A Phenomenological Study on Veterans' Military Sexual Trauma and Its Impacts on Intimate Partner Relationships

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Department of Community Care and Counseling, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

Liberty University

2023

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Abstract

The purpose of this phenomenological study is to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. The theory guiding this study is attachment theory. Therapies such as cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), and eye-movement desensitization and reprocessing (EMDR), demonstrate they could help victims of military sexual trauma (MST) minimize the suffering of post-traumatic stress disorder (PTSD), major depressive disorder (MDD), substance use disorder (SUD), and a host of other debilitating diseases that may have developed as the result of their MST, which could cause difficulties in their intimate partner relationships. Interviewing each participant, this study collected the stories of active-duty service members and veterans who have experienced an MST. MST can come in many forms, but this study focused on service members who have experienced sexual harassment (SH) or sexual assault (SA). SH and SA can be experienced by everyone, but this study focused on heterosexual service members. Those interviews, once analyzed using narrative and grounded theory analytics to articulate the similarities, outlined what similarities each person experienced, if they have received treatment, and which treatment was the most effective. How has the military sexual traumatic event you experienced impacted your intimate partner sexual relationship is what this study set out to answer.

Keywords: intimate partner relationships, military sexual trauma, sexual harassment, sexual assault, PTSD

Dedication

I dedicate this work to all military sexual abuse survivors.

Acknowledgments

There were no louder cheerleaders than my God, my partner, Brian, my Chair, Dr. James Kasten, and my Reader, Dr. Al Sarno who prayed, helped, and patiently guided me get through this journey. I could not have done this without the four of them. I am blessed to have had them in my corner throughout this process.

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List of Abbreviations

Acceptance and Commitment Therapy (ACT)

Childhood Sexual Abuse (CSA)

Cognitive Behavioral Therapy (CBT)

Cognitive-Behavioral Conjoint Therapy (CBCT)

Cognitive Processing Therapy (CPT)

Couples Satisfaction Index (CSI)

Defense Health Agency (DHA)

Department of Defense (DoD)

Eye Movement Desensitization and Reprocessing (EMDR)

Intimate Partner Violence (IPV)

Item Response Theory (IRT)

Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ)

Military Sexual Trauma (MST)

National Archives and Records Administration (NARA)

National Healthcare Services (NHS)

Posttraumatic Stress Disorder (PTSD)

Prolonged Exposure Therapy (PE)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Sexual Assault Prevention and Response (SAPR)

Startle, Physically Upset by Reminders, Anger, and Numbness (SPAN)

Substance Use Disorder (SUD)

Veterans Administration (VA)

Veterans Health Administration (VHA)

World Health Organization (WHO)

Chapter One: Introduction

Overview

The purpose of this phenomenological study was to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. The researcher structured this chapter and presented the background, which included who this problem affected, who knew about it, and what they were doing about it. The researcher then stated why she chose a brief overview of why MST, as a phenomenological research topic. Next, an explanation of the problem and purpose statements, followed by the significance of this study, was addressed. Eventually the researcher provided research questions and definitions pertinent to MST .

Background

Since the inception of our military forces, about 41 million people have served in its Army, Navy, Air Force, Marines, Coast Guard, and as of December 3, 2020, Space Force (National Archives and Records Administration [NARA], 2022). The military peaked during WWII, with over 14 million service members (NARA, 2022). But as of late, the numbers have been much lower. Less than 1.5 million service members are on active duty, and about 1.5 million serve in the reserves (NARA, 2022). The National Center for PTSD reports that in veterans who use Veterans Administration (VA) health care services, about 23 out of 100 women (or 23%) said that they were sexually assaulted while serving, and 38 out of 100 men (or 38%) have experienced sexual harassment while serving (VA.gov, 2018). Because there are more male veterans, this number reflects the sad truth that over half of the MST survivors are male (VA.gov, 2018).

Military sexual trauma is a term used by the VA to describe any experience of sexual assault or sexual harassment suffered during military service (Department of Defense Sexual Assault Prevention and Response [DoD SAPR], 2022). It can also involve acts that forces someone to do something sexual against their will. Such activities can be threats of adverse treatment if that act is not performed (Castro et al., 2015). Conduct also involves sexual contact when a person is sleeping or if that person is overpowered by physical force to have sex (Castro et al., 2015). It is also not limited to grabbing and touching in a manner that makes someone feel uncomfortable (Castro et al., 2015). Sexual assaults in the military pose a substantial threat to military readiness since there are serious health consequences and lower performance outcomes related to sexual assaults (Castro et al., 2015). Though the military's efforts to destroy sexual assault within the services have intensified since it became known in the late 1990s, some still believe that their efforts are half-hearted and inconsistent (Castro et al., 2015). But in recent years, the Department of Defense (DoD) has worked diligently to eradicate it.

MST does not only hurt individuals, but it also drives a wedge between servicemembers and other unit affiliates (Laws et al., 2016). People who experience MST almost always stop trusting their peers and leaders, and they must deal with the stress of war without a social support network to help them deal with or protect them from these stresses (Laws et al., 2016). For MST experiences that are made public through a formal complaint because there were witnesses to the event or because rumors about the event were spread, the unit relationship quality mediation may be capturing negative social interactions that happen after the tragic event (Laws et al., 2016). Researchers of MST believe that after a trauma, the survivor is in a harmful social environment where they feel constantly threatened (Laws et al., 2016). Unfortunately, this makes it more likely that the survivor will be retraumatized (Laws et al., 2016).

Numerous studies have documented the prevalence of sexual assault among active duty and military veterans. More than three percent of male Gulf War-era service members and 41 percent of female Gulf War-era service members reported having been sexually assaulted (Kintzle et al., 2015). Nearly half of female pre-9/11 veterans who served in the military reported being sexually assaulted and assaulted while serving in the military (Kintzle et al., 2015). These findings demonstrate that the United States Armed Forces should better address sexual assault (Patel et al., 2022). MST is a critical concern due to its high prevalence and numerous adverse physical and mental health consequences (Burns et al., 2014). According to studies, those who have been sexually assaulted report their disclosures as unplanned and are more likely to do so on social networks (Rufa et al., 2022). This makes it difficult to accurately capture the number of assaults in the armed forces, making it difficult for commanders, the DoD, and the VA to take prompt action (Rufa et al., 2022).

Undoubtedly, we spend much of our day at work, and violence in the workplace has far-reaching implications for professional and mental healthcare requirements (Rabelo et al., 2019). The workplace in a war zone is not immune to the terrors of such violence (Rabelo et al., 2019). MST prevalence was higher among those who reported receiving VA medical services after leaving the military, an estimate that was even greater than that derived from VA screening records for veterans who served during Operation Enduring Freedom/Operation Iraqi Freedom (Barth et al., 2016).

Not only women are survivors of sexual assault, but male servicemembers have reported sexual harassment, sexual assault, and rape during wartime and deployment (Mondragon et al., 2015). When women were absent from the battlefield, men also experienced sexual traumas (Sexton et al., 2018). Stigma was the most frequently cited barrier to MST reporting (Blais et al.,

2018). Those who claimed the perpetrator was a fellow unit member had the highest secrecy rate (Blais et al., 2018). Because MST is commonly perceived as a "women's issue," this may make providers less likely to screen male servicemembers, and men less likely to report it (Katz et al., 2012). In addition to the MST, servicemembers reported numerous war-related sources of stress (Katz et al., 2012). Men who disclosed unwanted sexual experiences during military service were significantly more likely to have suicidal ideation, 11 times more likely to have created a suicide plan, and seven times more likely to have attempted suicide during military service than men who did not disclose such experiences (Bryan et al., 2015).

Regarding the prevalence of sexual harassment and sexual assault in the armed forces, numerous studies have been conducted. Still, there are only preliminary studies examining the relationship between MST and mental health issues resulting from MST in intimate partner relationships (Thomas et al., 2021; 2020). The DoD has separated sexual harassment and sexual assault for decades (Stander & Thomsen, 2016). All sexual harassment, assaults, and rapes are classified as sexual traumas by the military (Stander & Thomsen, 2016). The DoD SAPR Program Procedures (2015) define sexual harassment as actions or requests of a sexual nature, unwanted sexual advances, or other sexualized behavior that can cause a person to view their working environment as hostile – one in which they feel uncomfortable working due to the nature of the perpetrator's actions. This type of harassment, when repeated regularly, can cause a person to constantly fear that the requestor will conduct threats to make their workplace more uncomfortable or even feel that an assault is imminent (DoD SAPR, 2015).

Sexual assault, on the other hand, is defined as intentional sexual contact in which the victim is coerced, threatened, or intimidated by another who can use their rank or authority to harm the victim if they do not comply (DoD SAPR, 2015). Even though the DoD has clearly

distinguished between sexual harassment and sexual assault, certain behaviors qualify as both (Stander & Thomsen, 2016). These sexual harassments or sexual assaults can lead to a diagnosis such as post-traumatic stress disorder, depression, substance use disorder, chronic pain, sexual difficulties, and anxiety in servicemembers who do not deal with the trauma immediately (Stander & Thomsen, 2016).

Historical Context

The Veterans Administration (VA) has been identifying active-duty service members and veterans who have suffered from military sexual traumatic events for so long that they have mandated that veteran facilities, when processing active-duty service members back into civilian life, ask service members two specific questions regarding MST (Goldberg et al., 2019). It is mandated that the processing officer ask exiting service members the following questions: (1) while you were in the military, did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks and (2) while you were serving in the military, did someone ever use force or the threat of force to have sexual contact with you against your will (Goldberg et al., 2019). Though answering either of these questions in the affirmative does not indicate that a service member is dealing with any stressors that may have accompanied the unwanted behaviors, has been diagnosed with PTSD as a result of the MST, or needs mental health care treatment, it does indicate that sexual harassment or sexual assault is so prevalent that it is now part of the screening process for service members leaving the armed forces (Goldberg et al., 2019).

Those who answered in the affirmative, however, may have experienced a harrowing MST, are suffering from stressors that accompany the MST, and will require mental health care treatment to manage the effects of these stressors (Goldberg et al., 2019). Even though there are

numerous studies describing MST, whom it affects, the prevalence of MST within the services, and what the DoD is doing to combat those behaviors and limit opportunities that can lead to an MST, there are few studies on how a person who has experienced an MST can successfully function in intimate partner relationships (Goldberg et al., 2019).

Social Context

It is unacceptable for a service member to engage in sexual harassment or sexual assault against another service member (DoD, 2022). There is no justification for committing such a heinous offense. Baca (2011) argues that it may be because the perpetrator wishes to demonstrate dominance and control over the victim. Also, why are so many instances of sexual harassment and sexual assault but so few reports? Unfortunately, there are several explanations for this. According to Groves (2013), even though sexual assault is a crime, it is difficult for some survivors to report the assault. In addition to the stigma of appearing weak (mostly male survivors) that comes with reporting sexual harassment or sexual assault (Blais et al., 2018), the survivor may lack confidence in the leadership's ability to act (Sadler et al., 2018).

According to a study by Gurung et al. (2018), the struggle LGBT service members face with MST and sexual orientation discrimination is shocking. As with numerous studies before this one, their findings demonstrated that MST and sexual orientation discrimination are prevalent among this population, and the DoD and VA should immediately reevaluate their accountability and oversight practices (Gurung et al., 2018). The solution to having fewer or no MST survivors is to instill respect and professionalism in service members toward their fellow service members (Klein & Gallus, 2018). Even though this armed forces social problem occurs within the military ranks, it affects the entire country. The military was established to serve and protect the nation, so everyone suffers when the protectors are not protected from themselves

(Klein & Gallus, 2018). Klein and Gallus (2018) strongly recommended that these recommendations be implemented immediately to create a military where respect and professionalism are the guiding principles.

Theoretical Context

John Bowlby's attachment theory has been fully realized as a life-span framework for understanding human development (Crowell et al., 1999, p.434), important for comprehending the long-term effects of early attachment experiences on psychological and physical health (Sable, 2008). Bowlby's original idea that sparked widespread interest in attachment was his perspective on the nature of the baby-caregiver link; nevertheless, there is now a vast body of literature and research on adult attachment, including how the theory might be beneficial in clinical practice (Sable, 2008). The mother-child connection is a subconscious relationship between the newborn and the primary caregiver that becomes the driving force for a pattern of actions throughout the infant's lifetime (Freud, 1932). The attachment theory, developed by Bowlby who expanded on Freud's theory, believed that attachment is one specific aspect of the relationship between a child and a parent with its purpose being to make a child safe, secure, and protected (Bowlby, 1969, 1973, 1980).

With hundreds of studies conducted over decades, we now have a massive and coherent database that acknowledges and outlines the most fundamental aspect of our human nature: we are social animals destined to bond (Johnson, 2019). Bowlby (1980) believed that intimate relationships were the "hub around which a person's life revolves from birth to death". Like Darwin, Bowlby was interested in how animals manipulate their environments to improve their chances of survival, and how they manage situations where they are most vulnerable (Johnson, 2019). Bowlby integrated a systems approach that emphasizes interpersonal interactional

patterns and circular feedback loops, or what he called the "outer ring" of actions, with inner intellectual and expressive processing, or what he called the "inner ring" of answers (Bowlby, 1973; Johnson, 2019). This current research study aspired to add to Bowlby's (1969) attachment theory by way of Johnson's (2019) attachment in practice concentrating on how MST survivors described their sexual traumatic event as it related to their intimate partner relationships.

Situation to Self

My motivation for conducting this research was to discover what I could do to raise awareness about MST and its impact on intimate partner relationships. Since my MST, I have repeatedly relived that event in my intimate partner relationships. When I am with my partner, and something about the MST event is familiar to me, it prevents me from being the best partner I can be. Sometimes the memory causes me to avoid all intimacy. Though my MST haunts me frequently, I have learned to cope with the residual effects, which is something that many service members and veterans do not. My best friend recently reported several military sexual traumatic events that happened to her while she was in the war zone. Her military sexual traumatic events prevent her from having healthy intimate partner relationships, have aided her increased tobacco use, and have contributed to her gambling disorder diagnosis.

I began this doctoral journey shortly after receiving my master's degree in school counseling, believing that once I was finished, I could focus on educating the youth. Traumatic events in my life resurfaced after learning more about therapies like cognitive behavioral therapy, cognitive processing therapy, and eye desensitization movement and reprocessing therapy. No trauma was as vivid as the one I endured as an Army soldier while serving my country. Though I had served my country in a conflict zone, witnessing horrific acts of violence, terror, and even death, none of those events compared to the trauma I experienced when I was

sexually assaulted. It was then that I realized it was critical to investigate this phenomenon known as military sexual trauma further. I have discovered that I am not the only MST survivor who was unable to express what had happened to them at the time. Then, for the next 34 years, I could not bring myself to talk about it. I did not talk about it because it made it real to me. I thought that if I did not talk about it, it was not real, it did not happen, and I wouldnot have to relive it. Unfortunately, the trauma continues to live in my mind, heart, and relationships, and never in a positive way.

There is a trauma reappraisal or schematic revision when traumatic events are repeatedly assessed using any past cognitive schemas (Mercado et al, 2015). I wish to continue this journey of discovery with other MST survivors hoping to find ways to live the best life possible with our intimate sexual partners. MST victims may behave in ways that are damaging to any intimate sexual partner connection if these repeated comparisons are frequent and bothersome (Mercado et al, 2015). We could move on to live beautiful lives with our strength, courage, and trauma-informed therapy techniques, and perhaps help others by letting them know they are not alone, and it is not their fault. They can find healing from this suffering through CBT, CPT, and EDMR, reducing the harm it causes to their intimate sexual partner relationships (Mercado et al, 2015). These treatments can assist them in refocusing those frightening thoughts and feelings into ones that they and their partners can benefit from. I was able to identify themes in the various viewpoints of the individuals studied by listening to their firsthand accounts of their traumatic event (Creswell & Poth, 2018).

Problem Statement

The problem was that there are few studies addressing the impacts that a military sexual traumatic experience can have on intimate partner relationships for active-duty service members

and veterans. Traumatic events have lasting impacts on those who experience them, including challenges with social connections, psychological health, and physical wellness (Kimerling et al., 2016). The VA's national screening program asks every active-duty service member and veteran who is treated in the facility, about whether they have ever had MST and though this helps the VA track how frequently MST is happening, it does not identify how the VA can help those victims who are unable to develop or maintain healthy intimate partner relationships. It is not enough to track the number of MSTs without helping eliminate or minimize the pain that the MST has left behind, especially as it relate to intimate partner relationships. Data from the VA's national MST screening program reveal that about 1 in 3 women and 1 in 50 men respond in the affirmative when a VA provider questioned them about MST and their experiences with it (DoD SAPR, 2022).

The rising cost of service members' and veterans' mental and physical tolls of war that the enemy has inflicted upon them, should cause all to ponder why more is not done to stop the horrors of sexual maltreatment, as the vast majority is inflicted by others in the same uniform. There are screening mechanisms in place, but they only capture what has happened, but not how to prevent or help manage it. Throughout the literature review on this topic, numerous quantitative studies were conducted that addressed how service members and veterans who suffered an MST can also develop psychiatric illnesses such as PTSD, anxiety, depression, eating disorders, substance use disorders, etc. (O'Brien & Sher, 2013). There were also many studies surrounding how to address said PTSD, anxiety, depression, eating disorders, substance use disorders, etc. symptoms, but there was limited research on how these survivors navigate their way back to or through a healthy intimate partner relationship. Murdoch et al. (2014) assert that there is an unsatisfactory amount of research establishing any claims that those who have

experienced MST are well enough to develop healthy intimate partner relationships. To date, the few quantitative studies addressing sexual satisfaction do not suffice what is needed. This transcendental study strived to, using the phenomenological research design, explore the impacts that military sexual trauma has on intimate partner relationships among military service members and veterans.

