment than white women (Berdahl & Moore, 2006; Bergman & Drasgow, 2003; Hughes & Dodge, 1997), others have found no differences (Wyatt & Riederle, 1995) or that Black women have lower rates (Piotrkowski, 1998). Buchanan, Settles, and Woods (2008) believed the inconsistency in past studying is an artifact of (1) "the majority of studies examining racial differences in the frequency of overall sexual harassment, but not in sexual harassment subtypes" (p. 348) and (2) "focusing solely on the frequency of overall sexual harassment masks potential racial differences" (p. 348). They then "propose that differences in Black and White women's socio-historical experiences in the United States have resulted in differing gender-role norms regarding work and family caretaking, social status, and race-based sexual stereotypes" (p. 348). These differences may influence the "subtypes of sexual harassment that are experienced, such that gender harassment may be more frequently targeted toward White women, and sexualized forms of harassment may be more commonly directed toward Black women" (p. 348).

With the metaphor and framework of intersectionality, complex intersections between race, sexism, sexual assault and sexual harassment can be observed. For veterans who are both Black

and female, “their membership in multiple marginalized groups, combined with sexualized stereotypes, may make [them] more prone to experience sexualized forms of sexual harassment” (Buchanan, Settles, & Woods, 2008, p. 349). Drawing upon feminist analyses of the double jeopardy of race and sex and the cult of true womanhood, Buchanan, Settles, and Woods (2008) examined the intersection of race, rank, sexual harassment frequency, and psychological distress for Black and White female military personnel (N = 7,714). Their “[r]esults indicated that White women reported more overall sexual harassment, gender harassment, and crude behavior, whereas Black women reported more unwanted sexual attention and sexual coercion” (Buchanan, Settles, & Woods, 2008, p. 347). In essence, they found that Black women “reported experiencing the more severe, but less common forms of sexual harassment, whereas White women reported experiencing the more common but less severe sexual harassment subtypes” (p. 358).

Buchanan, Settles, and Woods (2008) believed that historical and sociocultural underpinnings of white women reporting higher gender harassment rates is associated with “[t]raditional work-related gender-role expectations for white women” (p. 355). They noted that there is still a belief that women should “remain in traditionally female jobs and/or workplaces and that working should be secondary to caring for their families” (p. 355). They also noted that “gender harassment may serve to remind them of their place” (p. 355), a place which has been determined by the patriarchy.

Buchanan, Settles, and Woods (2008) observed that Black women in contrast to white women “have always been expected to work, even in domains that are traditionally deemed appropriate only for men” (p. 355). Therefore, they reasoned that the presence of Black women in the military “may not evoke criticisms about the appropriateness of their presence as working women to the same extent as does the presence of White women” (p. 355). In addition, they also

noted the possibility that sexualized stereotypes, especially the Jezebel image, "were more salient than general work-related gender-role norms, resulting in Black women experiencing more unwanted sexual attention and sexual coercion (i.e., more sexualized forms of harassment), but not gender harassment, than White women" (p. 355).

Neville, Heppner, Oh, Spanierman, and Clark's (2004) examination of the self-esteem of Black and white college rape survivors reflected Buchanan, Settles, and Woods's (2008) later finding that there is a difference in cultural attributes. Neville, Heppner, Oh, Spanierman, and Clark (2004) found that Black women were more likely to internalize the "Jezebel" image following sexual assault. Therefore, not only might the Jezebel image of Black women be believed by the perpetrator of MST, the victim might also internalize the archetype following sexual assault or harassment, and, to some degree, see herself in the Jezebel image (Browne & Kennelly, 1999; Neville, Heppner, Oh, Spanierman, & Clark, 2004; Perkins, 1983).

However, counter to Buchanan, Settles, and Woods's (2008) initial belief that the addition of race into the MST equation would result in Black women's reporting more prevalent and more severe psychological stress, in reality, results indicated that although race predicted psychological distress, "white women reported more [incidence of] psychological distress than Black women" (p. 357). Even though Black women reported more psychological distress following gender harassment than White women, white women reported higher incidence.

Perhaps the increased incidence in white women is due to the intersection between traditional feminine gender norms crossing with the hypermasculinity in the military culture, which creates an environment that may punish women, through gender harassment, for deviating from housewife femininity through gender harassment. Nicole Buchanan also noticed a similar pattern of psychological stress in her previous work on Black and white sexually harassed college

students (Rederstorff, Buchanan, & Settles, 2007). That Black women reported less stress under harassment came as a surprise for Buchanan, Settles, and Woods (2008), because they had initially reasoned that "Black women's increased vulnerability would exacerbate their distress once harassed" (p. 357). Buchanan, Settles, and Woods (2008) believed these results may be related to cultural differences in the manifestation of psychological distress, because previous studies, such as that of Franko et al.'s (2005), found that white women more readily report symptoms of depression, whereas Black women are more likely to report symptoms of somatization (Franko et al., 2005).Although their sample was not of Black female veterans, it is possible that a similar phenomenon occurs with Black female veterans due to their collective experience of racism.

Buchanan, Settles, and Woods's (2008) finding exemplifies how intersections are non-linear, not *additive and negative.* As mentioned previously in the section on racism, each negative variable that is added to a problematic situation does not make the situation incrementally worse, but merely adjusts the complex presentation of the situation (Crenshaw, 1989; Pedulla, 2014).

Perhaps differences in reactions to MST are related to historical and sociological adaptations and subconscious internalizations of Black women and white women regarding sexualized trauma. It is difficult to know for certain though, because both Black and white victims may vary individually. In terms of psychological distress, Buchanan, Settles, and Woods (2008) suggested that the extent of the distress increases with the frequency and severity of sexual assault and harassment. For instance, "although Black officers were less distressed at low levels of sexual coercion, as coercion became more frequent, their distress increased significantly, and at high levels, all groups were similarly distressed" (Buchanan, Settles, & Woods, 2008, p. 347). Similarly, other research suggests that distress increases during prolonged or consecutive traumas (Briere, Kaltman, & Green, 2008; Loeb et al., 2018; Myers et al., 2015).

Perhaps due to the historical context of laws that allowed rapes of slaves, intersections with the Jezebel image held by some white potential perpetrators, and being a female minority in the male military, Black women reported more psychological distress after sexual assault than white women (Burge, 1988; Kelly et al., 2014). Perhaps these intersections contribute to finding that Black rape survivors were more likely to feel that they are at risk for being victimized and sexually assaulted than their white counterparts (Wyatt, 1992). Perhaps these intersections provide an explanation for why Black women internalize attributes of blame and report lower self-esteem than their white counterparts (Neville, Heppner, Oh, Spanierman, & Clark, 2004).

Perhaps even factors of socio-economic status in the military, such as rank, decrease the risk of MST, as Buchanan, Settles, and Woods (2008) found that those of lower rank are more vulnerable and are at greater risk of sexual coercion and sexual harassment in the military (Buchanan, Settles, & Woods, 2008). Black women of higher rank appear to be especially resilient to the negative psychological effects associated with sexual coercion and sexual harassment, perhaps because this resilience may be the same characteristic that helped them reach the rank in the first place (Buchanan, Settles, & Woods, 2008) and Black women of a higher rank may have more power to take disciplinary actions against perpetrators (Firestone & Harris, 1999; Gruber, 2003; Sadler et al., 2016).

Perhaps due to the intersection of their many historical traumas, discrimination and MST, Black women may be equipped with coping skills that help combat trauma differently than their white counterparts, despite high levels of exposure to race-based trauma and discrimination (Carlson et al., 2018). Research suggests that Afri-culturally sanctioned coping strategies, such as spiritual and collective coping in religious or group-focused activities, promote post-traumatic resilience in Black women (Myers et al., 2015; Utsey, Bolden, Lanier, & Williams, 2007). Another

recent study has suggested that "resilience factors including self-reliance and emotion regulation were higher in Black women" (Gur et al., 2020, p. 1). Perhaps these historically developed coping mechanisms emerged as a result of the collective trauma—sexism and racism—experienced by Black females.

I say "perhaps," because in complexity there are no simple-cause-and-effect relationships. There are only intersecting axes that may create trends or erupt into absolute chaotic and individually varied results.

What is being done about MST events?

Based on the current understanding of the event of MST, the DOD has added measures to its military operations to decrease the prevalence of sexual harassment and sexual assault in the military. Because the current body of literature does not offer much information on the experiences of Black female service members with a history of MST, there are no particular interventions for this group.

Similar to how veteran suicide is being understood with the executive order and national strategy in Chapter 1, a rule-of-thumb heuristic based on the white female majority has been used by researchers in this section, and rarely were interventions tailored to Black servicewomen, Black female veterans, and other minority demographics ever specified. While the approach still needs to be grounded in a deeper understanding of minority demographics, the DOD has implemented the following five interventions in order to decrease the prevalence of MST in the military.

(1) Providing initiatives for the highest echelon of the military to learn new policies and procedures regarding MST, such as

> senior leader workshops, the development of a curriculum to train prevention personnel on key competencies, webinars to teach foundational concepts and skills, and partnerships with the Centers for Disease Control and Prevention to provide technical assistance at all command echelons. (Department of Defense, 2019, p. 24)

(2) Increasing "awareness and efforts to help military sexual trauma (MST) survivors have a voice and be heard when reporting this crime" (Brownstone et al., 2018, p. 1) through the initiative of the Department of Defense and their probe into the handling of MST report claims at several military bases (Brownstone et al., 2018).

(3) Developing assessment tools for training new sexual assault victim advocates, revising policies to encourage greater help-seeking and improve support, and providing a safe helpline as a resource for sexual assault victims (Department of Defense, 2019).

(4) Encouraging sexual assault reporting in order to "punish perpetrators, promote recovery, facilitat[e] treatment, and improv[e] military readiness" (Department of Defense, 2019, p. 17).

Appendix D includes additional efforts to eliminate MST. For a more complete and extensive list of hundreds of recent policy and procedure changes for military leadership (including Congress, the Secretary of Defense, Combatant Commanders, Service Secretaries, DOD Inspector General, the Judge Advocate General, and the Sexual Assault Prevention and Response) prior to Fiscal Year 2019, see the *Report of the Defense Task Force on Sexual Assault in the Military Services* by the Department of Defense (2009).