Purpose Statement

The purpose of this phenomenological study was to describe military active duty and veterans' experiences with intimate partner relationships after a sexually traumatic event. At this stage in the research, military sexual trauma was defined as experiences of sexual assault or sexual harassment suffered during military service (Department of Defense Sexual Assault Prevention and Response [DoD SAPR], 2021). The theory that guided this study was attachment theory, as attachment is fundamentally an interpersonal theory that places the individual in the context of his or her closest relationships with others (Bowlby, 1969; Johnson, 2019). It is believed that human beings' most fundamental survival tactic is to form bonds with one another, but it may be difficult to bond on this level with another when there are lingering emotions disturbing the connection. Bowlby's theory prioritizes the importance of fear and is fundamentally interested in emotion and the control of emotion (Johnson, 2019). Johnson (2019), who puts Bowlby's theory into practice, states that many emotional systems interact with attachment. Attachment theory is a developmental theory; therefore, it deals with growth and flexible adaptability as well as the factors that hinder or promote these adaptations (such as a traumatic sexual event) (Johnson, 2019). Johnson's (2019) belief that more tuned-in attention to another adult and more responsive caring are linked to secure attachment. Naturally, this security is maintained along a continuum and is not a constant stable state, but instead varies slightly

depending on the connections and circumstances involved. Security in partnerships is linked to increased levels of arousal, intimacy, and pleasure, as well as greater sexual satisfaction (Birnbaum, 2007). Sex, a human bonding activity, has an emotional imprint that varies with different attachment patterns and the coping mechanisms and social engagement methods that go along with those forms (Johnson, 2019).

Significance of the Study

This transcendental phenomenological research study could add empirical, theoretical, and practical significance to the current fields of research on military sexual trauma and trauma-informed care. The data gathered here could assist in starting a conversation about sexual trauma and its impacts on intimate partner relationships.

Empirical Significance

Studying the lived experiences of service members and veterans who have survived an MST has a couple of empirical significances. First, this study was significant for active-duty service members and veterans who have suffered an MST, therapists, and counselors who will treat those who have experienced an MST, military leaders, who lead those who have fallen victim to an MST, and those who are perpetrating MSTs. What is known about MST is that it can lead to active-duty service members and veterans falling victim to other mental health disorders such as PTSD, SUD, AUD, MDD, etc. (Lande et al., 2017). What is unknown is what an MST can do to the survivor's mental status as it relates to the survivor's intimate partner relationships.

Second, research on how service members and veterans who have survived an MST can help navigate successful intimate partner relationships and develop a healthy, secure attachment by becoming emotionally open, sensitive, and involved (Johnson, 2008, 2010). This study adds

to the secure attachment and the military sexual trauma literature by concentrating on MST survivors and their intimate partner relationships.

Theoretical Significance

The results of this study added to the literature on Bowlby's (1969) attachment theory and promotes Johnson's (2019) attachment theory in practice, emotionally focused therapy. Bowlby's (1969) theory has helped explain reasons for distinctive attachment behaviors that cause stressors in people's mental health and relationships. Attachment-based therapy, in which the therapist builds a trusting relationship with the patient and tackles patterns stemming from the patient's early attachment experiences, is an effective method for addressing the widespread problem of attachment difficulties (Holmes, 1995; Johnson, 2019). Using interviews to investigate how military sexual trauma survivors described their sexual traumatic event as it relates to their intimate partner relationships, this research was able to highlight common themes and shared narratives about the phenomenon.

Practical Significance

Practically, understanding the impact that an MST has on an active-duty service member or veteran is invaluable. The armed forces' most important resource is its human resource (Rasmussen, 2013; Murdoch et al., 2014; Klein & Gallus, 2018). When a unit's most valuable resource is damaged or malfunctioning, the unit also malfunctions (Klein & Gallus, 2018). The DoD must take care of its human resources because without them, there are no influential armed forces, and should there be a reason to deploy these human resources, they will prove useless (Klein & Gallus, 2018). The military culture is different from what civilians may understand, but their community is not immune to sexual assaults (Lande et al., 2017). Those sexual assaults can turn great service members into substandard ones, not because of who they are but because of

who they have become (Murdoch et al., 2014). It is essential that service members, on and off the battlefield, trust one another, but if they are taxed with sexual harassment and assault, they will not perform as well as they can without the additional stressors (Baca, 2011; Carson & Carson, 2018; Haaken & Paler, 2012). This study could assist political and military leaders in understanding the ramifications an MST can have on a service member and hopefully help them develop successful ways to combat this phenomenon.

Research Questions

The purpose of this phenomenological study was to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. For this study, one central research question was posed so those factors can be explored as they relate to the central phenomenon (Creswell & Poth, 2018). These research questions were vital to this study because they demonstrated to other researchers, military leaders, and anyone reading this study that the behaviors resulting from an MST are critical to understanding as they can contribute to the effectiveness of the armed forces. This central research question assisted in guiding this phenomenological research study which will help the researcher understand and describe the impacts a military sexual traumatic experience can have on mental status and intimate partner relationships for active-duty service members and veterans.

Central Research Question

The central research question asked was, *How do MST survivors describe how their sexual traumatic event impacts their intimate partner relationships?* McCarthy and Farr (2011) discussed the impact of sexual trauma on sexual desire and function, outlining different types of sexual trauma, such as childhood sexual abuse, adult sexual assault, and intimate partner violence, and their impact on sexual desire and function. McCarthy and Farr (2011) found that

various psychological factors deriving from sexual trauma can have a significant impact on a person's sexual desire and function. The purpose of this central question was to describe and understand the phenomenon that impacts a military sexual traumatic experience can have on mental status and intimate partner relationships.

Sub-question One. The first sub-question asked was, *How do participants describe the impact their MST, and other associated mental health diagnoses because of their MST, have upon their ability to have a healthy intimate partner relationship?* In a 2011 study, Taft et al. investigated the relationship between PTSD and intimate relationship problems. They used a meta-analysis to synthesize the results of 112 studies that examined the association between PTSD and various aspects of intimate relationships. They found that individuals with PTSD were more likely to experience intimate relationship problems, including poorer communication, more conflicts, and lower relationship satisfaction, than those without PTSD (Taft et al., 2011). They also found that the association between PTSD and intimate relationship problems was stronger for women than for men (Taft et al., 2011).

Sub-question Two. The second sub-question asked was, *How do participants describe their experience with sexual dysfunction as the result of their MST?* There are studies that link sexual dysfunction to military sexual trauma. For example, Georgia et al. (2017) examined the indirect association between sexual assault experiences, intimacy, and mental health. The study's findings revealed that sexual assault experiences were negatively associated with both relationship satisfaction and mental health. However, intimacy was found to mediate the relationship between sexual assault and relationship satisfaction, indicating that the negative association between sexual assault and relationship satisfaction was partially explained by lower levels of intimacy (Georgia et al., 2017).

Sub-question Three. The third sub-question asked was, *How do participants describe their experience of relationship dissatisfaction once they have shared their MST with their partner?* With MST, achieving satisfaction in a relationship can be a difficult task. Funk and Rogge (2007) presented a study that aimed to increase the precision of measuring relationship satisfaction using the Couples Satisfaction Index (CSI) using item response theory (IRT). Funk and Rogge (2007) explained the advantages of using IRT to improve the CSI's precision, and detail the methods used in the study, including data collection and analysis. The results of the study suggest that using IRT to score the CSI leads to a more precise measure of relationship satisfaction. The authors provide evidence that the revised scoring method has advantages over the original method, including greater sensitivity to differences in relationship satisfaction and a reduced ceiling effect.

Definitions

In this dissertation, the following phrases and meanings were relevant and utilized throughout. According to the literature, these terminology and meanings were associated with the subject matter, theoretical framework, or this study's research methodology.

1. *Alcohol Use Disorder (AUD)* – A problematic pattern of alcohol use leading to clinically significant impairment or dis tress, as manifested by at least two of the following, occurring within a 12-month period: (1) alcohol is often taken in more significant amounts or over a more extended period than was intended, (2) there is a persistent desire or unsuccessful efforts to cut down or control alcohol use, (3) a great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects, (4) craving, or a strong desire or urge to use alcohol, (5) recurrent alcohol use resulting in a failure to fulfill significant role obligations at work, school, or home, (6) continued

alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol, (7) important social, occupational, or recreational activities are given up or reduced because of alcohol use (8) recurrent alcohol use in situations in which it is physically hazardous (9) alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol, (10) tolerance, as defined by either of the following: (a) a need for markedly increased amounts of alcohol to achieve intoxication or de sired effect (b) a markedly diminished effect with continued use of the same amount of alcohol, (11) withdrawal, as manifested by either of the following: (a) the characteristic withdrawal syndrome for alcohol or (b) alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms (APA, 2013).

2. *Adult Attachment Interview (AAI)* – A semi-structured psychodynamic-type interview in which the subject is encouraged to talk about their early attachments, give illustrated accounts of their parents' characteristics, and to describe any significant losses and childhood traumata. The transcripts are then rated, not so much for content as for style, picking up features like coherence of the narrative and capacity to recall painful events. Subjects are classified into one of four categories: 'free to evaluate attachment', 'dismissing of attachment', 'enmeshed in attitudes towards attachment', and 'unresolved/disorganized/disorientated'. When given to pregnant mothers the AAI has been shown to predict the attachment status of the infants at one year with 70 per cent accuracy (Fonagy et al., 1991a).

3. *Ambivalent Attachment* – A category of attachment status as classified in the Strange Situation (q.v.). The infant, after being separated and then re-united with its mother, reacts by clinging to her, protesting in a way that can't be pacified (for instance, by arching its back and batting away offered toys), and remains unable to return to exploratory play for the remainder of the test. Associated with mothers who are inconsistent or intrusive in their responses to their babies. This is sometimes described as 'hyper-activation' (Mikulincer and Shaver, 2007).
4. *Attachment* – The condition in which an individual is linked emotionally with another person, usually, but not always, someone perceived to be older, stronger and wiser than themselves. Evidence for the existence of attachment comes from proximity seeking, secure base phenomenon (q.v.) and separation protest (Holmes, 2019).
5. *Avoidant Attachment* – Together with ambivalent attachment (q.v.), the second main category of insecure attachment delineated in the Strange Situation (q.v.). Here the child, when reunited with its mother after a brief separation, rather than going to her for assuagement (q.v.), avoids too close contact, hovering near her in a watchful way, and is unable fully to resume exploratory play. Associated with mothers who are mildly aggressive with, reject or ignore their babies. Sometimes designated as 'hypo-activation' (Mikulincer and Shaver, 2007).
6. *Cognitive Behavioral Therapy (CBT)* – A form of psychological treatment that has been demonstrated to be effective for a range of problems, including depression, anxiety disorders, alcohol, and drug use problems, marital problems, eating disorders, and severe mental illness (APA, 2013).

7. *Cognitive Processing Therapy (CPT)* – A specific cognitive behavioral therapy that helps patients learn how to modify and challenge unhelpful beliefs related to trauma (APA, 2013).
8. *Defense Health Agency (DHA)* - A joint, integrated Combat Support Agency that enables the Army, Navy, and Air Force medical services to provide a medically ready force and ready medical force to Combatant Commands in peacetime and wartime (Defense Health Agency, 2022).
9. *Department of Defense (DoD)* – America's oldest and largest government agency, founded in 1994, the DoD is responsible for providing the military forces needed to deter war and protect the security of our country (Department of Defense, 2022).
10. *Depression* – The most common mental disorder; people may experience physical, cognitive, and social changes, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities. (APA, 2013).
11. *Drug Use Disorder* – A pattern of harmful use of any substance for mood-altering purposes; patterns of symptoms resulting from the use of a sense that you continue to take, despite experiencing problems as a result (APA, 2013).
12. *Epoche* – The elimination of suppositions and the raising of knowledge above every possible doubt (Moustakas, 1994, p. 26).
13. *Eye Movement Desensitization and Reprocessing (EMDR)* – A psychotherapy treatment initially designed to alleviate the distress associated with traumatic memories (Shapiro, 1989a, 1989b).

14. *Intimate Partner Relationships* – With respect to a person, the spouse of the person, a former spouse of the person, an individual who is a parent of a child of the person, and an individual who cohabitates or has cohabited with the person 18 USC § 921(a)(32).
15. *Intimate Partner Violence (IPV)* – Physical and/or sexual assault of a romantic partner (Semiatin et al., 2017).
16. *Major Depressive Disorder (MDD)* – the mental disorder characterized by a pervasive and persistent low mood that is accompanied by low self-esteem and by a loss of interest or pleasure in normally enjoyable activities (APA, 2013).
17. *Military Sexual Trauma* – A term used to describe sexual assault and threatening sexual harassment that occurs while an individual is on active duty (Department of Veterans Affairs, 2022).
18. *Posttraumatic stress disorder (PTSD)* – A condition that develops in some people who have experienced a shocking, scary, or dangerous event (APA, 2013). PTSD may include flashbacks with hallucinatory quality, and hypervigilance may reach paranoid proportions. But a traumatic event and characteristic symptom features relating to reliving or reacting to the event are required to make the diagnosis (APA, 2013).
19. *Prolonged Exposure (PE)* – A therapy that teaches individuals to gradually approach their trauma-related memories, feelings, and situations (American Psychological Association, 2013).
20. *Sexual Dysfunction* – refers to a variety of issues that can arise at any stage of the sexual response cycle and prevent a person from experiencing sexual satisfaction (McCabe et al., 2016).

21. *Sexual Assault* – A physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty (Beckman et al., 2018). Sexual assault includes behaviors ranging from unwanted sexual touching to rape (Kahn et al., 2018).
22. *Sexual Harassment* – Unwelcomed sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature (Department of Veterans Affairs, 2022).
23. *Substance Use Disorder (SUD)* – The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems; an essential characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders (APA, 2013).*Transcendental phenomenology* – A distinctive qualitative research methodology where the researcher studies multiple participants' lived experiences and focuses on the common themes found within the participant's detailed descriptions (Creswell & Poth, 2018; Moustakas, 1994).
24. *Veterans Administration (VA)* – An agency of the federal government that provides benefits, health care, and cemetery services to military veterans (Department of Veterans Affairs, 2022).
25. *Veterans Health Administration (VHA)* – Home to the United States' most extensive integrated healthcare system consisting of 171 medical centers (Va.gov, 2022).

Summary

This chapter summarized the background, the problem, and the purpose of this study. The overarching problem was that some active-duty service members and veterans who suffered an

MST may find it challenging to navigate the memories of their MST and their intimate partner relationships. In addition to presenting the theoretical frameworks, the phenomenon of interest, *military sexual trauma*, was defined. A synopsis of why this sensitive subject was chosen was also highlighted in this chapter. Although there was limited research on how the person suffering from MST copes with intimate partner relationships, there is noteworthy literature outlining what MST is, its prevalence throughout the armed services, how MST can be prevented, and what mental illnesses can arise from an MST, so that information was presented as well. Also in this chapter, research questions were produced to help understand how a military sexual traumatic event can impact future intimate partner relationships for military service members and veterans. Finally, this chapter concluded with a list of literature-validated, relevant terms.

Chapter Two: Literature Review

Overview

The purpose of this phenomenological study was to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. To locate a wide variety of sources, these concepts and terms were searched from numerous search engines and databases, including APA PsyNET, EBSCO Information Services, Google Scholar, PubMed, and Web of Science. Most literature reviewed was published after 2013, but some resources are from earlier dated publications because this problem has been around well before 2013 and those documents assited in showing historical context. Some key terms and concepts were ascertained for this literature review and include MST, post-traumatic stress disorder (PTSD), cognitive processing theory (CPT), substance use disorder (SUD), and depression. A shortened summation of the main ideas and topics raised by the literature concluded this chapter.

Theoretical Framework

Qualitative research might benefit from the use of a theoretical framework (Miles et al., 2020 as cited in Garvey & Jones, 2021). Such frameworks might have been derived inductively from previous research or developed based on preexisting concepts or published works (Miles et al., 2020, as cited in Garvey & Jones, 2021). When there is a large quantity of data that needs to be analyzed, a theoretical framework can help direct attention to a particular phenomenon that is of interest (Miles et al., 2020, as cited in Garvey & Jones, 2021). The theoretical framework that is appropriate to address how service members and veteran survivors of military sexual trauma describe their sexual traumatic event as it relates to their intimate partner relationships is John Bowlby's (1969) attachment theory.

Edward John Mostyn Bowlby, the son of a renowned surgeon to the King of England was born in 1907 (Bennett & Nelson, 2010) into a family of seven children. He was sent to boarding school at the tender age of eight, as was customary among wealthy English families (Bennett & Nelson, 2010). He expressed dissatisfaction about the decision his parents made, reported telling his wife that he would never send a dog to school at such a youthful age (Karen, 1994 as cited in Bennett & Nelson, 2010). According to his son, Sir Richard Bowlby, he experienced an even earlier rupture due to the unexpected loss of his caregiver when he was only four years old (Bennett & Nelson, 2010). The effect of this upbringing, and the society that encouraged it, are visible in much of Bowlby's theory on the affectional needs of children (Karen, 1994 as cited in Bennett & Nelson, 2010). Bowlby conceptualized attachment theory in terms of an innate human need to feel connected to others, arguing that the quality of our interpersonal connections has a far greater impact on our mental health than any other factor (Schwartz, 2015). Bowlby's central argument was that children need consistent, loving care, and that if that bond is ever severed, abused, or inadequate, it can cause emotional harm (Bennett & Nelson, 2010). This belief and its various consequences for theory, research, and treatment form the central axis of attachment literature (Bennett & Nelson, 2010).

Bowlby (1969, 1973, 1980) proposed attachment theory on the premise that humans, like many other animals, have a natural tendency to make and maintain lasting affectional bonds, or attachments, to familiar, irreplaceable others and that, once established, the quality, security, and stability of these ties is related to emotional health and well-being. Bowlby developed the idea to make sense of his and social worker James Robertson's observations of small children who had been taken from their parents and placed in the care of strangers (Schwartz, 2015). Bowlby (1969, 1973, 1980) recognized the sorrow of separation and the grief of loss in articulating what

it was like for these children to be alone, attempting to manage without the comfort and reassurance of their accustomed caretakers. Because of this, he began to worry that his time apart from his own parents had severed their unique bond (Bowlby, 1969).

Bowlby advocated for further study to identify the specific kind of caregiving experiences children require to build resilience and self-assurance (Holmes, 1995). His claim that safety played a crucial part in adaptation altered the emphasis of child development from the sexuality and conflict emphasized by the orthodox psychoanalytic developmental paradigm to the comfort and familiarity provided by relationships (Holmes, 1995). Bowlby chimed in with an ethological-evolutionary perspective, suggesting that the biological role of a mother's care for her child is protection from danger rather than oral requirements and feeding as Freud theorized (Holmes, 1995). Bowlby combined an ethological perspective with ideas from control theory to propose a system of innate actions to explain how a newborn forms and maintains the bond necessary for its emotional and physical well-being (Holmes, 1995). Coupled with the works of Mary Ainsworth (1978) and her *Strange Situation* technique, four types of attachment emerged: secure, anxious, avoidant, and disorganized (Holmes, 1995).

Secure Attachment

A solid relationship is formed when a baby believes that their primary caregiver will consistently provide comfort, understanding, and safety in times of stress (Holmes, 1995). When something dreadful happens, children who have a strong bond with their caregivers seek help (Holmes, 1995). They may also separate from their caregivers without fear since they are confident that the people to whom they are linked will return (Holmes, 1995). Strongly devoted adolescents typically have intimate relationships with others and experience less loneliness (Holmes, 1995). With *Secure Adult Attachment,* they frequently form beneficial interactions

based on trust and vulnerability (Johnson, 2019). Because of the reliability they experienced at the outset of their bonding processes, people maintain the conviction that their efforts would be rewarded (Johnson, 2019).

Anxious Attachment

When children acquire worried, insecure patterns of interaction because of inconsistent care from their primary caregivers, they develop anxious attachment, also known as ambivalent attachment (Holmes, 1995). These habits, like those of other attachment types, can be carried over into other relationships. Children who are anxiously connected are more likely to be nervous about going to school and meeting their peers (Holmes, 1995). Adults with *Anxious Adult Attachment* style may look clinging and devote excessive time and energy to their relationships (Johnson, 2019). They may, for example, overanalyze talks or a partner's behavior, looking for problems where none exist (Johnson, 2019).

Avoidant Attachment

Children with avoidant attachment have learned that their primary caregiver cannot provide their needs on a constant basis; therefore, they rely on themselves (Holmes, 1995). Adults who have *Avoidant Adult Attachment* tendencies may look disinterested in their relationships (Johnson, 2019). They dislike being reliant on others and do not want people to rely on them (Johnson, 2019). They may struggle to be sensitive or intimate in relationships, resulting in a lack of fulfillment, connection, and general support (Johnson, 2019).

Disorganized Attachment

Disorganized attachment was established as an attachment type some years after the first Strange Situation study (Holmes, 1995). Researchers noticed that some children reacted to reunions with their caregivers in unexpected ways, combining elements of anxious and avoidant

attachment (Holmes, 1995). Some youngsters seemed to want to punish their caregivers for abandoning them, whilst others appeared to be scared or conflicted (Holmes, 1995). Some even assumed the role of caregiver, calming their parents (Holmes, 1995). Children with attachment disorders may struggle with angry or oppositional behavior as they grow. For adults with *Disorganized Adult Attachment,* their relationships might be bewildering, frightening, or surprising (Johnson, 2019). While they crave connection, many are skeptical that their spouses/significant other would reciprocate (Johnson, 2019).

Bowlby's (1969) attachment theory offers a useful framework for examining the experiences of survivors in their relationships after the MST. And for those who were cohabitating with the same significant other throughout the MST, the information gained will be immeasurable. The survivors' in-depth recollections of their ordeals aim to shed light on the ways in which the MST influenced their personal connections with one another and how they dealt with the fallout.

Related Literature

A broken bone can be mended, but relived memories from an MST could harm a survivor for a lifetime (Blais & Livingston, 2021). In addition to PTSD, MST survivors are susceptible to mental health disorders and concerns such as anxiety, substance use disorder, depression, and sexual difficulties (Blais & Livingston, 2021). The link between MST and sexual function was discovered to be indirect, as evidenced by increased depression intensity and more negative self-schemas about sexual performance (Blais & Livingston, 2021). Through these mediators, only MST was unrelated to sexual function (Blais & Livingston, 2021). The inability to satisfy one partner in a physical sense can lead to many problems within the relationship. Being a survivor of sexual harassment, sexual assault, or rape has its challenges when it comes to intimate partner

sexual relationships (Schry et al., 2015). Sexual trauma can negatively impact a person's social life as it pertains to intimate partnerships in ways that are unique to the couples as well as in ways that are the same globally (Schry et al., 2015). There can be a host of things that leads to intimate partner violence (IPV) but there are studies that indicate that military sexual trauma can be associated with future IPV events with women prior service members (Relyea et al., 2020). Even though women with childhood sexual assault (CSA) histories had a threefold greater risk for previous year IPV as compared to women with no CSA histories, women who have suffered an MST are also predisposed to IPV (Iverson et al., 2013).

Trauma is a psychological reaction to a catastrophic occurrence, such as an accident, assault, or natural catastrophe (Huang et al., 2014). After an incident, astonishment and disbelief are frequent emotions (Huang et al., 2014). Age, sexuality, social class, race, nationality, or gender identity are all irrelevant factors in trauma (SAMHSA, 2022). In American societies, trauma is a regular occurrence for both adults and children, and it is particularly prevalent in the lives of those who have mental and drug use problems (SAMHSA, 2022). Due to this, it is becoming more and more evident that treating trauma is necessary for providing appropriate behavioral health care as well as for the process of rehabilitation and recovery (SAMHSA, 2022). Traumatic experiences significantly negatively impact people, families, and economies. While many survivors of traumatic events continue to live without experiencing any long-term harm, some will struggle and develop traumatic stress responses. How a person handles a distressing experience is personal and is pegged on many individual factors, their including support system and emotional maturity, etc. (SAMHSA, 2022).

There have not been many studies that highlight the damage service members, and their intimate partners suffer when one has experienced an MST (Katz, 2015). The incidence of sexual

assault and harassment experienced by United States Armed Forces members has reached epidemic proportions (Katz, 2015). Its survivors often suffer devastating, lifelong consequences to their careers, health, relationships, and psychological well-being (Katz, 2015). MST differs from other forms of military trauma such as combat, and discusses its prevalence, neurobiology, and social contexts as well as unique stressors of betrayal, injustice, struggles with issues of reporting and disclosure, and impact on relationships and sexuality (Katz, 2015). Sexual assault is an insidious problem in the United States Armed Forces.

Sexual Dysfunction and MST

Sexual dysfunction refers to a variety of issues that can arise at any stage of the sexual response cycle and prevent a person from experiencing sexual satisfaction (McCabe et al., 2016). Desire, arousal, orgasm, and resolution are the four stages of the sexual response cycle (McCabe et al., 2016). Morral's et al. (2014) report provided an evidence-based analysis of the prevalence, causes, and consequences of sexual assault and sexual harassment in the military. Using a mixed-methods approach, including surveys, focus groups, and interviews, to collect data from active-duty service members and civilian employees of the DoD, they found that these problems are widespread and have significant consequences for victims, perpetrators, and the military. Morral et al. (2014) also identified a range of factors that contribute to these issues, including organizational culture, leadership, and gender-based power dynamics.

There are studies that link sexual dysfunction to military sexual trauma. For instance, Barth et al. (2016) examined the prevalence of MST and its correlates among recent veterans. Barth et al. (2016) conducted a cross-sectional analysis of data collected from a nationally representative sample of veterans who served in the military post-9/11. The sample included 1,183 veterans who completed the survey, with a response rate of 64.2%. The study found that

the prevalence of MST was high among recent veterans, with 14.9% reporting sexual assault and 48.6% reporting sexual harassment during their military service. Barth et al. (2016) also identified several correlates of MST, including being female, younger, single, less educated, and experiencing combat exposure. The study provides important insights into the prevalence and correlates of MST among recent veterans, highlighting the need for increased efforts to prevent and address MST in the military.

O'Driscoll and Flanagan (2016) also investigated the relationship between sexual problems and PTSD following sexual trauma. The authors conducted a meta-analysis of 22 studies that examined the prevalence of sexual problems and PTSD in survivors of sexual trauma. The study's findings revealed that sexual problems were highly prevalent in survivors of sexual trauma, with rates ranging from 34% to 93%. PTSD was also found to be highly prevalent, with rates ranging from 15% to 100%. The meta-analysis also revealed a significant positive correlation between sexual problems and PTSD, indicating that sexual problems were more likely to occur in individuals with PTSD following sexual trauma. The study also found that the severity of sexual problems was significantly associated with the severity of PTSD symptoms. This suggests that the more severe the PTSD symptoms, the more severe the sexual problems are likely to be.

Georgia et al. (2017) examined the indirect association between sexual assault experiences, dyadic relationship satisfaction, intimacy, and mental health. The authors utilized data from a community sample of 344 couples and used structural equation modeling to analyze the data. The study's findings revealed that sexual assault experiences were negatively associated with both relationship satisfaction and mental health. However, intimacy was found to mediate the relationship between sexual assault and relationship satisfaction, indicating that the negative

association between sexual assault and relationship satisfaction was partially explained by lower levels of intimacy. Furthermore, Georgia et al. (2017) found that mental health partially mediated the relationship between sexual assault and relationship satisfaction, suggesting that the negative association between sexual assault and relationship satisfaction was also partially explained by the impact of sexual assault on mental health.

McCall et al. (2009) proposed model to understand the impact of sexual assault in the military on sexual satisfaction in women veterans. McCall et al. (2009) argued that there is high prevalence of sexual assault in the military and its negative impact on mental health outcomes. They then propose a conceptual model that suggests how sexual assault in the military can affect sexual satisfaction in women veterans. The proposed model considers various factors, including the nature of the assault, the military culture, and the individual's coping mechanisms.

Van Berlo and Ensink (2000) conducted a thorough review of the literature on the impact of sexual assault on sexual functioning and provided a comprehensive overview of the various sexual problems that can arise after sexual assault and the factors that contribute to these problems. The article begins by discussing the prevalence of sexual assault and the ways in which it can impact survivors. The authors then review the literature on sexual functioning after sexual assault, including changes in desire, arousal, and orgasm, as well as sexual avoidance and aversion. The authors also discuss the psychological and emotional factors that can contribute to sexual problems after sexual assault, such as post-traumatic stress disorder, depression, anxiety, and shame. Van Berlo and Ensink (2000) highlight the importance of addressing these factors in the treatment of sexual assault survivors. The article concludes with a discussion of treatment approaches for sexual problems after sexual assault, including cognitive-behavioral therapy, psychodynamic therapy, and pharmacological interventions.

PTSD and MST

The National Healthcare Services (NHS) (2022) describes PTSD as an anxiety condition brought on by extremely upsetting, frightful, or disturbing experiences. It is a condition marked by an inability to recuperate after being exposed to or seeing a terrible incident. Symptoms include nightmares and flashbacks, feelings of loneliness and guilt, anger, difficulty sleeping, insomnia and trouble concentrating. The syndrome can endure for months or even years, with triggers causing strong physical and emotional responses as well as recollections of the event. Avoiding circumstances that trigger trauma, increased sensitivity to stimuli, anxiety, or depression are the other possible symptoms (NHS, 2022). In addition to using drugs to alleviate symptoms, treatment options include various forms of psychotherapy. Some MST sufferers end up with clinically severe symptoms of PTSD (Kintzle et al., 2015).

Sexual trauma experienced during military duty is linked to PTSD, depression, and suicidality in both men and women, claim Baca et al. (2021). They carried out research evaluating the issues of mental health of 268 service members seeking medical treatment who had survived MST to bolster this claim. The findings revealed that compared to women, veteran men had considerably higher suicidal behavior but no greater PTSD or depression ratings. In comparison to CST survivors, MST survivors exhibited significantly greater PTSD and depressive symptoms scores when gender was considered, but not suicidal behavior. Kelly et al., (2013) also conducted research to establish the relationship between lifetime traumas such as MST and PTSD, almost all the participants, at 94%, reported having had depressive symptoms post MST. Kelly et al. (2013) established a clinically significant relationship between PTSD and MST. Therefore, from the analyzed articles (Kelly et al., 2013; Baca et al., 2013), individuals

with PTSD may struggle to control their feelings and responses to traumatic event-related stimuli. They may also develop various symptoms, such as dream sequences, avoiding stressors, drastic consequences in thoughts and feelings, and altered physical and psychological responses. As a result, MST can exacerbate survivors' feelings of insecurity, powerlessness, and horror, leading to PTSD (Kelly et al., 2013). For MST survivors to address the harmful repercussions of the trauma they have experienced, they must receive proper mental health care and support (Kelly et al., 2013).

Through identifying specific PTSD symptoms, MST was linked to alcohol and drug use abuse (Hahn et al., 2015). That is to say, the link between MST and subsequent alcohol use disorders (AUD) and drug abuse is at least partly caused by the progression of PTSD symptoms in people who have had MST and/or been in combat (Hahn et al., 2015). Negative urgency was directly and indirectly linked to drinking problems through PTSD symptoms and drinking (Hahn et al., 2015). Negative urgency can predict alcohol issues independently and through PTSD symptoms (Hahn et al., 2015). It can also lead to a weakened heart rate variability (Lee et al., 2013). Conversely, an MST could lead to PTSD or depression (Lee et al., 2013). When a person falls survivor to an MST, more than their bodies are harmed; their mental stability is also challenged (Lee et al., 2013).

Depression and MST

According to Chand et al. (2021), depression is a prevalent psychiatric health illness affecting millions worldwide. It is typified by continuous experiences of melancholy, despair, and loss of enthusiasm for former hobbies and activities. Depression can profoundly influence an individual's life, negatively impacting personal connections, careers, and general well-being

(Chand et al., 2021). Among the many impacts of depression is suicide ideation (Pellicane & Ciesla, 2022).

The World Health Organization (WHO) (2021) further defines depression as a mental disorder characterized by a persistent sense of sorrow and a loss of excitement. Depression is distinct from common mood changes and quick emotional reactions to problems in daily life (WHO, 2021). Depression may develop into a significant medical illness, especially if it is recurring and of a moderate to a severe degree. The impacted individual could suffer severe suffering and perform poorly at work, school, and in relationships (World Health Organization [WHO], 2021). Other signs may include difficulty concentrating, feelings of overwhelming guilt or low levels of self-worth, a lack of optimism for the future, disturbed sleep, and changes in eating or weight (WHO, 2021). Any activity that elicits emotions involving sorrow or lack of excitement can trigger depression (WHO, 2021).

As such, MST's description suggests an action that can significantly increase depression among the survivors. This assertion is supported by bodies of research that link MST to depression. For instance, O'Brien and Sher (2014) conducted a study to determine the role of MST in the emergence of mental and physical problems in male and female service members. This is because MST is linked to pre-combat horrific memories and chronic consequences such as psychological and medical disorders (O'Brien & Sher, 2014). This systematic review included an online screening of the significant behavioral research repositories to find papers on the sociological, epidemiological, and clinical aspects of MST and its link to psychological and medical disorders. According to O'Brien and Sher's (2014) study, most research suggests that MST is connected to a rise in psychiatric pathologies such as PTSD, drug and alcohol addiction and dependency, depression, anxiousness, anorexia nervosa, and suicidal thoughts. Their

research confirms the link between MST and an increased occurrence of psychological and physical illnesses such as depression. However, according to O'Brien and Sher (2014), there are several differences between the sexes in the prevalence incidence of MST. Some characteristics, like previous horrific memories, potentially cause the individual to be more sensitive to the medical and psychosocial sequela of MST. The study found that MST is a substantial healthcare concern that impacts both genders and should receive greater attention and therapeutic services committed to it (O'Brien & Sher, 2014).

Moreau et al. (2022) undertook a similar study investigating the mental health repercussions of MST. This was because, while MST is well documented in the United States, less is recognized concerning MST and its implications in other military contexts or places, especially Europe. As such, Moreau et al. (2022) used a nationally representative sample survey of more than 1200 army men and 230 army women in the French Armed Forces to undertake multivariate analysis and support vector regression, employing simple and multivariable intermodal regressions to assess the interactions between various forms of MST and mental health outcomes. The findings revealed that female veterans or active service members are more likely than males to encounter MST in its various manifestations (Moreau et al., 2022). Moreau et al.'s., (2022) study also reveals that females are more likely than males to experience mental health challenges or complications because of their encounter with MST.

Furthermore, Moreau et al. (2022) found that the probabilities of symptoms of depression were six times greater in women and eight points greater in males who reported repeated sexual traumas compared to individuals who experienced zero MST. Moreau et al. (2022) indicated that MST relates to cognitive impairments, including depression and PTSD, among French members of the military, particularly women. According to Moreau et al. (2022), the increased risk of

MST combined with psychological trauma necessitates prophylactic efforts to minimize MST and diagnostic measures that would provide sufficient counseling services.

Davies's (2020) research on the consequences of MST and symptoms of depression on successful integration reveals that MST adversely influences survivors' psychological health. One reason MST may lead to depression, according to Davies (2020), is unfavorable emotions from friends and family about sexual harassment or sexual misconduct. Davies (2020) contends that adverse feelings may be more noticeable because loved ones are often the first to hear the news, and the survivor is probably anticipating favorable reactions. This causes stress on the survivors, who eventually acquire depressed symptoms (Davies, 2020). Also, the survivors find it hard to reconnect with their close support system, including their close partners (Davies, 2020).

According to Leslie and Koblinsky (2017), most female military members are afraid of communicating their challenges and sentiments with their families for fear of encumbering them or not receiving sympathetic responses. Even if they disclose details on how they thought, adjustments in societal beliefs may have a detrimental impact on female veterans' opinions of their friends and family. According to Goodcase et al. (2015), people acquire adverse perceptions due to trauma, culminating in interpersonal conflicts as the veteran misinterprets the motives of others. For instance, if a spouse attempts to demonstrate signals of compassion for the spouse after learning of the previous sexual trauma, the male or female military person may perceive this as invasive or overwhelming since her beliefs regarding how much they can rely on and confidence in everyone else has altered (Goodcase et al., 2015). Consequently, the spouse may become the object of rage which may lead to marriage issues and violence against intimate partners (Leslie & Koblinsky, 2017).