Conclusion of the event(s) of MST.

After exploring mental models used by military and veteran leadership, systemic factors that contribute to how men view women, and patterns associated with women veterans with a

history of MST, I discussed the event of MST. By exploring context before the event, I learned the interdependencies surrounding the event. Had I started with MST, deeper elements of mental models, structural elements, and patterns may have been missed. Ultimately, this bottom-up, systems-informed way of viewing the event of MST has provided context to the problem of MST and helped to develop a more complete understanding of Black females, patterns associated with MST, and MST itself.

Conclusion of Literature Review

In this chapter, I examined the current understanding of Black female veterans with a history of MST. Using Kim's (1999) iceberg model, I adopted a systems approach to examine available literature according to Kim's levels of understanding: mental models, underlying structures, patterns, and events.

Chapter 1 provided an example of how reductionism contributed to the type III error. In order to avoid committing a type III error, I used holism with the iceberg model to view the event of MST as "more than the sum of [its] parts" (Jackson, 2004, p. 4). By using holism, I examined "networks of relationships between the parts . . . in terms of how they give rise to and sustain in extensive the new entity that is the whole" (Jackson, 2004, p. 4). By using the bottom-up approach with the iceberg model, I was able to identify networks of relationships between mental models, underlying structures, and patterns that give rise to the event of MST.

Ironically yet intentionally, I used reductionism to categorize information. The literature itself used reductionism, which "sees the parts as paramount and seeks to identify the parts, understand the parts and work up from an understanding of the parts to an understanding of the whole" (Jackson, 2003, p. 3). The literature itself was often reduced and siloed into topics without looking at the larger picture, such as MST and race, MST and suicide, PTSD, IPV, homelessness,

gender and MST, sexual harassment versus sexual assault, law and MST, race and COVID-19, the VA system and MST, the VA system and race, and the VA system and COVID-19. Had I used the iceberg model in a top-down, instead of bottom-up fashion, I also would have been using the same reductionist approach. For this reason, in the following section, I propose a framework for stakeholders, such as military and veteran leadership, to more adequately address problems, such as MST, faced by Black female veterans.

CHAPTER 3: FRAMEWORK FOR INTERVENTION

In Chapter 2, I reviewed literature using the iceberg model of Daniel Kim (1999) to provide a deeper understanding of the current reality of Black female veterans with a history of MST. Chapter 1 introduced the concepts of wicked problems, complexity, VUCA, how military and veteran leadership tend to think about problems, and the Cynefin framework (Snowden & Boone, 2007; Snowden et al., 2021). I also discussed the way in which suicide is being inadequately formulated and addressed by military and veteran leadership as demonstrated by policies in the national strategy and executive order that are examples of a type III error. In this chapter, I discuss a framework for intervention through a modified Cynefin framework that involves Black female veterans in decision-making.

In Chapter 1, I argued that MST exhibits Starr's (2020) characteristics of wicked problems. For instance, MST does not have a single predictable or preventable cause, making it difficult or impossible to solve (Department of Defense, 2019; Kimerling et al., 2015) (characteristic 1) (Starr, 2020). There is also no definite formulation to adequately represent the cause of MST, as there are many interdependencies that are not well understood, such as rape culture, perpetrator behavior, and the views of men towards women (Department of Defense, 2019) (characteristic 2) (Starr, 2020). Decreasing the MST rate does not require right or wrong answers, but just better answers,

which might be emergent and not at the discretion of experts (characteristics 3 and 4) (Starr, 2020). Finally, each case of MST has interdependent circumstances that are essentially novel and unique (characteristic 5) (Starr, 2020), and attempts to decrease MST rates require one-shot operations, as there are no given alternative solutions but only possible ones (characteristics 6, and 7) (Starr, 2020).

MST, then, is a wicked problem within a complex evolving system. Complex evolving systems "create novelty, self-organize, evolve, and adapt to a changing environment, usually generating more complexity in the process" (Heylighen, 1997, p. 31). Military and veteran leadership understand that problems within complex evolving systems can be VUCA (volatile, uncertain, complex, and ambiguous), a concept that originated in the United States War College (Gerras, 2010; Whiteman, 1998). The emergence of technology, globalization, and multiple complex, interdependent variables has created a complex and rapidly evolving VUCA environment.

Despite having an understanding of VUCA, in the context of Black female veterans with a history of MST, there seems to be confusion as to what makes their problems complex. Numerous articles in the literature discussed MST, its collateral damage, and structural elements as complex (Brown, 2008: Brownstone et al., 2019; Christensen, 2019; Department of Defense, 2009; Hoover, Luchner, & Pickett, 2016; Myers et al., 2020). However, the word "complex" is often not defined or well understood. Solutions cannot be determined until the problem is adequately formulated (Mitroff & Featheringham, 1974).

I argue that military sexual trauma is a complex evolving system problem among Black female veterans. Research on Black female veterans has described those of African American descent as experiencing a complex relationship between gender, race, and class (Carlson et al.,

2018; Crenshaw, 1989; Kimerling et al., 2016; King, 1998; Yancy, 2020). Black female veterans are faced with many complex problems in addition to MST. While seeking help for their problems, they have to navigate not only the complexity of civilian life (Burkhart & Hogan, 2015), but also the VA healthcare system (Brooker, 2014).

The VA is the largest "national health care system and is unique in that it preferentially enrolls the most complex patients into its healthcare plan" (Heyworth et al., 2020, p. 2) and is the only healthcare organization that specializes in MST-related treatment. However, Black veterans are at "risk of experiencing discrimination within the VA health-care system . . . [and] are more likely than their White counterparts to discontinue mental health treatment and report provider dissatisfaction (Carlson et al., 2018, p. 749).

> According to Pourdehnad, Starr, Koerwer, and McCloskey (2020), one
>
> cannot approach problem[s] with the same thinking that enabled [them]. Solutions for this are not right or wrong or true or false, but better or worse. Solutions are emergent; there are no experts who can solve this problem on their own. (p. 1)

The Cynefin framework is part of a framework of intervention that I propose can be used in the future to approach MST and other problems faced by Black female veterans. Conceptual frameworks, such as the Cynefin framework, can be used to understand and make decisions about wicked problems. A conceptual framework is a network of linked concepts, theories, and presumptions that can be used to help understand the elements of a phenomenon, phenomena, or a system.

The Cynefin framework is a tool that can be used to determine and describe the domain of problems experienced by the Black female veteran population. In addition to suggesting in Chapter 1 that veteran leadership missed the complex domain of veteran suicide, I argue that MST also has

been described as being complex without defining the word “complex” or tailoring thinking and decision-making to the complex domain.

The Cynefin framework has been implemented as a tool within the governmental and military domains, such as Department of Homeland Security (Department of Homeland Security, 2015) and military strategists in the Department of Defense and Armed Forces (Marcella, 2010). With the disruption of COVID-19 and the release of Snowden’s work on COVID-19, the Cynefin framework has recently been recognized by some psychologists at the VA (Watson, 2020). Cody et al. (2020) also used the Cynefin framework in the clinical domain when categorizing complexity as a factor for task allocation among general practitioners and nurse practitioners. Earlier, Brooker (2014) used the Cynefin framework in the context of MST in the *Military Law Review* when discussing Uniform Code of Military Justice, MST, and the complexity involved.

Snowden and Boone’s (2007) Cynefin framework is named after the Welsh word “that signifies the multiple factors in our environment and our experience that influence us in ways we can never understand (p. 70),” and “allows executives to see things from new viewpoints, assimilate complex concepts, and address real-world problems and opportunities” (p. 70). The Cynefin framework is a protocol to help leaders diagnose a situation by level of complexity, that is, a degree of unpredictability in a social system in which many individuals or groups interact (Benjamin & Komlos, 2019, p. 5). According to Snowden and Boone (2007), complex problems exhibit “flux and unpredictability” (p.73), involve “many competing ideas” (p.73), and require “creative and innovative approaches” (p.73).

To review, in the Cynefin framework, there are five contexts into which a situation can fall: simple, complicated, complex, chaotic, and disorder:

Figure 3: Cynefin Framework

Simple problems are occurrences in which cause-and-effect relationships are evident to everyone and are appropriate for repeating patterns and consistent events. The leader's job is to ensure proper processes are in place, communicate effectively, and delegate (Snowden and Boone, 2007).

Complicated problems are occurrences in which cause-and-effect relationships are made evident by experts, and there may be more than one answer. The leader's job is to create a panel of experts and listen to conflicting advice (Snowden & Boone, 2007).

Complex problems are occurrences in which there is unpredictability, no right answers, emergent patterns, many competing ideas, and a need for creative and innovative approaches (Snowden & Boone, 2007).

Chaotic problems are occurrences in which there is high turbulence, many decisions, no time to think, high tension, and no clear cause-and-effect relationships (Snowden & Boone, 2007).

Disorder is a state in which a leader does not recognize the occurrence or situation as one of the abovementioned levels of complexity (Snowden and Boone, 2007).

An aspect of the Cynefin framework that I did not address in Chapter 1 was the leader's job when dealing with complexity. According to the Cynefin framework, the leader's job when

working in a complex environment is to probe, sense, and respond. To probe is to search thoroughly, ask questions about, and explore. To sense is to navigate through problems through intuition or inferences from available or emergent patterns or information. To respond is to make a decision or take action based on probing and sensing.

When a context is complex, such as the context in which MST occurs for Black female veterans, a leader must be willing to sense, probe, and respond differently in order to adopt a complexity-informed approach. However, Snowden and Boone (2007) note that many leaders who face complex problems are susceptible to "fall back into habitual, command-and-control mode" (p.73), "look for facts instead of patterns" (p.73), and seek an "accelerated resolution of problems or exploitation of opportunities" (p.73). Brooker (2014) notes that military and veteran leadership are especially susceptible to treating all problems as if they are simple or complicated, as a result of "the military culture's emphasis on command and control and doctrinal support for maintaining an offensive posture and exploiting opportunities" (Brooker, 2014, p. 109).