Hiraoka et al. (2016) also found that veterans who have endured MST frequently mention having depression. There is also substantial evidence suggesting Acceptance and Commitment Therapy (ACT) can be utilized to treat major depressive disorder in civilians and army veterans. However, more research is needed, particularly among individuals who have been traumatized (Hiraoka et al., 2016). A 21-year-old female Veteran seeking therapy for depression related to MST is shown in this clinical case study using Acceptance and Commitment Therapy (ACT) (Hiraoka et al., 2016). The veteran's depression symptoms significantly improved with therapy (Hiraoka et al., 2016). She also demonstrated increased present-moment awareness, tolerance for uncertainty, and the ability to make choices consistent with her beliefs (Hiraoka et al., 2016). The significance of these findings for treatment is reviewed, focusing on the distinctive features of employing ACT in managing veterans' depression associated with MST (Hiraoka et al., 2016).

Substance Use Disorder and MST

An important public health problem, MST, is linked to negative psychiatric consequences such as a higher chance of suicide, emotional problems, anxiety, and substance use disorders (Goldberg et al., 2019). An individual who consumes one or more drugs in a way that significantly impairs or distresses their life is said to have a substance use disorder (Bush et al., 2016). Numerous studies have been conducted on drug abuse as a psychiatric complication of MST, with contemporary research concentrating on gender variations in substance use among MST survivors.

According to Goldberg et al. (2019), people who have undergone MST are more likely to be diagnosed with an SUD. This is most likely because MST has a history of causing a myriad of mental challenges, such as PTSD, stress, and anxiety. People who suffer from these problems

may encounter difficulties with the trauma they have undergone and may turn to drugs or alcohol to relieve their symptoms. Reliving military sexual traumatic experiences may also create feelings of remorse, humiliation, and self-blame, which can hasten the onset of substance use disorder (Goldberg et al., 2019). Many people who have endured MST may believe they are not deserving of assistance or care, which could lead them to put off getting psychiatric help for health issues (Goldberg et al., 2019).

In a study conducted by Gilmore et al. (2016), they looked at sexual identity as a moderating factor of the association between a valid MST test and depression, anxiety, and SUDs in 494,822 service members accessing Veterans Health Administration (VHA) treatments who had served in Iraq and Afghanistan. According to their research, females were significantly more likely than males to have a positive MST test and a SUD (Gilmore et al., 2016). This result is in line with Polusny's et al. (2014) study, which found a higher association between females' and males' exposure to trauma and negative mental health impacts.

The gender perspective is crucial since women with SUDs have different risk factors, presenting issues, co-occurring conditions, clinical implications, and relapse triggers than males (Greenfield et al., 2007). These distinctions might not be completely resolved in studies that examine the SUD problem generally and in mixed-gender contexts (Greenfield et al., 2007). Most people who have had MST are typically aware of their surroundings and do not readily trust anyone, even those close to them. According to Greenfield et al. (2007), the opposite sex may trigger these individuals. Additionally, no medication has been analyzed and evaluated for a diverse population of women who have problems with SUD (Greenfield et al., 2007). Studies are looking at women-only group therapies for pregnant and childcare women experiencing drug use problems.

Substance use disorders, which can appear completely different in men and women, are among the indicators of trauma exposure, which place the greatest public health responsibility on society (Goldberg et al., 2019). Women veterans' SUD and PTSD symptomology are affected independently by military sexual assault and other military stressors. Women who have experienced both military sexual assault and other military stressors are more likely to have both SUD and PTSD, as well as SUD without co-occurring PTSD (Yalch et al., 2018).

Gilmore et al. (2016) found that after interaction with MST, females may be significantly inclined to develop SUDs (Grant et al., 2015). There is a scarce body of literature on how the impacts of alcohol and drug use disorders differ from one another (Grant et al., 2015). In several research documents, they both are categorized as substance use disorders in general (Grant et al., 2015). Yet alcohol use disorders and drug use disorders have both been connected to adverse consequences, even though drug use disorders are frequently connected to more social upheaval and mental disorders than alcohol use disorders individually (Moss et al. 2015). As a result, to accommodate each, multiple intervention programs may be required (Moss et al. 2015).

Retired female service members have a high incidence of experiencing MST, which is common and linked to substance abuse and mental health issues (Lee et al., 2020). MST may or may not lead to PTSD (Lee et al., 2020). It frequently results from the idea of alcohol expectation (Lee et al., 2020). Alcohol expectancies are a person's perceptions of the consequences of drinking (Lee et al., 2020). The MST survivors may turn to alcohol in the hopes that it would help them with their difficulties because of guilt, humiliation, or even the desire to forget the terrible memories of their experiences with sexual harassment or assault (Lee et al., 2020).

In their 2014 study, *Addictive Behaviors*, Creech and Borsari looked at the connection between female veterans who had been subjected to MST and alcohol misuse. The findings found the complexity of the connection between MST and substance abuse. A considerable overrepresentation of alcoholics experienced MST in principle and military sexual harassment, according to multivariate analyses (Creech & Borsari 2014). MST was also linked to alcohol consumption, as all those who said they had consumed excessive alcohol within the previous month also claimed to have had MST (Creech & Borsari 2014). This result is like the Kimerling et al. (2010) study, which demonstrated a considerably increased hazard ratio of satisfying the checklist for co-occurring substance dependence in individuals who have encountered MST. Kimerling et al. (2016) asserts that MST is an important public health concern since it can have profound and long-lasting repercussions on survivors' mental health and well-being.

The elevated risk of substance dependence among survivors is one unfavorable effect of MST that has drawn a lot of attention (Yalch et al., 2018). The use of drugs or alcohol in a way that is damaging to the user or others is referred to as substance abuse (Yalch et al., 2018). Substance addiction can have detrimental effects on social and vocational functioning, as well as physical and psychological health (Yalch et al., 2018). Previous research with military and civilian samples has identified significant PTSD symptom connections with problematic alcohol, drug use, and depression (Semiatin et al., 2017). These findings support the idea that service members may self-medicate stress and anxiety symptoms with substances as part of a larger pattern of poor coping and experiencing avoidance (Semiatin et al., 2017).

The association between MST and alcoholism vanished once alcohol-related assessments and coping mechanisms were carefully considered, according to Creech and Borsari's (2014) study. The conclusion that MST alone did not contribute to enhanced alcohol use has significant

ramifications for the significance of MST in anticipating drinking addiction (Creech & Borsari, 2014). Alternatively, alcohol usage seems to be impacted by both avoidant coping mechanisms and favorable assessments of the consequences of drinking, in this case, alcohol expectations (Creech & Borsari 2014). These results are in line with existing research that suggests that positive expectations may operate as the main motivations for drinking behavioral patterns. In contrast, negative expectations and assessments could be more closely associated with the desire to cut back or stop getting drunk all together (Ramirez et al., 2020). These findings align with earlier studies that connected avoidant coping with higher excessive drinking (Ribadier & Varescon 2019). The strong relationship between avoidance coping with favorable assessments was of special interest, since it shows that avoidance coping is closely related to high alcohol usage levels for female veterans who had favorable assessments of how drinking can impact them (Creech & Borsari 2014).

This perspective is in accordance with social cognitive theories of alcohol consumption, which postulate that drinking behaviors can be predicted by the interaction of variables, including expectations for alcohol use, and coping mechanisms and psychological pain (Hasking et al., 2011). These results also demonstrate that alcohol consumption, which is dependent on the degree of avoidance coping or alcohol expectancy, is one of the significant challenges faced by MST survivors (Creech & Borsari 2014). MST may influence alcohol use, but it does not significantly contribute to alcohol abuse or excessive drinking, according to research by Creech and Borsari (2014) on the behavior of alcohol users among MST survivors.

Homelessness and MST

Homelessness is defined by Shinn and Khadduri (2020) as the circumstance of not getting a constant and sufficient home to stay in, which frequently results in a person or their

family residing in makeshift accommodations, on the sidewalks, or in various public locations. While there are numerous causes, the primary causes of homelessness include impoverishment, a lack of adequate accommodation, joblessness, and emotional difficulties (Shinn & Khadduri, 2020). While MST does not feature prominently when discussing homelessness, the psychological impacts of MST have the potential to cause homelessness.

Additionally, Klingensmith et al. (2014) noted that regardless of other socio-demographic, military, and mental health characteristics, MST is linked to increased rates of numerous psychiatric morbidities and suicide, lower functioning and life quality, and greater use of mental health therapy. According to these findings, MST is common among United States soldiers and is linked to a higher health burden (Klingensmith et al., 2014). For example, the findings can be used to identify at-risk vets and to quantify the health hazard and needs related to MST in this group (Klingensmith et al., 2014). These mental difficulties that are associated with MST can contribute to homelessness.

To determine the pervasiveness of homelessness as it correlates to MST, researchers must investigate the relationship between MST and psychological conditions and characterize psychological health usage among homeless women and men (Pavao et al., 2013). Pavao et al. (2013) argued that the interaction of MST is linked to several psychological disorders, with earlier exploratory study findings implying that MST could well be linked to homelessness among female veterans, despite most research findings on MST being limited to a national perspective for both genders. To validate such findings, slightly above 126,500 homeless veterans who sought VHA outpatient treatment in 2010 were the subject of a nationwide, cross-sectional investigation by Pavao et al. (2013). The study results of Pavao et al.'s (2013) study showed that 39% of female and 3% of male veterans were homeless and had an experience with

MST. The findings also revealed that, when contrasted to other homeless service members of both genders, most service members who encountered MST had substantially higher levels of depressive symptoms, trauma-related stress and anxiety, and other emotional problems, including, alcoholism, bipolar disorders, psychological issues, and self-harm (Pavao et al., 2013). Additionally, almost all homeless veterans had at least one mental-health appointment, and MST military personnel used many more psychiatric visits than non-MST veterans (Pavao et al., 2013). The study results indicate that homelessness is a significant issue amongst veterans, and it is more prevalent among the veterans that experienced MST. Their findings identified a significant percentage of homeless veterans receiving VHA assistance had experienced an MST, and individuals who have had MST are more likely to have a psychiatric condition.

A study conducted by Nichter et al. in 2022, investigated the prevalence and correlation between homelessness and mental health disorder. The study was predicated upon the background that among United States military veterans, homelessness is a significant public health issue that has not received appropriate attention from recent population-based research. Their 2019–2020 National Health and Resilience in Veterans Study analyzed the occurrence and determinants of homelessness in addition to the relationships involving homelessness and veterans' productivity, suicidal tendencies, and potential existing psychotic symptoms (Nichter et al., 2022). While the original goal of the study was to look at the prevalence and correlates of homelessness with mental conditions, the findings found that 10% of veterans are homeless, with 80% reporting having been homeless at some point after serving in the military. The prevalence of psychiatric morbidities was 49% among homeless veterans, which is a significant number. The findings also indicated that MST significantly affected homeless veterans' psychiatric morbidities (Nichter et al., 2022). In the study, Nichter et al. (2022) concluded that American

veterans who have suffered homelessness are a subgroup at significantly increased risk for poor psychological well-being and suicide, with MST being one of the most significant risk factors for homelessness. They argue for the adoption of a policy to address the root causes, such as MST, before things spiral more out of control.

Another study conducted by Lucas et al. (2022) also addressed the issue of homelessness amongst veterans, with a particular focus on the causative factors such as mental illness, financial difficulties, and prior traumatic experiences such as MST. Lucas et al.'s (2021) objective was to expand on the existing research that does not take into consideration the relationship between homeless encounters and military sexual assault, depressive disorders, PTSD, anxiety, and overall well-being amongst service members. More than 500 former service members participated in the study. The findings revealed that both male and female service members who had MSA and had been literally or figuratively homeless were much more susceptible to encountering trauma, anxiety, and physical ailments (Lucas et al., 2021). The findings demonstrated that while homelessness is a significant problem for United States military veterans, the MST experiences exacerbates the issue.

Tsai et al. (2020) carried out another research as it relates to homelessness and sexual trauma. The goal is to calm public worries regarding fresh surges of homelessness amongst young veterans and queries regarding a potential sleeper influence. The sleeper effect is a prolonged vulnerability that intensifies with time. The findings revealed that on average, most homelessness occurred 5.5 years after being released from active duty. Chronic mental illnesses like depression, anxiety, and substance use disorders are among the sleeper effects identified by Tsai et al. (2020). The concerning trend is that most military veterans who become homeless after discharge had a traumatic event either as a child or while serving in the military (Tsai et al.,

2020). The reported childhood traumas usually entailed sexual harassment, interpersonal difficulties, etc. These traumas are the contributing factors to the mentioned sleeper effects (Tsai et al., 2020). When active in the military, participants identified sexual military assault as a driving factor to chronic mental conditions that would later lead to homelessness (Tsai et al., 2020).

Most of these studies have confirmed that homelessness is a growing phenomenon among veterans who are faced with many challenges. This phenomenon is met with growing bodies of literature to find the root cause of such a surge in homelessness. Most results attribute it to chronic mental conditions such as PTSD, depression, anxiety, substance use disorder, etc. The discussion around these mental conditions has attributed them to existing or prior trauma while active or before military service. MST, especially amongst women, is a significant traumatic experience that has been mentioned in most current studies as a factor contributing to such chronic mental diseases. According to Leslie and Koblinsky (2017), most military members are afraid of communicating their challenges and sentiments with their families for fear of encumbering them or not receiving sympathetic responses. This leads to a reserved veteran who fears judgment from family members and is more likely to adopt an aggressive attitude toward loved ones to avoid unnecessary associations with them. This can contribute to a lack of intimacy among the survivors (Leslie & Koblinsky, 2017). Bimpson et al. (2020) connected homelessness to family failure. As such, the chances of intimate relationship resulting from homelessness is minimal. Coupled with mental challenges resulting from MST, the relationship with an intimate partner will be significantly hampered (Bimpson et al., 2020).

The LGBTQ Community and MST

Military personnel, veterans, and their families are reeling from over a decade of war (Tinney & Gerlock, 2017). Although sexual violence occurs in same-sex relationships, most studies focus primarily on heterosexual relationships. It provides information on the scope of sexual violence, adverse childhood experiences in the military and veteran populations, complex trauma, the intersection of sexual violence and co-occurring conditions, and how sexual violence affects intimacy in relationships (Tinney & Gerlock, 2017). It also addresses implications for practice, such as in screening, assessment, and intervention.

The term military sexual trauma borrows from the Department of Veteran Affairs definition that describes it as any violent sexual harassment, aggravated sexual assault, or unwanted sexual advances that took place while the person was engaged in active military service and includes MSA. MSA is a more limited concept that excludes sexual violence and perhaps other forms of physical assault, which is frequently more prevalent than MST. Current studies often exclude MSA as they are more focused on the MST, which leaves the milder incidences, including MSA, unstudied. These studies are based on the investigations of the people that majorly identify as straight. The prevalence of MST, as addressed in many studies are mainly based on such group identities leaving the minority, such as the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) community, behind. This is primarily because much of the data and statistics available are not categorized, and the studies on LGBTQ group experience with MST are not widely studied or highlighted in the United States.

The scarcity of data on the LGBTQ community is because gender identification and gender sensitivity are a relatively new concept that, even today, remains contentious issue within the general population (Gates & Herman, 2014). However, despite the scarcity of studies on

MST and MSA, it is essential to note that these minority service people are an important consideration in sexual assault discussions (Gates & Herman, 2014). In a 2015 Morral et al. study, it was established that LGBTQ military personnel are more likely to experience sexual assault than the wider population and that LGBTQ is the most vulnerable minority in the military due to the amount of discrimination they face in their daily life (Gates & Herman, 2014).

However, there are very few bodies of literature that focus on the LGBTQ population and MST. For instance, few studies have specifically attempted to highlight the prevalence of MST amongst LGBTQ veterans, including Brown & Jones (2016), who did not categorize or investigate the percentages by gender, the occurrence of MST with transgender soldiers close to 16%, contrasted to 6% or non-transgender soldiers. Lindsay et al. (2016) assessed the incidence rates as well. They found that MST was prevalent in transgender soldiers who had participated in the most recent wars in Iraq and Afghanistan at a frequency of 15% generally, 20% for transgender men, but 13% for transgender women. In addition, Beckman et al. (2018) found that 17% of transgender veterans had MSA, while rates varied dramatically across transgender men and women, with transgender men experiencing MSA at a rate of 31% versus 16%. Beckman et al. (2018) also connected MST to adult sexual assault before enlisting in the military using adjusted regression models.

According to Beckman et al. (2018), early exposure to sexual trauma is the primary cause of MST among LGBTQ veterans, especially transgender veterans. The average community has a known correlation between past sexual assault and subsequent assault (Davies, 2020). This is relevant to the military, as demonstrated by Sadler et al.'s (2003) research project of 506 female veterans of the Vietnam and Middle Eastern Wars. Of the people participating, 14% reported being subjected to sexual harassment before and/or during their military service. Because there is

limited study on LGBTQ experiences with MST, these figures are restricted to individuals who identify as straight women. However, Beckman et al. (2018) assert that the experiences of all veteran survivors are similar regardless of their gender orientation.

No matter a survivor's sexual orientation or gender identity, MST can negatively impact their mental health and well-being (Kimerling et al., 2016). However, it is crucial to keep in mind that owing to potential prejudice and stigma they may experience within the military, LGBTQ individuals may be at a greater risk of suffering MST (Gurung et al., 2018). According to research, LGBTQ service members may be more likely to encounter sexual assault or harassment than heterosexual service members and may be less likely to report these incidents out of fear of prejudice or retaliation (Gurung et al., 2018). According to Schuyler et al. (2020), service members who identified as LGBTQ had a higher risk of sexual harassment, stalking, and sexual assault while serving in the military due to the wide unacceptability of the community.

In a population of regular users of the VHA, Shepherd et al. (2018) conducted a research study to assess experiences regarding health care between LGBT women and non-LGBT women. Compared to non-LGBT women veterans, the findings showed that LGBT women veterans missed appointments for essential care more frequently in the previous year due to anxiety about socializing with other veterans. The results of this study assert the argument that additional stressors and difficulties LGBTQ people may experience due to their sexual orientation or gender identity may exacerbate the detrimental effects of MST on them (Lofgreen et al., 2017). For instance, while seeking treatment for the impacts of MST, LGBTQ people may encounter further stigma and prejudice or believe that the healthcare system is failing to recognize or effectively meet their needs (Lofgreen et al., 2017).

On a closer analysis, it is evident that transgender men are more likely to experience MST than transgender females, as indicated by Lindsay et al. (2016). Findings that 20% of transgender male veterans have experienced MST against 13% of transgender females. This assertion is supported by Beckman et al. (2018), who found an even higher figure of 31% and 16% for transgender males and females, respectively.