When a leader is dealing with an oppressed or marginalized population, I argue that the leader should include the oppressed and marginalized in the process of seeking solutions. I argue that to adequately formulate and address problems in the military, Black female veterans must be incorporated as decision-makers, advisors, participants, and resources. In the context of the Cynefin framework, stakeholders, such as Black female veterans with a history of MST, must be doing the sensing, probing, and assisting with the responding and be involved in the process as much as possible.

Leaders in the VA and DOD at large do not have the unique experiences of Black female veterans, but have tried to solve their problems. Continuing to approach problems experienced by

Black female veterans without the input of the Black female veterans themselves will continue the trend of inadequately addressing their problems.

For complex problems, the Cynefin framework indicates that leaders should "increase levels of interaction and communication, create environments and experiments that allow patterns to emerge, [and] encourage dissent and diversity and monitor for emergence" (Snowden & Boone, 2007, p. 73). Furthermore, leaders should "encourage dissent and diversity" (Snowden & Boone, 2007, p.73). Black female veterans can help generate innovative ideas that help leaders with development and execution of complex decisions and strategies. A healthy competition of ideas is what creates successful dialogue and fosters innovation (Brooker, 2014; Snowden & Boone, 2007).

Not only will the incorporation of Black female veterans in the sense-making and decision-making process increase collaboration and innovation, it also will help combat epistemic injustice, or injustice related to knowledge (Fricker, 2007). As mentioned previously, according to Fricker (2007), there are two types of epistemic injustice: testimonial injustice and hermeneutical injustice. Testimonial injustice is unfairness related to trusting the testimony or word of another person (Fricker, 2007). By incorporating Black female veterans in the process, by allowing them to probe, sense, and respond, the leader will be trusting their testimony. Hermeneutical injustice, which occurs when someone's experiences are not well understood—by themselves or by others—because these experiences do not fit any concepts known to them (Fricker, 2007). Black female veterans in particular have experiences that are often complex, ineffable, and unintelligible, and for these reasons, it is difficult for a white male military leader to conceptualize. Historical barriers preventing Black female veterans from participating in journalism, publishing, academia, law, and other institutions (owing to racism and sexism) has further obscured their

experiences and made their experiences more difficult to understand. By incorporating Black female veterans in the sense-making and decision-making process, the Black female veterans can provide insight gathered through their unique experiences.

The idea of involving individuals, who decisions are typically made *for* rather than *with*, in the sense-making process is not new. Over 50 years ago, Russell Ackoff noted that "[p]lanning in government and industry is seldom continuous, adaptive, or participative" (Ackoff, 1970, p. 769). In 1970, Russell Ackoff (1970) entered into a Black community in Philadelphia that had low literacy rates. The experts did not know how to address this problem, so they consulted Ackoff who suggested that they consult the children and individuals in the community to help foster solutions. He understood that "because plans cannot be imposed on a Black ghetto from above, they must be supported from below . . . , [and that] planning must be participative" (Ackoff, 1970, p. 769). He reasoned that

> Blacks should be given an opportunity to solve their own problems in their own way; that they will not, and should not accept white solutions because whites have demonstrated no particular competence in solving the Blacks' problems. Furthermore, Blacks could learn more from their own failures than they can learn from white successes. (Ackoff, 1970, p. 769)

Ackoff (1970) concluded that "the best the white community could do to help the Black community is to enable it to solve its problems in the way it, the Black community, wants to" (p. 769). He was able to change the paradigm because white leaders are always trying to plan for Black individuals rather than letting Black individuals plan for themselves. White leaders should instead support them with the resources required to implement their plans.

Similarly, Snowden and Bateson (2021) have recently taken genital mutilation and rape survivors in Africa and made them ethnographers. These ethnographers studied people at risk for rape in their community. Rape survivors serving as ethnographers probed with knowledge from their own experiences, sensed with intuition borne of their experiences, and responded with the wisdom that evolved from their experience. They also suggest that rape survivors have the unique intuitive ability to sense micronarratives and identify minute details that might not be obvious to the leaders and others in the community without this experience (Snowden & Bateson, 2021).

Problems experienced by Black female veterans, such as MST, can be addressed on multiple levels of leadership and of the community, and even the smallest changes within individual communities can foster change across the system. The "butterfly effect," part of chaos theory in science, describes how small changes in a system can have large consequences or outcomes. Making the small change of incorporating Black female veterans in the process can help decision-makers foster solutions system-wide. By implementing this change in the military (division-by-division), the VA (facility-by-facility), and communities (community-by-community), the entire system can begin the take on characteristics borne of their smaller changes or initial events. Thus, addressing problems in mental models (reductionism), underlying structures (racism and sexism), patterns (childhood sexual trauma and intimate partner violence), and MST rates (punishing perpetrators) discussed in Chapter 2 can ultimately create system-wide change. While MST is not a solvable problem, MST can be addressed more thoroughly by incorporating the Black female veteran MST survivors in the process rather than making decisions for them. Therefore, through the butterfly effect, small changes at the person-to-person, organization-to-organization, or community level can ultimately influence greater system-wide change.

Incorporating Black female veterans in the decision-making process has several implications. In the following paragraphs, I provide my suggestions for the researchers as well as military and veteran leadership who typically make decisions *for* versus make decisions *with* Black female veterans.

For researchers, I recommend using community-based participatory action research (CBPAR) (Williams, 2020), such as photovoice (Wang et al., 1998) or other art-based methodologies (dance, storytelling, writing, and painting), which makes participants co-researchers and provides them with alternative ways to help express the narrative of their experiences. Not only is the position of the co-researcher empowering for the Black female population, but also it is emancipatory, because it provides them with the freedom to express their ideas when they have been historically silenced or ignored. When conducting community-based participatory action research, the Black female veterans themselves should also be given the opportunity to choose the medium of expression of their experiences. Incorporating Black female veterans as co-researchers can improve a study by allowing areas of complexity that are not readily apparent to the researcher to be considered or addressed.

For decision-makers in the military, Department of Veterans Affairs, and community-based nonprofits, I suggest that an effort is needed to build and rebuild relationships with Black female veterans so that they will be willing to assist with the process. This includes *listening* to their stories and their insight and *responding* based on this insight. Black female veterans must not only be given the opportunity to be external advisors to the leaders to sense, probe, and respond, but also be given the opportunity to act internally as stakeholders, employees, managers, and executives with the positional power to change the system. This means that human resource departments should hire Black female veterans for positions that advise on all matters that pertain

to their population. Incorporating Black female veterans both externally and internally can lead to small changes that, over time, lead to improving, reimagining, and redesigning the system. Finally, because sexual harassment and assault do not occur in a vacuum and are caused by perpetrators, I recommend that rapists and harassers be given the task to design a system in which MST is less likely to occur, given that women are part of formerly male-dominated environments.

CHAPTER 4: PATH TO CONCLUSIONS

Throughout this dissertation, I argued that problems, such as MST, faced by Black female veterans are complex, require a holistic, systemic view to understand their current reality, and require the insight and sense-making of Black female veterans themselves to adequately address the problem. As a Black female veteran with a history of MST, I had a personal purpose for selecting my topic. Although I had served twenty years in the military as a Nurse Corps officer, the Doctoral of Strategic Leadership program and the process of writing this dissertation has taught me alternative ways of formulating and thinking about problems. This education led me to reevaluate my previous military and nursing perspectives and approaches and to identify what has failed before in the context of my work in addressing the problem of MST in the Black female veteran population.

As I was writing Chapter 1, I had to question and assess what I learned in my military and nursing experiences, both of which embraced reductionism, rule-of-thumb, and evidence-based methods, which were useful in assessing simple and complicated problems, but, as I now know, are not adequate for addressing a problem within the complex domain. I knew the usefulness of evidence-based and reductionism through twenty years as a Nurse Corps officer. However, when I found an article from Kimerling et al. (2016) that stated that Black female veterans with a history

of MST were at high risk of suicide but were not mentioned in the executive order or national strategy, I saw a prime example of where mental models from my military and nursing experiences failed. Through heuristics and epistemic injustice, Black female veterans like me were left out. Dr. Larry Starr, my internal reader, and Dr. John Pourdehnad, my advisor, advised me that this is an example of a type III error, which is when one chooses "wrong problem representation . . . when one should have . . . chosen the right problem representation" (Mitroff & Featheringham, 1974, p. 383). I then pondered what else, besides reductionism and using heuristics, such as policies, had contributed to the type III error. Later, based on the Cynefin framework, I found that military and veteran leadership also have a domain problem and did not recognize that the environment that contains the problem of veteran suicide is VUCA (volatile, uncertain, complex, and ambiguous).

After further research, I realized that the exclusion of Black female veteran from the policies was not an isolated incident. As I began exploring problems faced by Black female veterans, I realized that there is a lack of information on Black female veterans with a history of MST, making the review of the literature extraordinarily challenging. When I came across Kimerling et al.'s (2016) study, I was initially alarmed by the statistics about MST and by reading that MST increases suicide risk for Black female veterans. However, finding how many Black female veterans actually die by suicide was difficult. It was challenging not only to find out how many Black female veterans there were, but also equally difficult to find the number of suicides in this population per 100,000 lives. Clearly something is wrong when an important human subpopulation has been virtually ignored by scholars and by the organizations purported to employ or serve them.

After months of reading hundreds of scholarly articles, I found Czekalinski's (2012) publication, estimating that fewer than 3 per 100,000 Black women veterans die by suicide per

year. Given that there are roughly 291,000 such women (Department of Veterans Affairs, 2020b), 9 would die by suicide per year and 72 would die by suicide before the end of the national strategy in 2028. It surprised me that the number is the lowest of all ethnic groups. Even though I initially assumed that many were dying per *day*, I found that Afri-cultural protective factors have contributed to this lower suicide rate (Kimerling et al., 2016; Myers et al., 2015; Utsey, Bolden, Lanier, & Williams, 2007).