To comprehend the backdrop of LGBTQ identifying veterans' perceptions and experiences and associated adverse consequences, including increased vulnerability to sexual assault, Beckman et al. (2018) used a very accurate framework called the minority stress model. Hendricks and Tesla (2012) claim that the model describes the various pressures LGBTQ soldiers may encounter due to their minority identities. The model explicitly recognized MST amongst LGBTQ veterans as being primarily caused by distal minority stressors, characterized as external incidents of sexism and prejudice. These could include getting asked about one's gender identification, being blackmailed with losing parental rights or one's professional career or being made to receive mental counseling (Beckman et al. 2018). Other factors include the so-called proximal minority vulnerabilities, which Beckman et al. (2018) characterized as internal systems like stress, nervousness, and worry over hiding one's actual sexual orientation. According to the paradigm, such minority pressures are frequently interconnected and could be linked to other broad concerns, including persistent sexual assault that results in MST.

The discrimination against LGBTQ people in the military stems from their sexual preference (Gurung et al., 2018). Discrimination based on gender identity is a problem that is widespread both within and beyond the service (Burks, 2011). This issue is well-documented outside of the army, demonstrating that LGBTQ civilians encounter discriminatory practices more frequently than non-LGB civilian populations over the course of their lifetimes (Burks,

2011). Even though there is less research on this subject in the army, the available study shows that discrimination against gays is a common occurrence, with 37% of the participants in a survey conducted by Estrada et al. (2011) reporting having experienced discrimination at least once. The fact that prejudice goes unreported because it is mistaken for hazing exacerbates this issue.

According to Mark et al. (2019), federal and state governments have worked to improve military diversity and provided protection for LGBTQ service members. The variety of the military has dramatically increased as a result (Mark et al., 2019). According to Anderson and Suris (2013), one of the main consequences of MST is the risk of poor mental and psychological illness. As such, Mark et al. (2019) assert that evaluating LGBTQ groups' fitness and well-being from the perspective of their safety and health at work in military duty is of the utmost relevance given the rise in diverse culture and recruitment programs that specifically target this community. Elliott et al. (2015) found that LGBTQ people are more likely than heterosexual and cisgender people to experience physical and psychological illness. LGBTQ military people may encounter comparable health disparities (Mark et al., 2019). It is further noted that the mental health of the LGBTQ is likely to worsen due to the development of depression and stress, especially after experience with sexual assault or trauma in the military.

Relyea et al. (2020) found mental challenges as one of the contextual elements that contributes to the connection between the previous history of MST and future experiences of IPV among United States Veterans. With incidence prevalence frequently larger among LGBTQ service members than non-LGBT service members, sexual abuse during service in the military has been associated with adverse medical outcomes in LGBTQ service members, including psychological distress (PTSD), mood disorders, drug use, and increased aggression towards close

friends and partners (Lehavot & Simpson, 2014). According to Schuyler et al. (2020), understanding the perspectives of LGBTQ service members who have survived might help care coordination efforts to minimize adverse health implications, such as prospective exploitation again and destructive behaviors like aggression—recognizing the sexual and psychological harassment perspectives of LGBTQ service groups to help prevent the development of more extreme or violent activities and provide timely treatment for those that are assaulted (Schuyler et al., 2020).

Some factors have not been studied extensively as the causative factors for LGBTQ MST survivors' engagement in intimate partner violence, yet they have been discussed in some literature. For instance, Renzetti and Miley (2014) found numerous similarities between LGBTQ and heterosexual relationships and LGBTQ intimate partner violence, including the importance of power structures, the cyclicality of violence, and the intensification of abuse through time. Meanwhile, some features of partner violence are exclusive to the homosexual experience. For instance, going out might discourage people from seeking help and serve as a cover for maltreatment (Renzetti & Miley, 2014). To escape stigma and discrimination, LGBTQ people regularly hide their gender expression or sexual orientation; abusers can leverage the power of this insecurity by deliberately coercing or blackmailing them with some threats go public (Renzetti & Miley, 2014).

And although spousal abusers do not utilize outing as a form of violence, survivors' unwillingness to come forward may prevent them from seeking the involvement of family, colleagues, or law enforcement, effectively alienating them from their abusive partners (Renzetti & Miley, 2014). Although not wholly specific to the LGBT experience, the history of stigma and prejudice is a significant factor in intimate partner violence within the LGBT community.

Beckman et al. (2018) claim that after being exposed to MST, the experiences of heterosexual people and LGBTQ people are remarkably comparable. As a result, IPV typically arises from the frustrations of the trauma's recurrent recurrence and the power relations that are prevalent among LGBTQ couples (Beckman et al., 2018).

Leaving the Military and MST

Serving in the military is challenging, demanding, and risky. According to a report by Morin (2011) that involved a sample of 1,853 service members, the men, and women who already have been part of the military also face difficulties upon transitioning to civilian life. Thirty percent of veterans report that re-entry was tough for them, a percentage that rises to 44% for those who worked in the decade following the September 11, 2001, terrorist attacks, even though more than 70% of service members reported having a fantastic experience transitioning to civilian society (Morin, 2011). This shows that service members leaving the military may be faced with anxiety and fear of the unknown when transitioning back to civilian life. There is limited research to satisfactorily determine the experience of service members leaving the military as they transition to civilian life, especially if they have experienced an MST.

Since trauma is a psychological reaction to a traumatic event, such as an accident, attack, or natural disaster, astonishment and bewilderment are common feelings following an incident (Huang et al., 2014). How the survivors handle the situation is essential. Studies have established that most survivors sink into drug and substance abuse and depression and are likely to be diagnosed with PTSD (Bell et al., 2018). Consequently, the support system is crucial for the survivors. However, the victimization of MST survivors is a common occurrence within the military and civilian society (Bell et al., 2018). This makes it difficult for the survivors to get the

assurance that their pain is shared and will be accepted within society should they leave the military (Bell et al., 2018).

Eckerlin et al. (2016) conducted a study investigating the impacts of MST on male service members. MST, which can arise from sexual aggression, violence, or intimidation, can affect the quality of life of service men and women along with their close relatives, co-workers, and communities. Although MST affects a more significant proportion of female US soldiers than male US soldiers, the DoD believes that the actual figures of afflicted men and women in all levels and fields of armed forces are virtually similar because around more than 80% of service members are men (Eckerlin et al., 2016). However, relatively little research has been conducted on the male perspective and the impact of MST on men. Among the consequences, as described by Eckerlin et al. (2016), is the difficulty in leaving the military since they fear being judged by the civilian population. Society has always put pressure on men to be the best and most challenging. The men in the military are perceived to be strong, according to Eckerlin et al. (2016), therefore when they are faced with integrating into civilian society, after having survived an MST, they may feel shame or guilt.

A study by Castro et al. (2015) on the prevalence of sexual assault in the military revealed that men are susceptible to military sexual assault. Yet, their plight is often ignored, making it difficult for veterans with MST to reintegrate into society. According to Castro et al. (2015), numerous survivors, whether military or civilian, consider the consequences and reaction to sexual assault as being more distressing than the incident itself. This is because survivors of sexual assault confront blaming, rejection, intrusions into their privacy, and skeptical inquiry in both military and civilian settings, even though abuse is blatant (Wood, 2019). As a result, to be accepted culturally and to avoid repercussions, most survivors in the military choose to remain

silent or refuse to disclose the assault (Wood, 2019). With such acceptance, leaving the attack environment may be the more straightforward thing, yet self-blame and feelings of shame may complicate assimilation into society (Castro et al., 2015). As such, deciding to leave the military was difficult. Additionally, Castro et al. (2015) add that the military service is patriarchal, so the environment may be difficult for many women who must endure a tough environment of jealousy and assault from male colleagues who may feel threatened by their rise. This may make such a soldier leave the service to have peace of mind (Castro et al., 2015).

Another challenge Bell and McCutcheon (2015) identified in response to MST is access to therapy and medical services. While the services were available for service members on active duty, medical services were not available for military personnel who had left active service until the law was rectified by the Department of Veterans Affairs. This made it difficult for the veterans to access important therapeutic education and services as recommended for a person with a history of trauma (Bell & McCutcheon 2015). Therefore, after leaving the military, the survivors were essentially left to chart their path, which made it challenging to reintegrate into society after their traumatic experience.

MST can have far-reaching and long-term consequences, compromising not only the military member's cognitive function, but also their capacity to perform their job and keep healthy connections with one another (Carlile, 2016). Many military people with MST might quit the military following their trauma (Monteith et al., 2019). A range of factors can impact this attitude, which includes fear of reprisal, a lack of assistance and resources, and the idea that they would not be capable of moving on from the horrific experience. Furthermore, the military culture can be antagonistic to those who disclose MST, triggering feelings of embarrassment, remorse, and solitude (Carlile, 2016).

The military's failure to support MST survivors might leave service personnel feeling alone and neglected (Zaleski, 2018). Military people who suffer from MST may believe they have nobody to resort to and should depend on their personal capabilities to face the ramifications of their trauma (Zaleski, 2018). As they strive to find a way forward, this might result in a sense of despair and desperation. The intention to terminate the military following an MST can be challenging, but it can considerably affect an individual's life (Monteith et al., 2019). While leaving the military may imply giving up their employment and the resources and assistance that accompany it, it can also bring a sense of independence and the possibility to rehabilitate and recuperate from the horrific experience (Monteith et al., 2019).

Some service members never get the assistance they need and end up developing mental illnesses that prevents them from being productive citizens after they have completed their military service obligation (Loucks et al., 2019). Women who have had MST may develop symptomatology and coping mechanisms that enhance their chance of being exposed to IPV and other mental health disorders or have shared risk factors for both (Dichter et al., 2017). For midlife and older women veterans, reporting sexual assault, sexual harassment, or physical victimization during military service was linked to poorer self-reported health (Gibson et al., 2016). Of veterans with clinically significant insomnia symptoms, only 47% of those who had both insomnia and MST thought that mental health services would be worth exploring (Jenkins et al., 2015).

When a service member is exiting the military, it is a requirement for the VA treatment facility processing the exit to ask if there are any problems surrounding a sexually traumatic event that happened while serving (Kimerling et al., 2007). There are two specific screening questions all exiting members are asked by the VA service provider. The first question all exiting

service members should be asked is, "While you were serving in the military did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks?" (Kimerling et al., 2007). This screening protocol affords the VA with epidemiological statistics regarding the lifetime prevalence of MST among treatment-seeking veterans. The second question all VA service providers will ask is, "While you were serving in the military, did someone ever use force or threat of force to have sexual contact with you against your will?" (Kimerling et al., 2007).

Distinguishing between harassment and assault in the screening process for MST is an important concept argued Blaise et al. (2019). Their argument is that the current screening process, which lumps harassment and assault together, may lead to underreporting of assault and may limit the effectiveness of intervention and treatment (Blaise et al., 2019). As a result, their review of the recent literature on the prevalence and impact of MST highlights the differences between harassment and assault (Blaise et al., 2019). They assert that harassment and assault have different psychological effects and that distinguishing between the two can help clinicians tailor their interventions to the specific needs of each survivor (Blais et al. 2019). They proposed a new screening tool that separates harassment and assault and assesses the severity and frequency of each. They suggest that this new tool could provide a more accurate assessment of the prevalence of assault and help clinicians develop more effective interventions and treatments.

Therapeutic Approaches and MST

Given the high prevalence of MST among service members and veterans, little is known about how contextual characteristics of the MST event or concurrent histories of other interpersonal traumas are linked to a variety of clinical presentations (Bennett et al., 2019). Bennet et al.'s 2019 study investigated the relationship between contextual factors of MST

events (number of perpetrators, location of MST, relationship to perpetrator, and location of MST) and a dual history of interpersonal traumas (including sexual abuse or assault throughout the lifespan, repeated MST, and intimate partner violence) and total symptoms and symptom clusters of PTSD. MST involving multiple perpetrators was associated with increased avoidance and arousal (Bennett et al, 2019). MST during combat deployment was related to greater hyperarousal (Bennett et al, 2019). Higher rates of reexperiencing and avoidance were found among veterans with a history of partner abuse (Bennett et al., 2019). Identifying phenotypic differences may aid in treatment planning and optimizing outcomes (Bennett et al., 2019).

Previous research has shown that MST influences an individual's health and well-being (Smith et al., 2020). Nonetheless, there is a lack of published empirical studies identifying protective variables for women who have undergone MST (Smith et al., 2020). Two distinct kinds of MST were assessed, namely harassment-only MST, and assault MST, on PTSD symptoms and social functional impairment in a sample of female veterans currently engaged in the civilian environment (Smith et al., 2020). Over the course of nine months, three distinct sets of information regarding MST's effects were gathered (Smith et al., 2020). The researchers found that MST, which encompasses both harassment and violence, was associated with considerably higher levels of PTSD symptoms and impairment in social functioning among women veterans working in civilian professions at three time points. This was true whether the women were employed full-time or part-time (Smith et al., 2020). The pattern of the data suggested that the support of coworkers can mitigate the intensity of the negative outcomes that women who reported MST faced (Smith et al., 2020). Statistics indicate that coworker assistance is an essential resource for female veterans who have suffered MST (Smith et al., 2020).

If a service member actively serving in the military musters the bravery to disclose a mental health illness, there is a high likelihood that they will not receive the necessary and deserved mental health care and this is an issue that numerous studies disregards (Mengeling et al., 2015). There is no record of the service member's condition after the complaint was submitted, but the primary concern is what the military can do to prevent the horrific event from reoccurring (Mengeling et al., 2015). It is probable that a survivor of sexual assault or harassment will need some time to report the occurrence, not only to commanding officers but also to a medical facility where they can obtain treatment for any mental health issues that the assault or harassment may have caused or exacerbated (Mengeling et al., 2015). As the assault survivor typically shares their experiences with unofficial sources of support such as friends and coworkers, survivors of sexual assault may find it beneficial to locate formal services such as counselling and reporting options, as well as to discuss these resources with one another (Holland & Cipriano, 2019). These individuals' responses can significantly impact he survivors' health and wellbeing (Holland & Cipriano, 2019).

It might be difficult for someone who has endured a horrific sexual experience to move on with their life. It has been determined that leaving the military without the necessary treatment to deal with flashbacks and feelings associated with the trauma, may intensify the trauma (Lehavot & Simpson, 2014). As a result of MST, numerous women suffer from PTSD, yet they do not receive the necessary treatment (Lehavot & Simpson, 2014). It is possible for female partners of male trauma survivors to be more cognizant of their partner's mental discomfort and behavioral changes, such as emotional withdrawal and numbing (Lambert et al., 2012). This, in turn, can affect the happiness of women in their relationships with their partners (Lambert et al., 2012). Skills Training in Affective and Interpersonal Regulation (STAIR)

consistently emphasized personal and interpersonal skills that facilitate exceptional social and role functioning (Cloitre et al., 2016). STAIR can help alleviate concerns that are not normally addressed in standard PTSD therapy (Cloitre et al., 2016). It is predicted that the treatment will reduce stress levels in patients and their families (Cloitre et al., 2016). This will be achieved through reducing the negative effects of MST and PTSD, such as social disengagement, antagonism, and aggressive conduct (Cloitre et al., 2016).

The VHA suicide prevention and mental health services are strongly recommended for people who have experienced MST (Kimerling et al., 2016). The VHA has launched several programs that can make it easier for individuals to receive mental health care and help prevent suicide (Kimerling et al., 2016). One initiative entails delivering training on mental health issues associated with MST (Kimerling et al., 2016). Building stronger referral pathways between suicide prevention coordinators and the medical healthcare system is another one of the VHA's objectives as it relates to MST and suicide prevention (Kimerling et al., 2016).

Understanding and treating PTSD, as it relates to MST, has never been more crucial given recent increases in the number of veterans and the proportion of women serving in the military (Stafford & Elzy, 2015). Regardless of the particulars, cultural influences continue to exert substantial influence over the decisions that sexual assault survivors must make, such as whether to disclose the incident (Stafford & Elzy, 2015). Stafford & Elzy conducted a review of the book *Understanding and Treating Military Sexual Trauma,* by Kristen Zaleski (2018), and found that it gives an extremely simplistic and, at times, inaccurate explanation of how traumatic experiences affect the brain and why cognitive-based therapies are ineffective. The author's findings do not support the claim that contemporary therapy procedures completely disregard the brain's right hemisphere (Stafford & Elzy, 2015). According to Stafford and Elzy (2015) this

book has far too many incorrect readings of the literature to be beneficial for furthering the area. Only empirical studies can identify which treatments based on theory are most beneficial, what the active substances are, and who they are most effective with (Stafford & Elzy, 2015). Clinicians and researchers have extra work to do because individuals with PTSD frequently exhibit minimal change in symptoms while receiving therapies with the strongest empirical basis (i.e., CPT and PE) (Stafford & Elzy, 2015). Persons who are interested in dealing with people who have MST should get specialized training from therapy specialists with a strong track record of research (Stafford & Elzy, 2015).

People with a PTST diagnosis can benefit from treatments such as cognitive behavioral therapy, cognitive processing therapy, and eye movement desensitization and reprocessing, which help patients transform their MST-induced negative ideas and beliefs. According to the studies of Whisman and Baucom (2012), mental health, well-being, and relational functioning are all interdependent. Each partner in a successful personal relationship must maintain a positive mental state, devoid of anxiety, stress, and fear (Whisman & Baucom, 2012). This is because a solid relationship can only exist when there is mutual courtesy, regard, and candor between the partners (Whisman & Baucom, 2012). Cognitive behavioral and cognitive processing theories can determine whether a person has a good and fulfilling intimate partner connection or one that is detrimental to their health (Whisman & Baucom, 2012). Active-duty service members or veterans who have endured an MST may discover that they are unable to give the foundations that their partners and successful relationships require because they are unable to function normally because to the stress they have endured (Blais, 2021). This may be because the sufferer may face obstacles that prohibit them from building normal intimate partner relationships (Blais, 2021).