Compared to suicide, I realized that MST was much more prevalent among Black female veterans, which led me to focus on MST while using suicide in the military to provide an example of the ramifications of a type III error. While it was equally difficult to pinpoint statistics for Black female veterans (owing again to heuristics, epistemic injustice, and context-free decision-making), I would estimate that with a population of about 90,000 Black servicewomen in the military today and with 1 in 4 (Cichowski, 2017) experiencing sexual trauma while in the military, approximately 22,500 would report experiencing rape, sexual harassment, or both during the time of the national strategy (2018-2028). From that point on, I made the decision to work against my habitual reductionism and take a deep dive into the current reality of Black female veterans with a history of MST. I believed that through this understanding, an alternative way of addressing the problem can be imagined.

As I was researching and writing Chapter 2, I realized how vast the problem of MST among Black female veterans is because it has many interdependencies. Due to the systemic nature of the problem, finding a stopping point to a topic that seems to have no end was challenging. I felt as though the literature review could continue on forever. Even though I was taking a systems approach, in early drafts, I habitually reduced everything down to the event of MST. I did not realize this until I had the idea to use Daniel Kim's (1999) iceberg model as a template for

understanding the literature from a systems view. However, applying the model was not enough to curb my penchant for reductionism and an analytical way of thinking. After submitting a draft to Dr. Larry Starr, he indicated that I was using a systems tool with an analytical mindset. Dr. Starr explained that the iceberg model is not a top-down model; it is a bottom-up model. I then realized that what I was doing was exactly what failed before.

As a veteran, I struggled with repressing my habits of using reductionism, command-and-control, and root-cause analysis. Perhaps, in part, this struggle was exacerbated because the literature itself is evidence-based, and, consequently, it was difficult to think about in a systems-informed way.

Earlier in this process, I came to believe that reductionism is bad. However, after pondering with this binary way of thinking, I realized that reductionism and holism both have their time and place. I realized that I had used reductionism and analytical thinking to select a topic for my paper, and I had used reductionism when I decided what to write in each chapter, each paragraph, and each sentence in order to produce focused writing. At the same time, I used holism to understand the context in which the event(s) of sexual harassment or assault in the Black female veterans occur(s).

As I was writing Chapter 3, I was uncomfortable with calling Chapter 3 a "methodology" as dissertation formats would prescribe. I realized that the word "methodology" suggests that a problem is solvable through a linear process. Instead, I selected the word "framework," which connotes *a* way to deal with problems, but not *the* way. I also realized that this framework needs to be another way of addressing this problem.

As can be seen by Appendices A, B, C, and D, I sifted through numerous interventions that were being undertaken to address MST, patterns associated with both MST, and systemic factors

that contribute to MST and the patterns. Because there were so many interventions that had been tried before, it was difficult for me to see where I could add value. However, I saw a gap in the literature, which was revealed through my early reductionism: There was a lack of literature on Black female veterans with a history of MST. This finding gave me a point *to* which I would head, rather than expand *from*. Since there was a lack of information on Black female veterans with MST and what can be done for problems faced by this population, I found an area for intervention. At this point, I was just not sure what exactly that intervention would be.

The first inkling of intervention came when I read Ackoff (1970). He suggested that Blacks should solve their own problems and that whites cannot foster solutions for Blacks. Because, by then, I was planning to suggest the Cynefin framework, while I was reading this article, I realized that there was a shortcoming to my plan. Although I found that the Cynefin framework had been used by the Department of Homeland Security (2015), Department of Defense (Marcella, 2010), and when discussing MST and the Uniform Code of Military Justice (Brooker, 2014), I was unable to find any evidence to support the use of the Cynefin framework by leaders working with marginalized populations and particularly Black female veterans. I learned from Crenshaw (1989) that when working with Black women, one must use an intersectional lens. This is when I began to question if the Cynefin framework would work. A month or so later, I found a recently released video of Dave Snowden (2021) discussing how rape victims served as ethnographers who aided leaders to sense and probe. After discovering this video, I realized that the military and veteran leadership could indeed use the Cynefin framework to aid in making decisions in collaboration with Black female veterans with a history of MST.

As a result, I then realized that this use of the Cynefin was what was missing from the repertoire of interventions that I found in my research. By incorporating Black female veterans in

making decisions within the complex domain, military and veteran leadership can be able to more adequately address their problems and design new solutions. Ultimately, I believe that this intervention will reduce the risk of future type III errors.

As I am writing this conclusion, I am proud of my contribution to the body of literature on this topic. I recognize that, even with my recommendations, the problem of MST cannot be completely solved. However, a system can be designed wherein it is less likely to occur. Designing such a system will require the designers to be systems-informed, complexity-informed, culture-informed, race-informed, violence-informed, gender-informed, trauma-informed, military-informed, intersectionality-informed, emancipatory-informed, and participatory-informed. To accomplish all these, part of the designer team *must* be the Black female veterans with a history of MST.

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APPENDIX A: WHAT IS BEING DONE ABOUT SEXISM?

Table 3. What is being done about Sexism?

(1) Passing sex and discrimination laws that seek to bar discrimination of the base of sex, such as the Fair Employment Act of 1941, Civil Rights Act of 1957 (race, color, religion, sex, national origin, and sexual orientation discrimination), Voting Rights Act of 1965, Employment Non-Discrimination Act, Equal Pay Act of 1963, the creation of the White House Council of Women and Girls in 2009, the Matthew Shepard and Byrd, Jr, Hate Crimes Prevention Act of 2009, and the Don't Ask, Don't Tell Repeal Act of 2010.

(2) Forming movements to end sexism and acts of sexism, such as rape, including the #metoo movement, Time's Up, and All Rise, to inspire and empower millions of survivors to speak out against a culture of systemic sexual violence and silence (Drake & Burgess-Mundwiller, 2019).

(3) Providing platforms in media (including news media, YouTube channels, podcasts, talk shows, social media, and written publications) for survivors of sexual assault in the military to tell their story in order to both empower them and promote cultural change toward the reduction of sexual violence towards women in the military as well as civilian society (Azoulay, 2008).

(4) Evolving rape narratives on platforms from the problematic confessional ("I was raped"), which "assumes secrecy, prohibition, sin, desecration, trespass, transgression, besmirchment of value as a sexual object, a morally pure women, and the patriarchal views of masculinity" (Azoulay, 2008) to the unedited exact script that allows the full story to be told (without producers sensationalizing and dramatizing by isolating parts featuring suffering), and further to an empowerment narrative that seeks to transform the perception of gender and sexual assault and harassment survivors (Azoulay, 2008).

(5) Providing more opportunities for Black women and women from other minority groups to tell their story in order to provide a narrative that is unique to them (Varsanyi, 2019), which is important because white women have had more opportunities historically to tell their stories.

(6) Working to expand movements against sexism like the #metoo movement from the civilian society into the military system, as literature supports that while "experiences and sequelae associated with MST may be unique in some aspects, sexual violence certainly is not unique to the military, and community organizing within the military against MST may help to further shift the culture to decrease the occurrence of sexual assault and sexual harassment" (Brownstone et al., 2018, p. 12).

(7) Avoiding the confessional framework for women in the military, a framework which takes the "suffering of survivors, center[s] them in the domestic realm, and provide[s] warnings that the military is unsafe for women, an implicit moral of its story is that women should stay at home instead of entering the military" (Wieskamp, 2018, p. 14), in order not to feed back into patriarchal narratives while describing the rape of women.

(8) Advising victims of sexual harassment and assault to recognize the "potential dangers in the sensational dimension of [their] appearances on television programs and their susceptibility to becoming again victims [in the] discourse of experts" (Azoulay, 2008, p. 237) who shape the narrative to be sensational by tragic, graphic, and dramatic details, thereby creating the message for other women to recognize their vulnerability and their need for protection from men (Alcoff & Gray-Rosendale, 1993; Azoulay, 2008).

(9) Recommending talk shows that feature survivors of rape "get rid of the experts and turn the rape victim into an expert on her own behalf, the only one able to relate and analyze an event and an experience that have become utterly private, they contrive for the rape victim a speech position outside the hegemonic discourse, a nonnegotiable position that is unwilling to come into contact with any other discourse" (Azoulay, 2008, p. 238).

(10) Recommending that interviewers of sexual assault or harassment survivors do not ask judgmental questions or prompts from interviews "that attempt to examine the rape victim's behavior at the time of the rape and even the very right of the studio audience to judge her behavior" (Azoulay, 2008, p. 237).

(11) Advising survivors not to give interviews if they are to appear on a program beside experts and to carefully vet the talk show or media platform before sharing their story (Alcoff & Gray-Rosendale, 1993).

(12) Promoting the empowerment framework, which "show[s] survivors as experts and modeling paths towards healing" (Alcoff & Gray-Rosendale, 1993, p. 15) and requires an outlook grounded in positive psychology and also requires interviewers to adopt a strength-based approach when creating prompts and asking questions, in order to emphasize the success story and positives of the survivor in spite of what happened during the incident of sexual trauma (Alcoff & Gray-Rosendale, 1993).

(13) Leveraging the empowerment framework to create a public-facing narrative of resilience and strength in multimedia in order to change the perception of women that underpins the rape culture in both military and civilian society in America (Alcoff & Gray-Rosendale, 1993; Wieskamp, 2018).

(14) Encouraging "sexual assault reporting, promoting recovery, facilitating treatment, and improving military readiness" (Department of Defense, 2019, p. 17) in order to punish perpetrators, increase the strength of the military, and push back against rape culture.

(15) Emphasizing that empowerment narratives of rape and sexual assault must do the following: (1) indicate the systemic relationship of sexual violence to stereotypes within patriarchy, and other factors (Wieskamp, 2018), (2) highlight successes, strengths, and positives of the survivors, (3) represent survivors as empowered experts by positioning storytelling as healing (Wieskamp, 2018), (4) "mode[l] paths toward overcoming adversity [by those who] have experienced gendered violence [through the stories' conclusions]" (p. 1), (5) enable survivors to redefine their experiences in more empowering ways and develop a new sense of self (Lawless, 2012), (6) transform a "victim identity" (Stern, 2014, p. 374) into a "healing, feminist identity" (Stern, 2014, p. 374) by enabling narrators to theorize their experience (Stern, 2014), (7) give new meaning to experiences by representing those oppressed by sexual assault in empowering ways (Wieskamp, 2018), and (8) broaden audience perspectives around sexual violence, culture, and rape myths (Wieskamp, 2018).