In many of the limited studies on MST and PTSD related to intimate partner relationships, it is necessary to conduct additional research to investigate the associations between PTSD, specifically as the result of an MST, and difficulties in the dynamics of intimate partner relationships. Taft et al. (2011) concluded after performing a meta-analysis of empirical studies comparing PTSD and challenges in relationships with intimate partners that there is a need for greater study on the subject. They are completely true when they state that little is known about the association between MST and relationship satisfaction with active-duty service members and veterans. Very few papers answered the question, "What is the relationship between PTSD, metastasized by MST, and good intimate partner relationships?" Researching this topic yielded limited studies

For decades, returning from war, service members have survived the loss of limbs, eyesight, hearing, and comrades (DoD SAPR, 2012). However, nothing is more demeaning, though, than going off to war only to return with the scars left after being sexually assaulted by the enemy or, worse, a fellow service member. These service members return from the battlefield with their lives, but many come back with scars that are undetectable by the human eye. Since the inception of the armed forces, service members have been sexually harassed, sexually assaulted, and even raped (DoD SAPR, 2012). It has only been since 1999 that the armed forces have been screening for MST. These heinous events may not only leave service members with physical scars but with emotional ones as well. MST is defined as any incident of sexual harassment or sexual assault while the service member was serving in the military (DoD SAPR, 2012). This conduct can involve unwanted sexual advances, requests for sexual favors, and deliberate or repeated offensive comments or gestures of a sexual nature when the submission to such conduct is made either explicitly or implicitly a term or condition of a person's job, pay, or

career; the submission to or rejection of such conduct by a person is used as a basis for career or employment decisions affecting that person; or if such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creates an intimidating, hostile, or offensive environment; and is so severe or pervasive that a reasonable person would perceive, and the survivor does perceive, the environment as hostile or offensive (House of Representative, Section 1561 of Title 10, USC, 2011).

In 2017, the Department of Defense (DoD) estimated that 1 in 23 women (43%) and 1 in 167 men (.6%) of men experienced sexual assault (Office of People's Analytics, 2017). Those who have fallen survivor to a military sexual traumatic event can testify that sexual harassment, sexual assault, or rape does not choose its survivors according to their race, rank, or sexual orientation, and no one is impervious to MST.

In a 2018 meta-analysis of more than 584 studies involving MST, 69 of these reports uncovered that MST could happen to any service member at any time, but women experience most MSTs (Wilson, 2018). Of the service members who reported an MST, when the measure assessed assault only, 1.9% of men and 23.6% of women reported the MST and 8.9% of men and 52.5% of women reported the MST when only harassment was assessed (Wilson, 2018).

Most military sexual traumatic events take place within the military setting and are most likely committed by military personnel (Skopp et al., 2020). Being aware of this information allows commanders at all levels and training officers the chance to intervene by bringing awareness to the problem and by conducting constant training. The DoD has, in the last 20+ years, done its best to stop sexual violence, but there are still many instances where service members have fallen victim to such traumatic events. The study found that often the offender and

the survivor must continue to work and often live (in the barracks when deployed) together, which can make healing for the survivor hard and re-victimization easier (Skopp et al., 2020).

Many of those service members, as they return from war, return to spouses, girlfriends, boyfriends, and intimate partners, but how they manage those relationships after living through that sort of trauma is still not well investigated. This is because there are numerous challenges associated with MST that need to be brought to light. For instance, military personnel recovering from an MST may have trouble forming close bonds with others. In certain situations, the abuse results in confidence issues, difficulties interacting with others, and concerns with sexual problems (DAV, 2022). Emotional difficulties brought on by guilt, humiliation, and rage over the trauma are also frequent (DAV, 2022). Many survivors also mention having trouble keeping their jobs after serving in the military (DAV, 2022). Knowing how to live a healthy life after surviving an MST is therefore important and there are limited studies that cover how service members, specifically men, do it. There are studies highlighting the prevalence of this phenomenon, though, but few highlight the struggles and triumphs after the trauma as it pertains to future intimate partner relationships. Additionally, numerous studies define the difference between sexual harassment and sexual assault. Still, there have not been enough studies conducted that examined the correlation between sexual harassment and sexual assault and how one, either, or both can affect a veteran's life after experiencing one, either, or both (Thomas et al., 2021; 2019).

Research in civilian and military populations has demonstrated that females who experience CSA are more likely to experience sexual assault in adulthood than females who did not experience CSA (Schry et al., 2016). Among veteran samples, however, little research has examined previous sexual assault as a risk factor for sexual assault and post-military sexual

assault (Schry et al., 2016). Schry et al. (2016) examined risk of sexual victimization in a sample of veterans who served during the wars in Iraq and Afghanistan. A sample of 3106 veterans (80.4% male) completed a measure of lifetime exposure to traumatic events, including sexual abuse and sexual assault (Schry et al., 2016). Logistic regression analyses were used to examine previous sexual abuse/assault as predictors of later sexual assault; analyses were conducted separately for males and females (Schry et al., 2016). In general, previous sexual abuse/assault was associated with later sexual assault in both male and female veterans (Schry et al., 2016). These findings have important assessment and treatment implications for clinicians working with veterans (Schry et al., 2016).

Cognitive Behavioral Theory and MST

There are several discussions on the possible treatment options for the MST victims who may not be able to maintain a satisfactory intimate relationship. For instance, Billette et al. (2008) looked at the impact of spousal involvement on the efficacy of cognitive-behavioral therapy (CBT) for women who have experienced sexual assault and have PTSD because of the sexual assault. Billette et al. (2008) argued that social support is an important factor in the treatment of PTSD and that the involvement of the spouse can increase the effectiveness of CBT. The results of the study showed that the CBT groups experienced a significant reduction in PTSD symptoms, depression, and anxiety compared to the control group (Billette et al., 2008). The group that received CBT with spousal involvement showed greater improvement in PTSD symptoms and social support compared to the group that received CBT without spousal involvement. Furthermore, Billette et al. (2008) found that the spousal involvement had a stronger impact on social support for women who had higher levels of PTSD symptoms at the beginning of treatment. It is evident that spousal involvement can enhance the effectiveness of

CBT for women who have experienced sexual assault and who have PTSD. Billette et al. (2008) also highlights the importance of social support in the treatment of PTSD and suggest that involving the spouse in therapy can be an effective way to increase social support and improve treatment outcomes.

A person's thoughts and feelings have a large and key role in the creation and development of psychological and behavioral responses to circumstances in life, according to the core tenet of cognitive-behavioral therapy techniques (González-Prendes & Resko, 2019). This theory posits that the primary determinants of someone's reactions and behaviors in dealing with life occurrences are cognitive processes, which take the shape of definitions, pronouncements, evaluations, and suppositions associated with life circumstances (González-Prendes & Resko, 2019). These processes either help or inhibit the process of adjustment. Cognitive-behavioral approaches of psychotherapy are underpinned by three essential presumptions (Dobson & Dobson, 2009). The first presumption is that cognitive content and mechanisms are understandable and knowable. Although some ideas or views may not always be immediately apparent to a person; with the right instruction and practice, people may learn to become conscious of them (González-Prendes & Resko, 2019). The second fundamental premise is that people's thinking ability influences how they react to environmental stimuli. Humans don't only respond to life's occurrences psychologically or behaviorally, according to this viewpoint. Instead, CBT contends that how people perceive and respond to their world is intertwined (González-Prendes & Resko, 2019). The third key tenet of CBT is that these thoughts and feelings may be focused, altered, and changed with purpose. As a result, the person's ailments will be lessened, and they will be more adaptable and functioning when such cognitions are adjusted in the perspective of more practical, fair, and rational thinking (González-Prendes &

Resko, 2019). This transformation may occur because of the person working independently, maybe with the assistance of self-help materials, or because of their participation with a registered professional in one of the numerous CBT procedures (González-Prendes & Resko, 2019).

As Castro et al. (2015) contend, sexual assaults in the military pose a substantial threat to military readiness since there are serious health consequences and lower performance outcomes related to sexual assaults. This indicates a serious need to address the challenges faced by military personnel regarding the traumatic experiences they encounter during their active-duty service (Castro et al., 2015). From this assumption, it can be concluded that the behavior and reaction of military personnel during intimacy with a sexual partner are informed by how they perceived the impacts and experiences when they were in a similar situation, especially during sexual abuse (Castro et al., 2015). Intimacy with a sexual partner reminds them of a situation of sexual abuse; as such, their reaction will be influenced by how they perceive such abuse (Castro et al., 2015). Assertions on the impacts of sexual assault by military personnel on their sexual performance in an intimate relationship can be explained using CBT (Castro et al., 2015). This is because theory suggests that the primary determinants of someone's reactions and behaviors in dealing with life occurrences are cognitive processes, which shape definitions, pronouncements, evaluations, and suppositions associated with life circumstances (Castro et al., 2015). Earlier encounters with MST can therefore affect the military personnel's actions in the future, including hindering their intimate relationship with sexual partners (González-Prendes & Resko, 2019). This point is further supported by one of the assumptions of cognitive behavioral therapy that people's ability to think influences how they react to environmental stimuli (González-Prendes & Resko, 2019). Humans don't only respond to life's occurrences psychologically or behaviorally,

according to this viewpoint (González-Prendes & Resko, 2019). CBT contends that how people perceive their world and how they respond to it are intertwined (González-Prendes & Resko, 2019).

Cognitive Processing Theory and MST

The second theory is the Cognitive Processing Theory. A comprehensive framework for analyzing and explaining the formation and progression of trauma-related stress is provided by CPT (González-Prendes & Resko, 2019). This theoretical model focuses on the notion that it is common for emotional responses to persist and influence one's actions long after the occurrence initially connected with the feeling has gone (González-Prendes & Resko, 2019). This psychological reliving can create a habit of trauma memory suppression and maintain the existence of PTSD (Ssenyonga et al., 2013). Memory information structures can represent emotions (Lang, 2019). When it comes to anxiety, stress, etc., the related memory contains details about the feared stimuli, explicit reactions including vocal, emotional, and physical ones, as well as the significance the person connected with that stimulus (González-Prendes & Resko, 2019).

According to this theory, recollections of a traumatic event trigger a sense of apprehension which in turn encourages people to engage in evasive and avoidant actions (González-Prendes & Resko, 2019). In other respects, a fear system is engaged in the mind when an individual is exposed to a stimulus that triggers recollections of a traumatic incident (González-Prendes & Resko, 2019). The individual then tries to suppress or get rid of this anxiety. However, this action usually has the unfortunate consequence of sustaining anxiety (González-Prendes & Resko, 2019). Based on this view, embracing this anxiety and then being able to experience it as less potent require frequent exposure to the painful memory in a secure,

therapeutic setting (González-Prendes & Resko, 2019). In a similar sense, MST is a traumatic experience that can lower the productivity and the performance of military personnel in an intimate relationship (Castro et al., 2015). This is because the MST experiences triggers the memory structure to register the memory as fear leaving the person doing anything to avoid experiencing such fear; and, in doing so, develop PTSD such that anxiety starts when exposed to an environment that stimulates the memory to recollect the traumatic experience (Castro et al., 2015).

Intimacy and sexual relationships can trigger memories of sexual abuse according to Mason and Lodrick (2013); thus, hindering the progression of a healthy intimate sexual relationship between military personnel who had earlier had a sexual assault with their current partners. CPT suggests that the trauma and the fear of the traumatic experience can only be overcome through exposure to the stimulus as opposed to the avoidance approach that the affected individuals usually employ (Mason & Lodrick, 2013). According to this theory, military personnel will have a healthy intimate sexual relationship with their partners only through continuous exposure to intimacy with a trusted partner (Mason & Lodrick, 2013).

Eye Movement Desensitization and Reprocessing and MST

For those struggling with stress, panic, depression, or trauma, eye movement desensitization, and reprocessing therapy, or EMDR therapy, is a successful therapeutic option. It's a means of moving on from the past. There have been discussions around the efficacy and effectiveness of EMDR in treating trauma such as MST, which forms the basis for the present discussion. Several scholars have defined EMDR differently, including its founder Shapiro (1989), who described it as a psychotherapy strategy that tries to alleviate stressful symptoms and repressed memories. The goal of this therapy, according to Valiente-Gómez et al. (2017), is

to program and incorporate painful experiences into the patient's typical chronological memories. The rehabilitation consists of a common framework with eight stages and joint excitability, typically lateral saccadic eye mobility. A substantial amount of research has demonstrated the effectiveness of eye movement desensitization and reprocessing therapy in managing traumatic stress and other psychologically damaging conditions like depressive episodes and trauma.

For example, in a 2013 report, Jonas et al. investigated the efficacy, complementary therapy, potential associated complications of psychological and pharmacological treatments for people with PTSD. This was achieved by statistical analysis using spontaneous models to assess aggregated effects (Jonas et al., 2013). The researchers also performed a systematic review utilizing Bayesian techniques and standardized strength of the evidence premised on the published frameworks to calculate the comparative effectiveness of intervention therapy. The results show that exposure therapy is effective for minimizing or managing depressive symptoms, PTSD, and other related conditions (Jonas et al., 2013). Their research also confirms the effectiveness of storytelling talk therapy, EMDR, CBT, and other treatments for depressive episodes, stress, PTSD and even substance abuse.

The World Health Organization (WHO) (2013) also suggested EMDR as the best psychotherapy for treating PTSD in patients of all ages. EMDR therapy is not only used to treat those with PTSD for it is now being used to help other diseases and associated conditions of PTSD (Novo et al., 2014). According to Fusar-Poli et al. (2017), traumatic experiences are one of the etiological causes of numerous psychiatric diseases, which is significant in this setting. As a result, research into EMDR therapy has expanded further than the treatment of PTSD, and several studies have examined its impact on a variety of other mental illnesses, including

psychotic episodes, bipolar disorder, clinical depression, mood disorders, substance dependence, and chronic back discomfort. Yet a few have touched on how EMDR can help manage MST.

Katz (2015) encourages the use of EMDR psychotherapy in the management of MST and provides an overview of the methodology employed for the management of MST in chapter nine of the book "*Treating Military Sexual Trauma*." The chapter ends with both the World Health Organization and multiple interest bodies, such as the Department of Veterans Affairs/Department of Defense Clinical Practice Guidelines, endorsing EMDR therapy's effectiveness (WHO, 2013). Positive psychological events were already identified as facilitator tools since the psychotherapist might use them to enhance clients' perceptions of their capacity to manage elements of their lives while receiving treatment (WHO, 2013).

Valiente-Gómez et al. (2017) found in their study to measure the effectiveness of EMDR beyond PTSD that EMDR was effective in improving the mental health quality of people diagnosed with other trauma-associated symptoms such as stress, depression, and substance abuse. EMDR therapy mainly draws its strengths from trying to suppress the previous unpleasant feelings with more recent memories (Valiente-Gómez et al. 2017).

According to Hurley (2015), MST is a substantial and pervasive problem that affects many veterans. MST can have a variety of damaging consequences on people's physical and psychological well-being as well as their capacity to work, make connections, and participate in other activities. Numerous interventions have emerged in recent years to aid soldiers who have undergone MST in overcoming the consequences of psychological trauma. Hurley (2015) adds that EMDR is one of these treatments that shows the most promise. Hurley (2015) also believes that the theory behind the therapy is that traumatic events are encoded differently than other experiences and that the eye movements, vibrations, or touches employed in EMDR can assist in

unleashing these recollections and enable individuals to integrate them more constructively. Reisman (2016) found that EMDR therapies significantly reduced PTSD, depression, anxiousness, and sexual problems in veterans with MST. The study was published in the Journal of Traumatic Stress and looked at PTSD Treatment for Veterans. This claim was further supported by Watkins et al. (2018), who found that EMDR treatment significantly improved overall functioning and quality of life for veterans with MST.

Veterans experiencing MST who have not reacted to other kinds of treatment have additionally been reported to benefit from EMDR therapy (Watkins et al., 2018). It is crucial to understand that EMDR is not a universal solution for MST and that certain service members may best gain from other various therapies, such as psychological treatment, pharmaceuticals, and support networks (Watkins et al., 2018). But EMDR is a powerful and useful method that can assist MST veterans in processing their painful memories and moving on with their lives (Watkins et al., 2018).

In their study to compare the efficacy of EMDR therapies on women experiencing violence from their partners to eclectic psychotherapy and a control condition, Tarquinio et al. (2013) found that EMDR was more successful in reducing clinical depression, fear, and depressive symptoms as well as the associated symptoms relating to emotional trauma. The EMDR group showed a considerable decrease in the occurrences of symptoms of depression, which was a positive finding and partially in line with the authors' predictions (Tarquinio et al., 2013)

Service members with MST can benefit from EMDR therapy as it is known to aid in the reduction of PTSD, depression, stress, and sexual problems symptoms and can enhance general life quality and functioning for veterans (Valiente-Gómez et al., 2017). Valiente-Gómez et al.

(2017) note that EMDR ought not to be perceived as the only treatment; rather, that a mix of other therapeutic approaches may be more effective. Prolonged Exposure Therapy (PE) is among the of cognitive behavioral therapies that entail progressively reintroducing veterans to the painful experiences connected to their MST to enable them to comprehend and transcend their concerns, according to Valiente-Gómez et al. (2017). A combination of these two approaches may help the service member or veteran overcome the challenges with MST as quickly as possible while embracing the new measures to live a normal life (Valiente-Gómez et al., 2017).

There are several consequences of using EMDR as an effective therapeutic intervention. Some MST survivors may suffer from unnecessary aggressiveness toward close ones, as well as a constant feeling of agitation or low self-esteem (Kats, 2015). These are some etiological causes of intimate partner violence which can leave the survivor and the perpetrator in a deep emotional state. EMDR is touted by Tarquinio et al. (2013) as an effective management tool or approach to managing both the survivor of abuse and the perpetrator. Therefore, Mark et al. (2019) advised that relevant authorities, and the survivors, identify and seek help immediately for early detection of any sign that can lead to violence against an intimate partner. Consequently, using EMDR can be an effective tool for such early detections (Mark et al., 2019).

Summary

MST has been a component of the military for as long as there has been a military. The scars of war are much greater than the ones we see. Unfathomable agony is experienced by some service members because of an MST. Because of the selfish conduct of another, many service members experience shame, remorse, and pain for the rest of their lives. While the DoD has tried to prevent service members from having to go through an MST in the first place and ensure that those who have suffered an MST receive the necessary mental health counseling to cope with the

trauma, there is little the DoD can do when one person is destined to harm another. There haven't been many studies that emphasize the harm that is done to service personnel and their intimate partner relationships when little or nothing is done to assist in healing the scars left behind by an MST.