(16) Providing examples of the success of empowerment narratives of rape, such as how women who "devote[d] themselves to education, new careers, and motherhood helped them rearticulate themselves after trauma" (Wieskamp, 2018, p. 13), became "leaders in addressing military sexual violence" (Wieskamp, 2018, p. 13), "avoid[ed] suicide" (Wieskamp, 2018, p. 13), and "start[ed] an organization" (Wieskamp, 2018, p. 13) in order to "avoi[d] harmful tropes of feminized suffering" (Wieskamp, 2018, p. 5).

(17) Cautioning rape survivors who tell their empowerment narrative that they must be careful not to present over-optimistically, as they would then be "enforc[ing] unrealistic expectations that one can miraculously return to the way things were before sexual violence, or circula[ting] an alienating formulaic narrative" (Wieskamp, 2018, p. 13).

(18) Embracing ironic juxtaposition in the plot of the narrative to show the complexity of the situation and personalizing the narrative by making it non-linear and non-formulaic. For instance, stories of female veterans can describe pride in their military service, followed by their logically contradictory disappointment in the military's failures to support them as women, protect them from rape, and prosecute the perpetrator, and provide proper treatment for their trauma at Veteran Affairs hospitals (Wieskamp, 2018).

(19) Recognizing that "women's stories have the empowerment potential to inspire fellow survivors to begin their own healing process without unraveling into a reductive discourse that renders closeted survivors into powerless victims" (Wieskamp, 2018, p. 14), which, overtime, can create an alternative, non-linear and holistic way of viewing sexual assault, survivors, and their stories (Guthrie & Kunkel, 2015; Wieskamp, 2018).

(20) Leveraging irony in rape narratives to describe "relationships between a problematic gender climate, institutional failures in addressing sexual violence, and the military's rape epidemic" (Wieskamp, 2018, p. 10) in order to "challenge the tendency to associate sexual violence with the individuals who perpetrate it, and invite viewers to question institutional norms surrounding sexual violence" (Wieskamp, 2018, p. 10).

(21) Advising survivors of rape against formulaic stories emphasizing perpetrators as "vicious villains" (Koelsch, 2014, p. 60) and survivors as "pure victims" (Koelsch, 2014, p. 60) without agency, because this can reinforce existing ideals about sexual assault and women and also "alienate those whose experiences differ from this model" (Wieskamp, 2018, p. 5).

(22) Stressing that "[f]ully empowering narratives must establish links between culture and rape practices while also representing those affected by gendered violence in empowering ways" (Wieskamp, 2018, p. 6-7) and incorporate empowering conclusions that "indicate possibilities of reclaiming power in the aftermath of assault, thereby enabling the audience to imagine the survivor as empowered" (Wieskamp, 2018, p. 7).

(23) Realizing that systemic factors, like "[c]ultural myths . . . [and] aspects of both American and military culture, must be addressed to more effectively prevent and respond to sexual assault" (Department of Defense, 2009, p. 6) and that "[e]liminating sexual assault requires a culture change, which reinforces the military's core values of honor, integrity, excellence, commitment, courage, loyalty, and selfless service" (Department of Defense, 2009, p. 1).

(24) Pushing back against sexist beliefs, jokes, and remarks through policy and procedures in order to slowly change male-dominated cultural norms and give way to more inclusive attitudes toward women (Department of Defense, 2019).

(25) Seeking ways to slowly change how the military views "the appropriate role for women in the military, [sees] occupational differences in women's acceptance, [embraces] cynicism about exceptions to standards based on biological differences" (Department of Defense, 2019, p. 5).

APPENDIX B: WHAT IS BEING DONE ABOUT RACISM?

Table 4. What is being done about Racism?

(1) Utilizing empowerment frameworks to build trust in Black communities (Ivankova, 2015; Williams, 2020), such as using community-based participatory action research (CBPAR) when researching Black participants. CBPAR is an approach that involves community members in the design and implementation of research projects, and can be used to empower marginalized communities to take action to improve their health status (Ivankova, 2015; Williams, 2020). It also not only "involves the community from project conception through dissemination" (Williams, 2020, p. 1) but also "seeks to change the underlying systemic issues that are critical to the community and embraces transformative strategies to effect sustained social change" (Williams, 2020, p. 1).

(2) Creating strategies to counter the effects of systemic racism through identifying ways changes can "occur within federal, state, county, and city governments; within private and nonprofit businesses and in the health care, food, housing, education, and justice arenas; and at the individual level" (Egede & Walker, 2020, p. e77).

(3) Denouncing racist beliefs and manifestation of racism system-wide with the objective being that "if everyone took a stand to stop racism and found a way to participate in sustainable change, . . . the result could be transformational" (Egede & Walker, 2020, p. e77).

(4) Recommending actions to mitigate structural racism described by Egede and Walker (2020), such as (1) "[c]hang[ing] policies that keep structural racism in place" (p. e77), (2) "break[ing] down silos and creat[ing] cross-sector partnerships" (p. e77), (3) "institut[ing] policies to increase economic empowerment" (p. e77), (4) "fund[ing] community programs that enhance neighborhood stability" (p. e77), (5) "be[ing] consistent in efforts by health systems to build trust in vulnerable communities" (p. e77), and (6) "test[ing] and deploy[ing] targeted interventions that address social risk factors" (p. e77).

(5) Embracing frameworks that adjust power dynamics in healthcare to help Black communities on the patient care level. This includes "emphasiz[ing] patient autonomy and provid[ing] tools for addressing socioeconomic or pathologic risk factors relevant to health outcomes" (Ordaz-Johnson et al., 2020, para. 7). This is accomplished by switching the role of the doctor from being a judge or an authority of healthcare to the student and perceiving the patient not as an ignorant and uninformed person but as an expert of their own experience (Hall, 2020).

(6) Recognizing that efforts to mitigate structural racism "will take consistent pressure to effect radical changes, . . . and evidence will need to be marshaled to guide ongoing revision" (Egede & Walker, 2020, p. e77).

(7) Making efforts to revise structural elements, like system logistics, economics, policies, and laws, that predominantly affect the Black population and limit their intergenerational economic mobility, such as unfair housing policies and limitations on student loans for formerly incarcerated persons (Egede & Walker, 2020).

(8) Creating positive momentum through funding of multi-level partnerships and pilot projects in underprivileged Black communities to "allo[w] multiple sectors to participate in meaningful systems-level work, buil[d] relationships across sectors, . . . identify ways to leverage and share infrastructure and financing, . . . increas[e] economic empowerment, . . . support structural interventions that build resilience, and alter the structural context of health, rather than merely mitigating social risk" (Egede & Walker, 2020, p. e77), such as improving their access to healthy foods, safety, and decreasing their exposure to environmental pollutants (Egede & Walker, 2020).

(9) Extracting lessons from the HIV/AIDS epidemic (which also affected marginalized populations) to discover ways to actively address the psychosocial influences that affect well-being and reduce health disparities for marginalized populations, such as Black individuals, during the COVID-19 pandemic in order to design interventions that promote health equity (Novacek et al., 2020; Valdiserri & Holtgrave, 2020).

(10) Recognizing that the health disparity created by inability to social distance during the COVID-19 pandemic in jobs predominantly filled by Black Americas is related to the higher prevalence of use of public transportation and higher likelihood of living in inner-city multi-generational households, which makes them more susceptible to contracting the virus (Egede & Walker, 2020; Rentsch et al., 2020; Ordaz-Johnson et al., 2020).

(11) Realizing that historical, systemic atrocities and inequities faced by the Black population from slavery to unethical experimentation (for example, the Tuskegee Study) present a barrier to building trust in the Black population (Egede & Walker, 2020; Ordaz-Johnson et al., 2020) and "has led to low screening rates in Black communities because of concerns about the possible uses of test results" (Egede & Walker, 2020, p. 9).

(12) Emphasizing the importance of addressing systemic healthcare inequalities to policy-makers, clinicians, and medical students so that they are informed of power

imbalances within medical systems and understand how interconnections between health care practitioners and patients impact the quality of care and create potential limitations and barriers (Egede & Walker, 2020; Green & Zook, 2019; Novacek et al., 2020; Yancy, 2020).

(13) Recognizing that with the increase in access to online healthcare, the Black patient can be educated on their condition prior to their appointment, which should be encouraged in order to empower them to continue to take control of their health and have curiosity for knowledge. However, self-diagnosis should still be discouraged (Young, 2015).

(14) Increasing efforts to create a diverse doctor workforce equipped with Black males and females to provide a patient with more options to find the right doctor who is compatible with them as an individual while also specializing in their medical needs. This ensures that doctors have cultural literacy and cultural humility, the lifelong commitment to self-evaluation, and commitment to redressing power imbalances in practice through one's continuous development of cultural competency (Greene-Moton & Minkler, 2020; Ortega, Hinojosa, & Figueroa, 2020; Tervalon & Murray-García, 1998).

(15) Training health care professions who work with Black individuals on how "the health professions intersect with other areas, the history of racism and its impact on health, and how the health field perpetuates social inequality and its relationship to health disparities" (Egede & Walker, 2020, p. e77).

(16) Educating healthcare professionals who work with Black individuals that they should acquire an "understanding of internalized scripts regarding race, . . . maintain ongoing self-reflection, and provide training in ways of supporting organizational change" (Egede & Walker, 2020, p. e77).

APPENDIX C: WHAT IS BEING DONE ABOUT THE COLLATERAL DAMAGE?

Table 5. What is being done about the Collateral Damage?

(1) Using theater as a treatment for posttraumatic stress disorder (Ali, Wolfert, & Homer, 2019; Ali & Wolfert, 2016; Franco, Hooyer, Ruffalo, & Fung, 2020).

(2) Engaging with military veteran college students in higher education settings (Dobson et al., 2019; Franco, Hooyer, Ruffalo, & Fung, 2020; Kent & Buechner, 2019).

(3) Addressing changes in veteran identity in the aftermath of moral injury and integrations between the chaplaincy and psychology (Antal et al., 2019; Franco, Hooyer, Ruffalo, & Fung, 2020).

(4) Allowing individuals departing the military to volunteer as a reintegration strategy in civilian life (Franco, Hooyer, Ruffalo, & Fung, 2020; Matthieu et al., 2019).

(5) Using music, mindfulness, yoga, and dance classes in the VA settings for MST-related PTSD (Landis-Shack, Heinz, & Bonn-Miller, 2017; Franco, Hooyer, Ruffalo, & Fung, 2020; Telles, Singh, & Balkrishna, 2012; Northcut & Kienow, 2014; Uebel, 2019).

(6) Using equine-facilitated cognitive processing therapy with veterans with PTSD (Wharton, Whitworth, Macauley, & Malone, 2019)

(7) Engaging veterans in advisory roles with VA health services research (Franco, Hooyer, Ruffalo, & Fung, 2020; Wendleton et al., 2019).

(8) Using photovoice as a strategy to increase trust and communication between veterans and larger institutions (Franco, Hooyer, Ruffalo, & Fung, 2020; True et al., 2019).

(9) Performing collaborative research on veteran homelessness issues (Franco, Hooyer, Ruffalo, & Fung, 2020; Nelson et al., 2019).

(10) Utilizing nature-based, wilderness, and challenge-based outward bound experience therapy, such as snowboarding, rock climbing, white-water rafting, camping, ropes courses, kayaking, canoeing, for veterans with PTSD (Dustin, Bricker, Arave, & Wall, 2011; Hyer et al., 1996).

(11) Using exercise-based approaches, such as bodybuilding, mindfulness-based stretching, long-distance running, Crossfit, walking, biking, basketball, and soccer, as part of a healthy lifestyle action plan for both male and female veterans

(Burgoyne-Goode, 2014; Caddick & Smith, 2017; DeLuca, 2019; Kim et al., 2013; Shivakumar et al., 2017).

(12) Exploring the lived experiences of recent military veterans using psychedelics as a strategy for self-medication (Franco, Hooyer, Ruffalo, & Fung, 2020; Hooyer, 2020).

(13) Using faith-based coalitions to support veteran reintegration hubs (Bennet et al., 2019).

(14) Allowing for collaborative design of veteran peer support training curricula (Franco, Hooyer, Ruffalo, & Fung, 2020; Ruffalo, 2017).

(15) Using strength-based approaches, like Appreciative Inquiry (Cooperrider & Whitney, 2005), with women veterans (Smith-Benson, 2020) to provide a more holistic and balanced approach. This approach is in contrast to traditional deficit-based approaches and is intended to help them lead more fulfilling personal and professional lives.

(16) Adding training aimed at identifying and addressing unconscious bias among staff and providers around assumptions concerning specific groups of veterans, such as women, minority veterans, and veterans with a history of substance abuse (Bloom, 2013; Lockyer, 2019; True, Rigg, & Butler, 2014).

(17) Leveraging strength-based approaches in select Veteran Health Affairs facilities to facilitate trauma-informed and patient-centered practice modalities (Piette et al., 2011; Briere & Scott, 2015; Brown, 2008; Christensen, 2018; LaVela et al., 2012; Hinojosa et al., 2010; Substance Abuse and Mental Health Services Administration, 2014).

(18) Implementing innovations that "focus on the whole person, not just the disease… includ[ing] providing complementary/alternative therapies, enhancing preferred options for care access and information and creating healing environments through noise reduction, music, and art" (Balbale, Morris, & LaVela, 2014, p. 188).

(19) Incorporating mind and body therapeutic techniques, such as meditation, yoga, and dance, to empower the client to recognize strengths and recognize negative thought patterns (Northcut & Kienow, 2014).

(20) Using recovery-oriented, anti-oppressive, strength-over-pathology, emancipatory, empowerment, and culturally competent strategies to help prevent retraumatizing veterans who seek treatment and to foster posttraumatic resilience (Christensen, 2018; Kelly et al., 2014).

(21) Leveraging photovoice to understand ineffable aspects of the recovery processes such as "pain, isolation, growth, transformation, and healing" (Quaglietti, 2018, p.

226) in veteran populations as well as women veterans with MST-related PTSD (Christensen, 2019; Christensen, 2018; Lockyer, 2019; Rolbiecki, Anderson, Teti, & Albright, 2016).

(22) Actuating participants to leverage the power of positive engagement with others, with themselves via self-talk, and with the therapist to construct ideas about resilience (valuing relationships or finding meaning in trauma) and enable them to cope, adapt, transform, overcome trauma, and ultimately "talk their reliance into existence" (Lockyer, 2019, p. 116).

(23) Providing individuals with previous traumatic experiences a predictable environment when seeking care to provide them with a sense of stability and control (Kelly et al., 2014).

(24) Leveraging positive approaches to provide patients with "tools to enhance their own health care experience" (Balbale, Morris, LaVela, 2014 p. 190), such as "lifestyle changes, . . . including eating healthier, exercising, enrolling in VA health and wellness programs, and following doctors' recommendations" (Balbale, Morris, LaVela, 2014, p. 190).

(25) Adding efforts to help VA healthcare practitioners recognize the importance of sensitively inquiring about in-military sexual assault and harassment and also recognize their role in patient education and addressing physical and emotional care relating to MST throughout women's lifespans (Mengeling, Booth, Torner, & Sadler, 2015).

(26) Adding efforts "to reduce logistical barriers (e.g., allowing time for health care visits) and stigma (e.g., enhancing training for all personnel who work with MST survivors)" (Holland et al., 2015, p. 253) in both VA and community-based practices.

(27) Requiring professionals who work with veterans to take "a Military 101 course, which educates non-military individuals about military culture, such as 'Treating the Invisible Wounds of War'" (Herlihy, 2014, p. 11), which is available through www.aheconnect.com.

(28) Using photovoice (Wang & Burris, 1997) with patients at VA centers to identify recovery themes such as dealing with pain, isolation, growth, transformation, and healing (Quaglietti, 2018, p. 226).

(29) Using photovoice (Wang & Burris, 1997) to probe into ways to improve the perceptions of patients at VA healthcare facilities. Balbale, Morris, and LaVela (2014) found that the following elements were relevant to the patient's experience: "(1) people, including communication with providers and staff; (2) places, including

décor and signage, accessibility and transportation; and (3) system-level factors, including programs and services offered and informational resources" (p. 194).

(30) Forming liaisons between VA healthcare provides who have experience working with MST survivors and community-based practitioners "to ensure that they have sufficient knowledge and competence to assess for MST and treat its health sequelae, as some survivors may choose to seek treatment outside of VHA" (Brownstone et al., 2018, p. 12).

(31) Providing information to clinicians that describes how "objectification, loneliness, and isolation . . . may affect women's ability to trust others as well as impart negative attitudes like disillusionment, resentment, and disdain toward military institutions" (Brownstone et al., 2018).

(32) Providing inquiry guidance for clinicians working with MST survivors, such as asking questions about Branch of Service, whether still in Active Duty or Reserve, and length of time in service, the women's veteran status, their deployment status, military occupation (for example, nursing), and military trauma history (although they may not disclose MST specifically) (Herlihy, 2014; Murdoch et al., 2006). This will help to build an understanding a patient's in-military experiences, build rapport, and "help physicians (and patients) place complicated presentations and behaviors into context and heighten diagnostic suspicion for some illnesses, . . . [and] provide much needed information for women's subsequent treatment" (Murdoch et al., 2006, p. 8).

(33) Teaching clinicians in the VA and community-based practices the incognito nature of the MST sequalea by instructing that MST is often guised by presenting behavior problems, such as substance use or military-condoned alcohol abuse (Knoedel, 2009; Herlihy, 2014), which they use to attempt to manage "intrusive thought, feelings, and images of rape . . . [while, at the same time] creat[ing] the appearance of being 'just like all the other guys'" (Herlihy, 2014, p. 13), but instead often increasing "aggression, re-enactment and re-victimization" (Herlihy, 2014, p. 13).

(34) Educating clinicians to the fact that imparting a military subtext for not seeking help for their symptoms of MST is the conditioned, implicit message in basic training. The military subtext includes being a good soldier who does not question authority, subsuming emotional needs for the mission, ignoring the physical needs and messages from the body, being strong and self-sufficient, not divulging negative

information about peers, and being "owned" by the military (Herlihy, 2014; Knoedel, 2009).

(35) Teaching clinicians how to promote trust and establish empathy in veterans who have experienced the trust violation of MST (Brownstone et al., 2018) through "demonstrating familiarity with and expressing appreciation for women's military history and experiences" (Murdoch et al., 2006, p. 8) in order to "shift any negative, service-related stereotypes or shame these women may have internalized" (Murdoch et al., 2006, p. 8).

(36) Educating clinicians who work with female veterans with a history of MST to use an assumption that "traumas present a challenge to our view of ourselves, others, and the world" (Bell & Reardon, 2011, p. 45). In this view, normal, maladaptive, or inadequate coping strategies or extreme behaviors are conceptualized as the veteran's attempt to fulfill needs for safety, connection with others, and a sense of control, attempt to manage the unmanageable, establish safety in what has been proven to be an unsafe world, and to find stability (Bell & Reardon, 2011).

(37) Teaching clinicians that veterans may have received negative responses when disclosing previously to others, be confused about their reactions to trauma, or think they may be going "crazy." With this knowledge, clinicians can use "this lens [to] hel[p] foster a collaborative, strengths-based relationship, . . . help survivors (re-)establish positive views of themselves and . . . help providers maintain their empathy and warmth even in the face of sometimes confusing, challenging, or seemingly contradictory behavior" (Bell & Reardon, 2011, p. 45). This helps clinicians engage "survivors in a discussion of what need might be driving a given reaction or behavior, the pros and cons of meeting the need in this particular way, and whether there might be alternative ways to meet this need that may be more congruent with the Veteran's larger life goals" (Bell & Reardon, 2011, p. 46).