Service members suffering from traumas such as MST can also develop psychiatric concerns such as PTSD, SUD, depression, anxiety, eating disorders, as well as other mental illnesses (O'Brien & Sher, 2013). Their diagnosed mental illnesses may be the direct result of being sexually traumatized (Murdoch et al., 2014) and there is a lack of research stressing or supporting any assertions that those who have experienced MST would be well enough to develop healthy intimate partner relationships. The use of certain therapeutic techniques such as cognitive behavioral therapy, cognitive processing therapy, and eye movement desensitization and reprocessing therapy are evidence-based methods that can aid in helping those survivors of MST process their trauma and reset their lives. This study intends to find out what happens to those military members and their intimate partner relationships after the trauma takes place and if it is feasible for MST survivors to emerge from the wreckage with a loving, caring intimate partner living in a healthy relationship.

Chapter Three: Methods

Overview

The purpose of this phenomenological study was to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. This section delved into the in-depth methodology, encompassing various topics such as research design, research questions, setting, participants, procedures, the researcher's role, data collection, data analysis, and any ethical considerations. The researcher used the demographic questionnaire, semi-structured interview method, journal prompts, and cognitive representations to collect participant data to answer the study's questions.

Design

The research was qualitative and took a phenomenological approach. Qualitative research design attempts to investigate and fully comprehend the thoughts, feelings, viewpoints, and interpretations of people or organizations through an in-depth assessment of their utterances, behaviors, and habits (Pathak et al., 2013). It is frequently used in sociology, humanities, and other fields where scholars aim to comprehend human nature and their perceptions (Pathak et al., 2013). The researcher selected qualitative design for the current study because it enabled the exploration of intricate and nuanced phenomena that are insufficiently represented by quantitative measurements. The study's objective was to gain a comprehensive understanding of how military sexual trauma impacts intimate partner relationships. The qualitative methodology allows the collection of rich and thorough data supporting this exploration (Creswell & Poth, 2018).

Though there were two phenomenological approaches to choose from; hermeneutic and transcendental. The transcendental phenomenological design was appropriate for this study

because it sought to unearth the significance of actual experiences and report on how people make sense of their experiences (Tuffour, 2017) and not that of the researcher. The hermeneutic approach assumes that the researcher is a part of the study, and that the researcher will be interpreting the meaning of the lived experiences (Creswell, 2013). The transcendental design is beneficial for delving into personal and confidential topics like sexual trauma and intimate relationships (Tuffour, 2017). Transcendental phenomenological research was consistent with this study's goal of understanding the subjective lived experiences of active-duty service members and veterans who had suffered from MST (Tuffour, 2017).

The German scholar Edmund Husserl, who aimed to transform philosophy back "to the objects part of the individual," is the contemporary pioneer of phenomenology (Armstrong, 2019). Husserl played a significant role in the development of transcendental phenomenology, a philosophical perspective on qualitative research methodology that aims to comprehend human experience (Moustakas, 1994). To view phenomena through clear lenses and enable their genuine significance to emerge organically with and within their own identity, pure transcendental phenomenology is based on the premise that all preconceived notions (epoche) must be left aside. This allows phenomena to be seen for what they truly are (Moustakas, 1994).

According to Husserl, conventional experimental knowledge, founded on empirical data collection and analysis, is insufficient for comprehending people's subjective experiences (Ebele, 2014). Instead, Husserl thought that studies of subjective experiences ought to be devoid of presumptions or hypotheses and that scientists should aim to comprehend the experience's fundamental characteristics as it is being lived (Ebele, 2014). He did not intend for philosophy to become experimental, as though "truth" could be established in an exact and unbiased manner (Armstrong, 2019). Instead, Husserl suggests that reflective thinking eliminates all implausible

presumptions (concerning the present state of objects) in the quest for underpinnings around which scholars could secure their understanding (Armstrong, 2019). Husserl believed that a straightforward explanation of the phenomena revealed by conscious experience would provide scholars with a solid base of essential information, supporting the claim that philosophy is more revolutionary and all-encompassing than conventional fields of study (Armstrong, 2019).

However, modern phenomenology has primarily given up Husserl's hope of discovering unquestionable underpinnings for knowledge (Eberle, 2014). The significance of ultimate expression and context in human experience has been underscored frequently by contemporary phenomenologists (Eberle, 2014). They contend that, contrary to Husserl's position, physical reality and social and cultural background cannot be categorized or separated from our personal experience (Eberle, 2014). As a result, more focus is now on the lived body and how our personal and cognitive environments shape our experiences (Eberle, 2014). As such, the transcendental phenomenological approach used in this study draws heavily from the contemporary interpretations that emphasize other factors explaining lived experience (Eberle, 2014). As described in Chapter Two, several factors have been linked to MST, such as depression, substance use disorder, PTSD, etc., that could be used to explain the phenomenon under investigation.

The transcendental phenomenological design is a suitable and efficient method for this study because it explores the subjective experiences of active-duty service members and veterans who have experienced MST and its effects on their intimate partner relationships. Therefore, this study implemented a transcendental phenomenological design. In-depth semi-structured interviews were used to collect data, which were then transcribed and analyzed using thematic analysis. The goal was to identify common themes and patterns in participants' experiences,

which were used to develop recommendations and strategies to reduce the impact of MST on intimate partner relationships.

The researcher's objective in Husserl's transcendental phenomenology is to attain transcendental subjectivity, which is a state in which the impact of the researcher on the inquiry is constantly assessed and biases and preconceptions neutralized, so that they do not influence the object of study (Neubauer et al., 2019). The researcher maintained objectivity and refrained from influencing the descriptions provided by the subjects. The researcher who can achieve the transcendental I state—a state in which the objective researcher moves from the participants' descriptions of the facts of the lived experience to universal essences of the phenomenon at which point consciousness itself could be grasped—was able to approach this lived dimension of experience (Neubauer et al., 2019).

Research Questions

For this transcendental phenomenological study, the following questions guided the research:

Central Research Question

How do MST survivors describe how their sexual traumatic event impacts their intimate partner relationships?

Sub-question One

How do participants describe the impact their MST, and other associated mental health diagnoses because of their MST, have upon their ability to have a healthy intimate partner relationship?

Sub-question Two

How do participants describe their experience with sexual dysfunction as the result of their MST?

Sub-question Three

How do participants describe their experience of relationship dissatisfaction once they have shared their MST with their partner?

Setting

This study focused on the lived experiences of those veterans who survived an MST. The participants were veterans who have since been discharged from their military service. All participants were recruited using social media recruitment ads and word of mouth marketing. The interviews for this study took place via Zoom, where the specific location and facility for each interview was determined by the participant. Given the recent global pandemic, it has become customary to conduct interviews utilizing this method, so many of the participants chose this method. Additionally, this method for the interview allowed the participants to choose the location that fit them best. Obtaining a representative sample of individuals who have experienced MST required accessing participants where they were. This setting offered the largest breadth of outreach.

Based on the topic of the study, availability of participants, and access to the target population, military installations and VA facilities was the best option to recruit participants. Organizational and leadership styles differ between military installations and VA facilities. A commanding officer, who oversees the installation's general management and the welfare of its members encamped there, is generally in charge of military sites (Krauthammer, 2009). A director oversees the delivery of medical care and other services to veterans at VA facilities (Krauthammer, 2009). Both military installations and VA facilities have guidelines and

processes for working with veterans, such as procedures for discussing problems related to sexual trauma and intimate partner relationships (Krauthammer, 2009). The researcher followed those guidelines for both military installations and VA facilities.

Participants

The veterans who have disclosed having experienced an MST made up the sample pool for this study. The researcher chose participants who satisfied the study's inclusion criteria using a purposive sampling strategy. Purposive sampling is a non-probability sample selection process that requires choosing research study participants based on predetermined standards or traits pertinent to the study's goals or research questions (Campbell et al., 2020). Instead of selecting participants randomly or using another method, the researcher used purposive sampling to choose the most likely participants to provide the study with the most useful or pertinent information. The participants who participated in the study met the following criterion:

(1) Be a male or female

(2) Be a veteran of the US Armed Forces

(3) Be between the ages of 18 and 65

(4) Has a history of MST

(5) Has or had an intimate sexual partnership since the MST

(6) Experienced other mental health diagnoses because of the MST

(7) Experienced sexual dysfunction since the MST

(8) Experienced relationship dissatisfaction since the MST

This sampling technique was suitable for this study because it enabled the choice of participants who had experienced MST, which was required to collect information pertinent to the study's research question. The sample size for this type of qualitative research was typically

between 12-15, and this study met that criterion. The inclusion criteria were used to identify potential participants using purposive sampling. The researcher also employed snowball sampling by asking participants to suggest other potential participants for the study. Participants were asked for demographic data such as age, gender, race, ethnicity, and military branch. The results section includes a tabular description of this information. The narrative accounts of each participant's experiences with an intimate partner and military sexual trauma was reported.

Procedures

Liberty University's Institutional Review Board (IRB) first granted approval before this study was carried out. Researchers needed to submit a thorough study protocol to the IRB for review to get IRB approval. The researcher completed and submitted the required paperwork and documentation for the IRB's review (Appendix B) to ensure that the interview questions were morally acceptable and complied with all applicable laws and regulations. The approval of the IRB was a crucial step in conducting this research study that involved human subjects (Spellecy & Busse 2021). IRB approval guaranteed the study's legality, ethics, and participant protection by removing any potential threats to their safety (Spellecy & Busse 2021). Information that included the research questions, study design, sampling techniques, data collection techniques, potential risks and benefits, and security precautions were all included in the protocol. The IRB examined the protocol to ensure that it was planned and carried out per institutional and federal policies and that the study's potential benefits outweighed any potential risks.

Finding potential study participants was the next step after receiving IRB approval. The researcher used purposive sampling to choose participants who satisfy the study's inclusion requirements. Military service members and veterans who have had intimate relationships after suffering a military sexual traumatic event met the inclusion criteria. Flyers and online

advertisements placed in military and veteran communities were used to find participants. Each participant had a private interview in a setting they chose as part of the data collection process (e.g., their home or a private room on the military campus via Zoom). The semi-structured interviews included open-ended questions to draw out in-depth descriptions of the participants' experiences with military sexual trauma and intimate relationships. The researcher used active listening techniques, empathy, and reflection to create a secure and encouraging environment for the participants to share their experiences.

With the participants' permission, the interviews were recorded using audio and video equipment to catch verbal and nonverbal cues. The researcher used a reflection journal to capture thoughts before and after each interview to record additional contextual information. The interviews were recorded on the Zoom platform using audio and video recording techniques. To ensure accuracy in the data collection process, the researcher let the participants know that the interview was being recorded. Before beginning the recording, the researcher explained to the participants how the data will be stored and used for analysis. The confidentiality of the data and the fact that only the research team had access to said data was disclosed to all participants.

As soon as the recording began, the researcher concentrated on paying attention to the participant's answers to each question, ensuring that the participant is comfortable with answering the questions posed. Following the interview, the researcher moved the data from the recording device's memory to a password-protected Google Drive that was only accessible to the researcher and her Chair. To ensure confidentiality, the original recording from the recording device was deleted. All personal identifying information was erased from the data before it was stored, and a unique identifier was given to it instead. The data will be kept for no longer than five years before being destroyed.

Following the conclusion of all interviews, the researcher had the audio professionally transcribed and then thematically analyzed the data. The researcher identified themes and patterns in the data and used them to develop recommendations for future research on the subject. These recommendations included advice and strategies that the DOD, VHA, VA, and MST survivors can use. The researcher protected the participants' identities throughout the study by using pseudonyms to maintain their confidentiality and anonymity. The researcher also took measures to ensure the participant's safety and well-being, offering resources and directing them to the right support services.

The Researcher's Role

The researcher's role in selecting the methodology is essential to the study's success. To choose an appropriate research design, the researcher must grasp the study problem and the research questions (Johnson et al., 2020). Because the researcher wanted to understand the lived experiences of military service members and veterans who have experienced military sexual trauma and how it has affected their intimate partner relationships, the researcher chose a qualitative research design and a phenomenological approach. The Department of Community Care and Counseling (School of Behavioral Sciences) at Liberty University, where the researcher had a particular area of interest, was crucial to this study because of its connections to the military and dedication to counselling service members and veterans. The researcher's connections with the department and access to potential participants made the recruitment process manageable. The researcher was aware of potential biases because this relationship may have affected the data collection.

Being a military sexual trauma survivor, the researcher brought a unique perspective to the research topic as the study's researcher. The significance of recognizing and addressing this

potential bias, which was the result of the researcher's experience with MST, impacted the researcher's feelings and responses throughout the research process. To lessen this, the researcher explained to the participants at the outset of each interview how she has a personal connection to the subject and how it might affect how she responds. Thanks to the researcher's transparency, participants were able to comprehend the researcher's viewpoint, which made them feel more at ease when sharing their own lived experiences.

The researcher kept a reflective journal throughout the process to further address potential biases and assumptions. After each interview, the interviewer made note of any feelings, ideas, and observations about the interview. The researcher recognized prejudices or presumptions by periodically reading and reflecting on the journal entries. Privacy and identities were kept secret. The researcher's responsibility in this study was to create an atmosphere where participants can speak openly and respectfully about their experiences with MST and intimate relationships. The researcher was dedicated to maintaining objectivity and conducting a rigorous and ethical study, despite the possibility that a personal experience with MST could have influenced feelings and reactions throughout the research process.

Data Collection

Demographic questionnaires, semi-structured interviews, cognitive representations, and journal prompts were the primary data collection methods for this study. Individual interviews were conducted, and the researcher used open-ended questions to encourage participants to express their thoughts and feelings freely. The questions elicited specific information about the participants' real-life military experiences, particularly concerning their sexual traumatization. The researcher's journal entries, made after each interview, captured the researcher's feelings,

thoughts, and presumptions regarding the study. These journal notes were also used to spot any biases that might affect the data collection and analysis methods (Audenhove & Donders, 2019).

Demographic Questionnaire

To collect each participant's age, gender, ethnicity, military service length, branch of service, last or current intimate partner relationship status, and date of the participant's military sexual traumatic event, a demographic questionnaire was constructed. In addition to collecting the aforementioned criteria, the questionnaire also afforded exploration as to why each participant was willing to take part in this study. The answers derived from the questionnaire gave the researcher the information needed to include the best participants for the study. Each participant was chosen in accordance with how they responded when asked if they had ever dealt with additional mental health disorders, sexual dysfunction, or relationship unhappiness following their military sexual traumatic event.

Semi-structured Interviews

Semi-structured interviews are a research technique used to conduct one-on-one interviews with participants in a qualitative study to gather data (Husband, 2020). They are the primary data collection method used in this study. Semi-structured interviews are those in which the interviewer has a general list of subjects or questions to cover but permits the interviewee some flexibility and the opportunity to follow up on any especially compelling or unprecedented responses (Qu & Dumay, 2011). Because it enables in-depth exploration of participants' experiences, perceptions, and perspectives, this technique is frequently used in qualitative research (Qu & Dumay, 2011). With this method, the interviewer and participant can have a more organic and natural conversation while the participant can express their observations and conclusions in their own words (Qu & Dumay, 2011). Semi-structured interviews were suitable

for this study because they enabled the researcher to investigate participants' traumatic experiences and how those experiences had impacted each participant's intimate partner relationships. This method's adaptability allowed further exploration of participants' experiences and viewpoints and obtained feedback on any interesting or unexpected responses.

Upon receiving confirmation from the IRB that the questions were appropriate for the study, the interviews began. Participants were contacted, and 90-minute interview times were scheduled. During the interview, each participant was given the opportunity to ask any questions of the researcher about the study. Before the start of each interview, the researcher reviewed with each participant the purpose and procedures of the study as well as what steps were taken to keep their personal identifying information as well as their answers confidential. Each participant was reminded that at any time during the interview if they were uncomfortable with any of the questions, the interview would stop immediately. All interviews were video and audio-recorded, and the audio was transcribed by a professional transcriptionist. The researcher has personal experience with the study's topic, so she journaled immediately after each interview. This not only addressed the epoche, but it also allowed the researcher the opportunity to demonstrate reflexivity.

The following questions were used to conduct the semi-structured interviews. Each question was designed with the following categories in mind: questions that build rapport, questions relating to the MST, questions relating to any other mental diagnoses, questions relating to sexual dysfunction, and questions relating to relationship dissatisfaction with an intimate sexual partner. However, all questions were developed to assist in answering the central research question. Each question was placed into a category designed to open the interview, and

purposefully guide the interview where the difficult questions are in the middle of the interview while bringing the interview to a close with specific questions about future actions.

1. Can you please introduce yourself and tell me a little bit about who you are?
2. Is there any topic or question you are uncomfortable discussing during this interview?
3. What motivated you to participate in this research study?
4. Before we begin, do you have any questions for me, specifically about this study?

Questions Related to the MST

5. Please describe the events that led up to your MST.
6. Please describe what you were feeling before your MST happened.
7. Please describe what you were feeling during your MST.
8. Please describe how you were able to stop the action.
9. Please describe what you were feeling after your MST happened.
10. Did you communicate with the perpetrator after the event, and if so, what was discussed?
11. Who did you notify in your chain of command of your MST?
12. Tell me about the investigation once you reported it to your chain of command.
13. What was the outcome of the investigation and was it handled to your satisfaction?
14. Since your MST, have you had interactions with other survivors of sexual trauma, and how did those conversations go?

Questions Related to Mental Health Diagnoses

15. Describe what assistance you received from a mental healthcare professional that you felt helped you process what happened.
16. What other mental health diagnoses have you received because of your MST?
17. What assistance are you receiving to help you with the subsequent diagnoses?

18. How have the new diagnoses impacted your intimate partner relationship(s)?

Questions Related to Sexual Dysfunction

19. What sexual dysfunction(s), mentally and/or physically, are you experiencing because of your MST?
20. Are there any other experiences or factors that have influenced your approach to intimate relationships after the trauma?
21. Have you ever felt unable to be intimate with your partner because of your MST? If so, can you tell me more about that?

Questions Related to Relationship Dissatisfaction

22. How do you disclose your MST to your romantic partner(s)?
23. How have your romantic partner(s) responded to the news of your MST?
24. How has your MST impacted your current (or most recent) relationship?