(38) Leveraging telehealth screening, remote therapy, and other healthcare resources, such as crisis hotlines (such as the National Domestic Violence Hotline), IPV-specific counseling (Strengths and Empowerment (RISE) (Iverson, Gregor, & Gerber, 2017), and Strength at Home (Taft, 2016), social media platforms, internal e-mails, and veteran-specific fact sheets (Veterans Health Administration, 2020), to help identify victims experiencing intimate partner violence during the COVID-19 pandemic. Information about increased risk, what to do, nearby shelters, and other medical, mental health, social work, financial, legal, shelter, and housing resources was also provided (Glass et al., 2017; Rossi et al., 2020).

(39) Providing "direct outreach to engage Veterans and Service members in a personal way that minimizes bureaucratic formality and helps the individual overcome stigma and barriers to care" (Department of Veterans Affairs, 2019, p. 70). The Veteran Centers' Veteran-to-Veteran peer model, described in the *Department of Veterans Affairs' (2019) Functional Organization Manual,* is "critical in helping Veterans

overcome stigma and combat-related avoidance tendencies" (Department of Veterans Affairs, 2019a, p. 70).

(40) Informing clinicians about the need for violence-informed care in order to recognize reactions to triggers to trauma during the patient's experience, as veterans may respond negatively to mental health treatment and clinicians' treatment expectations, such as keeping appointments, sharing personal details, and being locked in an inpatient psychiatric unit. Not being violence-informed can result in patients' aggressive and violent behavior, which, in turn, "leads to negative consequences that result in re-traumatization of veterans themselves and harm to health care personnel, for example, physically restraining an aggressive patient" (Kelly et al., 2014. p. 414).

(41) Advising clinicians about the need to fully "understand the role that previous trauma exposure, including childhood trauma, can play in veterans' current mental health treatment-seeking and responses to treatment[,and] [b]y responding appropriately, clinicians can decrease patient re-victimization and increase patient and staff safety" (Kelly et al., 2014, p. 414).

(42) Informing clinicians that culture must be taken into account when taking a trauma-informed approach, as female veterans can be retraumatized by being a female minority in male-dominated VA programs (Fontana & Rosenheck, 2006), especially if they have a history of MST (Kelly et al., 2014).

(43) Providing training for therapists who work with female veterans who are experiencing intimate partner violence on how to facilitate counseling sessions remotely without the IPV perpetrator's knowing, perform environmental safety checks using headphones and yes-and-no questions ("'Do you need to hang up?', 'Are you safe?', or 'Should I send 911?'" (Rossi et al., 2020, para. 8) which can be responded to with head nods (Rossi et al., 2020). Training also includes implementation of strategies to prevent monitoring through eavesdropping, recording calls, and looking at web browser history. This also includes protocols in case the perpetrator unexpectedly walks into the room (Rossi et al., 2020).

(44) Using feminist grounded theory and photovoice with suicidal female veterans following intimate partner violence and identifying that a relational approach between patient and clinician is vital in the care for suicidal female veterans (Taylor, 2020). The relational approach includes eliminating pressure from health care providers to continue using these skills (changing the way they think, feel, and behave) without being offered other forms of support and prioritizing their dignity, humanity, and need to connect with and be comforted by others (Taylor, 2020).

(45) Creating a model to understand the dynamic of suicidal female veterans who are experiencing IPV. In the model, the suicidal IPV victim who is seeking help goes from *abuser entrapment* to *trauma entrapment* to *system entrapment* with their objective to feel human. It has been shown that validation from health care practitioners move the veteran in the direction of feeling human while invalidation led to feeling dehumanized by the system, which intensified the feeling of being stuck in suicidality and disempowered them by granting more control to the IPV perpetrator (Taylor, 2020).

(46) Providing options for reporting suicidal ideation including 24-hour hotline and urgent care hotline facilities such as the VA Suicide Prevention Hotline 800-273-TALK (8255) (Department of Veterans Affairs, 2016).

(47) Implementing motivational means counseling to motivate a patient to choose to live and to eliminate access to preferred means of suicide (for example, handing over firearms, securing medications, and restricting access to belts, ropes, and knives). A safety plan with motivational means counseling can include (1) "recognizing warning signs that are proximal to an impending suicidal crisis" (Stanley et al., 2008, p. 3), (2) "identifying and employing internal coping strategies without needing to contact another person" (Stanley et al., 2008, p. 3), (3) "utilizing contacts with people as a means of distraction from suicidal thoughts and urges[, which] includes going to healthy social settings, such as a coffee shop or place of religion or socializing with family members or others who may offer support without discussing suicidal thoughts" (Stanley et al., 2008, p. 3), (4) "contacting family members or friends who may help to resolve a crisis and with whom suicidality can be discussed" (Stanley et al., 2008, p. 3), (5) "contacting mental health professionals or agencies" (Stanley et al., 2008, p. 4) and providing the patient with their contact information and non-business hour options, (6) and "reducing the potential for use of lethal means" (Stanley et al., 2008, p. 4).

(48) Providing culturally informed support groups (that is, groups that incorporate coping tenants such as religious, spiritual, and collective coping through group-focused activities (Utsey, Bolden, Lanier, & Williams, 2007; Myers et al., 2015; Novacek et al., 2020). These support groups can help decrease depressive symptomatology in African American women who have recently attempted suicide (Lincoln, Chatters, & Taylor, 2005; Kaslow et al., 2010; Novacek et al., 2020; Taha et al., 2015).

(49) Working with suicidal women to identify coping strategies, which "may involve . . . going for a walk, praying, listening to inspirational music, going online, taking a shower, playing with a pet, exercising, engaging in a hobby, reading, or doing chores" (Stanley et al., 2008, p. 6). Interpersonal coping strategies may include identifying key social settings and people (friends or family) in their natural social environment who may help take them outside themselves and distract them from

their suicidal thoughts and urges, such as coffee shops, parks, or malls, but not places with alcohol and drug use (Stanley et al., 2008).

(50) Using meaning-making and sense-making strategies to help suicidal women understand their life events, relationships, and self (Ignelzi, 2000) and reevaluate her position that her life is pointless, worthless, and full of suffering and turning her attention to what gives her life meaning (Gross, Laws, Park, Hoff, & Hoffmire, 2019).

(51) Creating smartphone applications, such as the Virtual Hope Box, to help suicidal individuals make meaning out of their experiences (Bush et al., 2014).

(52) Using Appreciative Inquiry (Cooperrider & Whitney, 2005) with suicidal individuals in rural Pennsylvania to "a) inquir[e] about the best of what services are known, available, and utilized by suicide survivors, b) imagin[e] what changes and enhancements are necessary for the services afforded to suicide survivors, c) innovate future recommendations for enhancing the existing services, as well as developing ideas for new services and d) implemen[t] change by addressing the findings of this study with appropriate community agencies and professionals" (Reno, 2016, p. 1).

(53) Preparing for increased call volume to the VA's suicide hotline during the COVID-19 pandemic (Myers et al., 2020; Ramchand, Harrell, Berglass, & Lauck, 2020) after recognizing that conditions, health anxiety, mass layoffs, and increases in loneliness from social distancing, lockdowns, and quarantining, have increased the risk for suicidal ideation and suicide (Bob Woodruff Foundation, 2020; Cacioppo et al., 2015; Käll, Backlund, Shafran, & Andersson, 2019; Tyrer, 2018).

(54) Encouraging social connection for veterans during the COVID-19 pandemic through internet-based cognitive behavior therapy (Ramchand, Harrell, Berglass, & Lauck, 2020) and through fostering community with local nonprofit veteran organizations providing means to connect, have fun, and socialize on Zoom, Google Hangouts, Skype, and other telecommunication platforms to foster support through camaraderie (Ramchand, Harrell, Berglass, & Lauck, 2020). This social connection can help decrease loneliness in veterans along with its negative health consequences (Käll, Backlund, Shafran, & Andersson, 2019).

(55) Using psychotherapy as a first-line modality for women experiencing MST-related PTSD, which includes cognitive processing therapy that addresses cognitive patterns, exposure therapy that may use virtual reality programs to allow patients to safely confront the traumatic situation, and eye movement desensitization and reprocessing (EMDR), which combines exposure therapy with eye movements (Conrad, Young, Hogan, & Armstrong, 2014; Department of Veterans Affairs National Center for PTSD, 2010; Haagen et al., 2015; Holder, Holliday, Wiblin, & Suris, 2019; Resick, Monson, & Chard, 2017; Surís et al., 2013).

(56) Prescribing medications, especially selective serotonin reuptake inhibitors (SSRIs), to decrease symptomology like hyperarousal, depression, and anxiety in female veterans with MST-related PTSD (Conrad, Young, Hogan, & Armstrong, 2014; Holder, Holliday, Wiblin, & Suris, 2019; Schmid, 2020).

(57) Recommending that the DOD take steps to achieve institutional transparency on the actual effects of help-seeking behavior for servicemembers who believe admitting PTSD symptomology would be career-ending. Steps can include publishing annual statistics in a centralized article (not numerous scatter research and new articles) on the number or percentage of clearances that were revoked due to reasons related to mental health in order to "mitigate concerns that seeking help will affect a Soldier's security clearance" (Hamaguchi, 2014, p. 208).

(58) Adding efforts to increase servicemember education about how seeking help for PTSD symptoms will not be detrimental to their careers, such as information on "exactly how information concerning mental health treatment is or is not used" (Hamaguchi, 2014, p. 208), which can be required as a part of AR 350-1, Army Training and Leader Development (Department of Army, 2014) and included as a part of the mandatory training on Soldier Resilience or the Army Suicide Prevention Program (Department of Army, 2014).

(59) Identifying more holistic PTSD therapies that are tailored toward women veteran populations after realizing that civilian-oriented therapies have poorer outcomes with women veterans. Veteran coping responses can be particularly intertwined with physical activity (Straud, Siev, Messer, & Zalta, 2019; Thomas et al., 2019; Hegberg, Hayes, & Hayes, 2019). Therefore, the following therapies may serve the female veteran population better than civilian-oriented therapies: nature-based, wilderness, and challenge-based outward bound experience therapy, exercise-based approaches, equine-facilitated cognitive processing therapy, arts-based efforts like theater, music, and dance, and mindfulness approaches, such as breathing exercises, meditation, and yoga (Ali, Wolfert, & Homer, 2019; Burgoyne-Goode, 2014; Caddick & Smith, 2017; Dustin, Bricker, Arave, & Wall, 2011; Franco, Hooyer, Ruffalo, & Fung, 2020; Landis-Shack, Heinz, & Bonn-Miller, 2017; Northcut & Kienow, 2014; Shivakumar et al., 2017; Telles, Singh, & Balkrishna, 2012; Uebel, 2019; Wharton, Whitworth, Macauley, & Malone, 2019).

(60) Using therapeutic approaches used for incest survivors for MST survivors who were betrayed by their "military family," such as transgenerational theory, attachment theory, emotionally focused therapy, and incest treatment models. These therapies are intended "to help the MST survivor and romantic partner process the trauma, . . . identif[y] projections present in the relationship, hel[p] the couple become more sensitive to emotional needs, and hel[p] create a secure attachment within the partnership, which allows the couple to continue processing the trauma even after the termination of therapy" (Goodcase, Love, & Ladson, 2015, p. 291).

(61) Studying how the COVID-19 environment is reminiscent of wartime (food shortage, chaos, and health risk) to provide context for why responses of veterans with PTSD can be varied and complex. During this time, some are stock-piling food and supplies (Brody, 2020; Liberzon & Sripada, 2007) while others "seemed unphased, and perhaps even vindicated, as they have been practicing social distancing (i.e., avoidance) for years" (Sciarrino, Myers, & Wangelin, 2020, p. 69). Sciarrino, Myers, and Wangelin (2020) hypothesize that the "alignment of internal anxious state and external chaotic environment may be resulting in the temporary relief of anxiety for some veterans with PTSD" (p. 70).

(62) Encouraging women veterans, who are now constituting about 20% of aging veterans (Spiro, Settersten, & Aldwin, 2016), to embrace intergenerational solidarity, a state of comradeship between aging veterans and their younger counterparts. Research indicates that veterans should strive for quality experiences with their grandchildren, as it can help reduce feelings of isolation during the COVID-19 pandemic (Marini, Pless-Kaiser, Smith, & Fiori, 2020; Monk, Ogolsky, & Bruner, 2016; Leedahl, Koenig, & Ekerdt, 2011; Sixsmith, Sixsmith, Callender, & Corr, 2014).

(63) Encouraging veterans with PTSD in the midst of the COVID-19 pandemic to stay connected with peers, remain hopeful, increase a sense of safety through a healthy lifestyle, being sanitary, use free mobile apps like PE coach 2, CPT coach, PTSD coach, and CBT-I coach (Sciarrino, Myers, & Wangelin, 2020, p. 69), engage in remote video sessions for PTSD cognitive behavior therapy and in prolonged exposure therapy with Veterans Affairs (VA) Video Connect, and make plans to cope with shelter-in-place measures if needed (Myers, Birks, Grubaugh, & Axon, 2020; Sciarrino, Myers, & Wangelin, 2020; Department of Veterans Affairs, 2020a).

(64) Responding to the COVID-19 pandemic at the VA by (1) training and supporting both the workforce and patients, (2) expanding the technology infrastructure, including distributing equipment, (3) providing consistent messaging to diverse stakeholders, (4) ensuring the needs of high-risk patients are met, and (5) maintaining or expanding, where needed, the capacity to support the private sector (Heyworth et al., 2020).

(65) Introducing critical interventions to the VA during the COVID-19 pandemic. Interventions include (1) improved technology infrastructure and access, which currently includes a loaned tablet program and equipment for remote patient monitoring like thermometers, pulse oximeters, and smartphones (with future plans to incorporate a digital stethoscope, point-of-care ultrasound, and home laboratory testing (Lakhe, Warrier, & Sinha, 2016)), (2) consistent communication through video conferences, traditional forms of written communication, the VA Insider, the

	VA website, e-mail, social media postings, and text messages (for example, a short message service (SMS) application for patient self-management named Annie) (Saleem et al., 2020; Yakovchenko, 2019), and (3) advances in primary and mental healthcare for high-risk populations, such as new disease management protocols for in-home COVID-19 isolation and quarantine, patients with multiple comorbidities, complex medical, social, and behavioral needs, and patients living in rural or broadband-poor areas where a quality connection pose a challenge (Heyworth et al., 2020).
(66)	Leveraging the Interstate Medical Licensure Compact, a multi-state licensure agreement among participating states, to work together to streamline the licensing process for physicians who want to practice in multiple states (Interstate Medical License Compact Staff, 2020) in order to provide access to veterans in remote areas by expanding a physician's ability to practice across state lines.
(67)	Having "special efforts directed to homeless veterans and veterans living in subsidized housing" (Heyworth et al., 2020, p. 6), which includes a process to screen veterans for the Federal Communications Commission's Lifeline program that facilitates access to technology (Federal Communications Commission, 2020), for veterans at risk for homelessness during the COVID-19 pandemic.
(68)	Working with homeless case managers to "understand how trauma related issues, including MST, may affect a Veteran's ability to obtain and maintain housing, healthy relationships, and employment" (Pavao et al., 2013, p. 540).

APPENDIX D: WHAT IS BEING DONE ABOUT MST?

Table 6. What is being done about MST?

(1)	Providing initiatives for the highest echelon of the military to learn new policies and procedures regarding MST, such as "senior leader workshops, the development of a curriculum to train prevention personnel on key competencies, webinars to teach foundational concepts and skills, and partnerships with the Centers for Disease Control and Prevention to provide technical assistance at all command echelons" (Department of Defense, 2019, p. 24).
(2)	Increasing "awareness and efforts to help military sexual trauma (MST) survivors have a voice and be heard when reporting this crime" (Brownstone et al., 2018, p. 1)

through the initiative of the Department of Defense and their probe into the handling of MST report claims at several military bases (Brownstone et al., 2018).

(3) Developing assessment tools for training new sexual assault victim advocates, revising policies to encourage greater help-seeking and improve support, and providing a safe helpline (Department of Defense, 2019).

(4) Encouraging sexual assault reporting in order to "punish perpetrators, promote recovery, facilitating treatment, and improve military readiness" (Department of Defense, 2019, p. 17).

(5) Recognizing that "[u]nlike combat experiences or hostile enemy actions, MST is a preventable occupational exposure" (Barth et al., 2016, p. 84). This means that the Department of Defense plays a critical role in preventing future generations of female veterans from experiencing the same assault and harassment as the generations before them (Barth et al., 2016; Wolff & Mills, 2016).

(6) Responding to requests to decrease the amount of "unacknowledged and unreported crime incidents, especially sexual assault where the offenders may be serial perpetrators" (Mengeling, Booth, Torner, & Sadler, 2014, p. 8) by launching the CATCH program to "improve the identification of repeat sexual assault offenders . . . [and] mak[e] Restricted Reports to confidentially provide information about the alleged offender and incident to law enforcement personnel" (Department of Defense, 2019, p. 16).

(7) Providing initiatives for the highest echelon of the military to learn new policies and procedures regarding MST, such as "senior leader workshops, the development of a curriculum to train prevention personnel on key competencies, webinars to teach foundational concepts and skills, and partnerships with the Centers for Disease Control and Prevention to provide technical assistance at all command echelons" (Department of Defense, 2019, p. 24).

(8) Increasing "education and legal prosecution of perpetrators in the military and increasing access to mental health services for individuals who have suffered from MST" (O'Brien & Sher, 2013, p. 269).

(9) Adding initiatives to encourage interpersonal support between leaderships, other comrades, and MST survivors to aid in the processing of sexual trauma (Brownstone et al., 2018; Golding, Siegel, Sorenson, Burnam, & Stein, 1989).

(10) Training women service members to help one another following sexual harassment or sexual assault (Burkhart & Hogan, 2015) and increasing initiatives to assist women in responding to sexual harassment by including policies and procedures to address the survivors' social isolation through having contact with other women (Pershing, 2003).

(11) Providing "prevention efforts that target service members most likely to perpetrate MST, . . . [such as] higher-ranking men in positions of power, [who] . . . could undergo training regarding how to hold power and privilege in ways that allow them to uphold the honor and duties of such positions" (Brownstone et al., 2018, p. 412).

(12) Emphasizing the need for improved enforcement of policies against sexual assault and harassment, as participants in Burkhart and Hogan (2015) noted that policies and procedures in the past have "not [been] enforced in order to protect servicemen's careers and to support the value of camaraderie for men over women, resulting in servicewomen feeling betrayed" (Burkhart & Hogan, 2015, p. 122).

(13) Looking for ways to allow survivors opportunities to provide feedback after a sexual assault trial, given that MST survivors' complaints are actually accepted for investigation within the bureaucratic system in the first place (Department of Defense Sexual Assault Prevention and Response Office, 2013).

(14) Recommending that the education programs about MST for military leadership incorporate multicultural awareness and draw on pedagogy, gender studies, psychology, and other professional training programs (Brownstone et al., 2018; Case, 2007; Goodman et al., 2004; McIntyre, 2002).

(15) Providing initiatives to inform survivors of MST about the justice process, such as what specifically happened to the perpetrator, to "help mitigate the negative attitudes [held by women] toward the military institution" (Brownstone et al., 2018, p. 12).

(16) Pushing the DOD and VA to actually listen to and understand the perspectives of MST survivors and put them in roles to both empower them as individuals and foster new solutions to the problem they have experienced (Brownstone et al., 2018; Fisher, 2010; Uebel, 2019; Wendleton et al., 2019).

BIOGRAPHICAL SKETCH

Paula Anne Smith-Benson was born and raised in Philadelphia, Pennsylvania. She received her bachelor's degree in nursing from Hampton University. She earned her master's degree in nursing from the University of Alabama at Birmingham. She served her country for twenty years in the United States Air Force receiving an honorable discharge in 2009. While on active duty, she worked as a Registered Nurse and a Certified Nurse Midwife. She traveled around the world and earned numerous awards and medals. She is a doctoral candidate in the Doctor of Management in Strategic Leadership Program at Jefferson University in Philadelphia, Pennsylvania.