Closing Questions

25. Is there anything else you would like to share?
26. I am hoping to forward my research to members of Congress and the Veterans Administration. Do you have a message for them that you would like me to pass on?

Questions one through four allowed the participant to tell the researcher a little about themselves, and it also allowed both the participant and the researcher to get to know one another, hopefully building rapport. Questions five through 14 specifically related to what happened before, during, and after the MST. Addressing sub-question one, question 15 through 18 were specifically designed to help answer how participants describe the impact their MST and other associated mental health diagnoses had upon their ability to have a healthy intimate partner relationship. Questions 19 through 21 addressed sub-question two, addressing how participants

described their experience with sexual dysfunction as the result of their MST. Questions 22 through 24 addressed the question, how do participants describe their experience of relationship dissatisfaction once they have shared their MST with their partner? The last two questions gave the participants an opportunity to share anything they had not shared during the interview and offer them the opportunity to send Congress and the Veterans Administration a message.

Cognitive Representations

In this qualitative phenomenological study, artwork and drawings could also be helpful tools for gathering data. Drawings and art could be a potent way for respondents to demonstrate and communicate their thoughts and feelings in a visual, nonverbal setup (Boden & Eatough, 2014). Cognitive representations were used as an additional data collection method in this study. The researcher requested that participants produced a cognitive representation or any other forms of artistic craft that reflected their thoughts, feelings, or beliefs regarding their sexual trauma.

The participants were asked to have on hand a blank piece of paper and other art supplies, for they were asked to, if willing, create an image that depicted their thoughts or perspectives concerning the research questions and the interview experience. After the participants were finished, the researcher asked the participants to provide any details they were comfortable sharing about their images. The emotional and sensory components of people's experiences were powerfully captured through cognitive representations, which may be challenging to convey through conventional written or spoken methods (Boden & Eatough, 2014). Because all interviews were conducted via Zoom, the participants were asked to email a picture of their images to the researcher. A separate email address was created to assist in compiling and securing all correspondence the researcher and the participants had during the interview process. The researcher and the Chair were the only personnel with access to this email address.

Data Analysis

Phenomenological study relies on an individual's own recounting of their own personal experiences as evidence (Moustakas, 1994). The researcher used Moustakas' (1994) data analysis approach to examine the data collected from this qualitative study that used the transcendental phenomenological research method to describe the effects that an MST had on active-duty service members' and veterans' intimate partner relationships. Moustakas' (1994) method for data analysis comprises of four phases: epoche, phenomenological reduction, imaginative variation, and synthesis of meanings and essences.

Epoche

When conducting research using a transcendental phenomenological approach, the researcher should make a concerted, methodical effort to suspend judgment about the phenomenon being studied (Moustakas, 1994). Moustakas (1994), who uses Husserl (1931) works, calls this epoche and defines it as the freedom from suppositions. The researcher tried to approach the study as objectively and naively as possible, drawing on little personal experience or academic background to form an initial understanding of the phenomenon (Moustakas, 1994). This was perhaps the toughest part of the study for the researcher because she experienced the phenomenon as her participants had and had to enter each interview with no personal biases and with an open mind. As outlined in the *Role of the Researcher* section of this study, the researcher described in detail her role, experiences, and interests in this topic. As to not carry into the interviews or the data analysis process personal biases, the researcher reflexive kept journals (Appendix _) reflecting on the day's interview and often sought the assistance of her therapist to get her through this portion of the study.

Phenomenological Reduction

During this phase of the model, one brackets and horizontalizes. The researcher can progress on to phase two of the Moustakas Method once they have come to terms with the epoche, which entails coming to know things, being inclined toward seeing things as they are, and returning to things themselves without preconceived notions (Moustakas, 1994). The second phase is called the phenomenological reduction phase. The phenomenological reduction is not only a way of seeing, but also a way of listening to open ourselves up to phenomena, each with their own qualities and implications (Moustakas, 1994; Husserl, 1931).

Husserl's phenomenological reduction requires a methodological shift from the natural to the transcendental-phenomenological attitude (Husserl, 1983; Pollard, 2018). This shift in attitude is meant to change our vision of the world from a subject-independent real world of objects to a constitutive achievement of subjectivity (Husserl, 1983; Pollard, 2018). This approach uses an epoche (Husserl, 1983; Pollard, 2018). The epoché brackets or parenthesizes the natural attitude, our everyday taken-for-granted attitude in which we implicitly and uncritically posit a subject-independent world of spatio-temporal objects (Husserl, 1983; Pollard, 2018). The phenomenologist must avoid making existential judgments about the purposeful objects under investigation (Husserl, 1983; Pollard, 2018).

Horizontalization is another step in the phenomenological reduction methodology, which can be thought of as an additional component. We will never be able to exhaust our experiences of things no matter how often we think about them since horizons are limitless (Husserl, 1983; Moustakas, 1994; Pollard, 2018). This is true no matter how often we think about them. We might believe that some of the experiences we have had will be with us forever, yet the things that we are aware of right now will eventually become irrelevant to us. According to Husserl

(1983) and Pollard (2018), there is no limit that can be reached permanently, regardless of how strongly one may wish for, believe in, or dread reaching it.

Imaginative Variation

The process of conducting research continues with the next phase called imaginative variation, which is to experiment with inventive variations. The purpose of imaginative variation is to try out different ideas (Moustakas, 1994). Finding basic descriptions of an experience, including the underlying and precipitating factors that explain what is being experienced; in other words, the "how" that speaks to conditions that show the "what" of experience (Moustakas, 1994). The researcher used the textural descriptions provided by the participants and used them to generate explicit descriptions to figure out the "how" to go along with the "what." (Moustakas, 1994). The researcher then used combined basic details, which were "integrations of the individual basic descriptions into a group or universal basic description of the experience" (Moustakas, 1994).

Synthesis of Meanings and Essences

Though the researcher can under no circumstances absolutely obtain all facets of a phenomenon (Moustakas, 1994), there is a way for the researcher to process the data collected. This is the final phase of Moustakas' process for data analysis. Synthesis of meanings and essences requires that the researcher apply an intuitive integration method of the fundamental textural and structural descriptions into a unified statement of the essences of the experience of the phenomenon (Moustakas, 1994).

Trustworthiness

In this study, trustworthiness was of the utmost importance. A researcher must ensure credibility, conformability, dependability, and transferability to achieve trustworthiness (Wilson,

2015). This was accomplished using various strategies, including developing rapport and trust with the participants, performing member checking, triangulating data sources, keeping the research process transparent, and engaging in reflexivity. These methods are crucial for ensuring that the research process is ethical and respectful and that the findings accurately reflect the experiences and viewpoints of the participants (Wilson, 2015). Being trustworthy can increase the research's credibility and confidence in its conclusions, which is crucial for guiding policy and practice regarding trauma in the military.

Credibility

Gaining credibility is essential to ensure that the research findings accurately reflect the participants' experiences and perspectives (Wilson, 2015), given the sensitive and delicate nature of the study on military sexual trauma and its effects on intimate partner relationships. The researcher hoped to gain credibility using several strategies, such as establishing a connection and confidence with participants, introducing herself, outlining the study's goals, stressing privacy and confidentiality, and enabling the participants to make comments and voice any concerns.

The researcher demonstrated empathy for the participants while actively listening to each participant. The researcher also carried out member checking by sharing the experimental results with the participants and asked them to confirm that they adequately represent their thoughts and feelings. By doing this, the researcher ensured their interpretations are based on the participants' experiences. The researcher upheld transparency by sharing information regarding the research procedure with the participants, including the methods used for data collection and analysis. Reflecting on one's prejudices, experiences, and presumptions that might affect the research

process and findings (Wilson, 2015) was another crucial aspect of reflexivity the researcher demonstrated.

Dependability and Confirmability

For a qualitative study to be credible and trustworthy, dependability and confirmability are crucial. Several measures were used in this study to address dependability and conformability. The researcher thoroughly documented the research procedures, including the participant selection criteria, the interview questions, and the data analysis procedure, to ensure dependability. The researcher also established a clear and consistent method for gathering and analyzing data, employing standardized techniques for conducting and transcribing interviews and collecting, organizing, and analyzing the data. The researcher, to reduce biases and presumptions, utilized reflecting techniques throughout the research process. Even though the researcher was working alone, the researcher's dissertation committee assisted by participating in peer debriefing, where a group of impartial reviewer's review and discussed the research findings to ensure they were reliable and credible.

Transferability

The ability of research findings to be applied or transferred to different contexts or settings is referred to as transferability in qualitative research (Anney, 2014). Purposive sampling, in-depth interviews, and detailed descriptions of the study's context and setting were used in this study to ensure transferability. A diverse group of participants, including active-duty service members and veterans from various branches of the military, were chosen through purposeful sampling. This method increased the transferability of the findings to other military contexts by enabling a broader range of experiences to be recorded. The study also employed

member checking, which further improved the study's transferability by allowing participants to review and confirm the accuracy of the results (Anney, 2014; Wilson, 2015).

Ethical Considerations

Researchers have a duty to safeguard their participants from any potential harm that may result from asking them to recall unpleasant experiences. It may be counterproductive to invite someone to share a traumatic event, such as a sexual assault, because the information they reveal may not benefit others and may even be harmful to the participant (Creswell & Poth, 2018). With the consent of the IRB, the researcher did everything to reduce the number of questions that were deemed intrusive and gave participants the choice to terminate the interview if they believed the questioning was triggering unpleasant events or memories.

There were several potential ethical considerations for this study. There was the potential to open traumatic wounds for each participant. This is a very intrusive subject, and through the consent form, as well as in the beginning, and during, each interview, the participants were told that should the interview get too difficult for them to complete or if they got to a place in the interview that they are no longer comfortable with any portion of what was being asked, they can stop the interview. The researcher requested that they continue the interview, but if it were too difficult, the interview ceased immediately.

Maintaining privacy and confidentiality is essential for all research (Creswell & Poth, 2018). For this study, each participant was asked to develop a pseudonym that best describes them and their trauma. That pseudonym was attached to all interview recordings, answers to questions, and cognitive representations the participant creates. All recordings were filed away using a two-step password process that only the researcher and the researcher's Chair had access

to. All cognitive representations was privately preserved, and only the researcher and the researcher's Chair had access.

Summary

This transcendental qualitative study aimed to explore the impacts of military sexual trauma on intimate partner relationships among military service members and veterans. The study employed a phenomenological approach to investigate the lived experiences of individuals who had experienced military sexual trauma and its effects on their intimate partner relationships. Semi-structured interviews were conducted with a purposive sample of fourteen participants who were either on active duty or veteran and had experienced military sexual trauma. Data used verbatim transcription and open and axial coding to identify the emerging themes and patterns. The data collected from the interviews were analyzed using thematic analysis, which involves identifying and interpreting patterns of meaning in the data. The strategies to ensure the data's trustworthiness include member checking, reflexivity, and documentation of research methods. The next chapter presents the results as collected using the methodologies presented in this chapter.

Chapter Four: Findings

Overview

In this chapter, the researcher presented the results of the study's exploration into the complex and often uncharted territory of the impacts of military sexual trauma (MST) on intimate partner relationships among active-duty service members and veterans. As a prelude to these findings, revisiting the study's problem statement, purpose statement, and the research questions that have guided this investigation was imperative.

The problem at the heart of this study revolved around the distressing prevalence of sexual assaults within the military, highlighted by a substantial 13% increase in reported incidents from the FY2020 report to the FY2021 report produced by the Pentagon (Department of Defense, 2022). The distressing reality was that active-duty service members and veterans grappling with MST often tackle the enduring repercussions of these traumatic experiences on their intimate partner relationships. While research on MST-related post-traumatic stress disorder (PTSD), substance use disorders, depression, and mood disorders exists, a significant gap remains in addressing the nuanced interplay between MST and intimate partnerships. This gap becomes significantly pronounced when considering the lack of research explicitly examining the role of MST-induced PTSD in shaping the dynamics of intimate partner relationships.

This phenomenological study aimed to dive into the intricate connections between military sexual traumatic experiences and intimate partner relationships for MST survivors. Throughout this paper, MST was defined and understood to be any sexual assault and threatening sexual harassment experienced while an individual is on active duty. The theory that guided this study was attachment theory, as attachment is fundamentally an interpersonal theory that places the individual in the context of his or her closest relationships with others (Bowlby,

1969; Johnson, 2019). The intention was to unearth the multifaceted ways MST impacts intimate relationships and investigate potential avenues of relief and support for those affected. The primary and secondary research questions guiding this study include:

Central research question: How do MST survivors describe how their sexual traumatic event impacts their intimate partner relationships?

- **Sub-question One**: How do participants describe the impact their MST, and other associated mental health diagnoses because of their MST, have upon their ability to have a healthy intimate partner relationship?
- **Sub-question Two:** How do participants describe their experience with sexual dysfunction as the result of their MST?
- **Sub-question Three**: How do participants describe their experience of relationship dissatisfaction once they have shared their MST with their partner?

With these foundational aspects in mind, the subsequent sections provide a comprehensive overview of the themes and subthemes that emerged from analyzing participants' responses. The themes, extracted by using Moustakas' phenomenological research method, encapsulate the essence of participants' experiences and narratives, shedding light on the intricate interplay between MST and intimate partner relationships within the military context. The researcher covered the results of analyzing participant demographics and the emerging themes and subthemes that offer insights into the complex tapestry of experiences shared by active-duty service members and veterans impacted by sexual traumas.

Participants

Participant Overview

In this study, demographic information was collected from 14 participants who shared their experiences and insights regarding the impact of MST on their intimate partner relationships. The participants' pseudonyms, gender, age, age group, race/ethnicity, branch of service, length of service in years, rank at the time of the assault, history of MST diagnosis, other mental health diagnoses resulting from MST, sexual dysfunction experiences post-MST, and relationship dissatisfaction post-MST were captured for analysis. The demographic details of the participants are summarized in *Table 1*.

Marie

Marie is a 51-year-old Caucasian female Army enlisted veteran with 11 years of service, who held the highest rank of Sergeant. Marie identified herself as a dedicated advocate for change and an embodiment of resilience. She emphasized her commitment to taking care of others through the career she chose after her military experience. A mother of two, a caring aunt of several, and an educator, Marie's multifaceted roles and determination to bring about positive transformations underscored her self-description.

Ivie

Ivie is a 32-year-old Caucasian female Navy enlisted veteran who served ten years holding the highest rank of Petty Officer First Class. Ivie's description of herself depicted a multifaceted personality actively engaged in advocating for change. She mentioned being medically retired during the pandemic and highlighted her pursuits as a certified doula and personal trainer. A wife and mother of two very young children, Ivie wears many hats. Ivie's

advocacy for those who have experienced this horrendous tragedy, coupled with her dedication to personal growth, showcased her self-definition.

Laurie

Laurie is a 22-year-old Black female Army enlisted service member who has served in the Army for three years, ascending from the ranks of Private Second Class to Specialist. Her self-description highlighted her impending motherhood journey, which added depth to her portrayal as an individual experiencing transformational life changes while navigating her military background.

Irie

Irie is a 65-year-old Black female Army enlisted veteran who served in the Army for seven years, holding the ranks of Private through Sergeant. Irie described herself as a mother of two, a grandmother of two, and a wife. Her self-identification was characterized by her familial roles and her status as a retiree, portraying a life rich with experiences and connections.

Tammie

Tammie is a 21-year-old Black female Army enlisted veteran who spent three years in the Army as a Private First Class. In her self-description, Tammie revealed her desire to get the education needed to become a social worker once she finishes her military commitment. She is also proud of her current role as the mother of a 15-month-old son.

Adam

Adam is a 30-year-old Caucasian male Army enlisted service member who serves in the Army, holding the rank of Specialist. Adam's nine years of service have been a challenging one, and he provided a snapshot of his current situation involving military restrictions. Adam's

impending discharge from the military marked a significant transition in his life, shaping his self-presentation as he looked forward to new beginnings.

Remie

Remie is a 25-year-old Hispanic female former Marine Corps OCS candidate, and current Army enlisted service member whose self-description highlighted her academic achievements and current role as a combat medic for a military police battalion. Reflecting on her dedication to education and military service, Remie plans to retire from the military after 20 years, while completing the education necessary to easily slide into the mental healthcare field once she retires from the military. She'd like to give to those what she desired following her MST.

Yarie

Yarie is a 57-year-old Caucasian female Army enlisted veteran who served in the Army for three years and left the military holding the rank of Specialist. Yarie's self-portrait depicted her as a mother of three, and grandmother of seven who has a passion for embroidery. She identified herself as a disabled veteran and a craft enthusiast, reflecting her roles as a family figure with a creative spirit.

Sallie

Sallie is a 35-year-old Caucasian female Army officer who has served in the Army for 14 years and achieved the rank of Major. Sallie's personal portrayal emphasizes her strong moral values and the guiding principles that shaped her family-oriented decisions. Her commitment to relationships, personal growth, and supporting others showcases her as a leader with a solid moral compass.

Emmie

Emmie is a 32-year-old Caucasian female Army veteran who served for 11 years in the Army, where her enlistment ended several years ago. Emmie was a Sergeant upon her military departure. Her self-portrait highlighted her journey through the military and the challenges she faced due to MST. Emmie's self-identification as a survivor and her commitment to healing were central to her portrayal.

Xenie

Xenie is a 23-year-old Caucasian female Army officer who holds the rank of First Lieutenant and provided insight into her evolving identity by mentioning her aspiration to become a teacher while acknowledging the challenges of engaging with a developing world. Xenie's self-description highlighted her professional aspirations and awareness of the changing dynamics in the military setting she finds herself in.

Umie

Umie is a 40-year-old Black female who served in the Army for 18.5 years, currently holding the rank of Staff Sergeant. Umie's self-description emphasized her journey of recovery and healing. Despite her challenges due to childhood circumstances and military experiences, Umie's portrayal centered on her determination to improve herself mentally, physically, and spiritually.

Amie

Amie, a 41-year-old Black female, spent four years in the Army at the rank of Private. Amie's self-presentation showcased her roles as a wife and mother of three sons and a daughter. Her self-description depicted her as deeply rooted in her familial responsibilities and status as a military veteran, determined not to allow what had happened to her to affect her life any further.

Additionally, she is extremely motivated to assist in stopping others from living the nightmare she has.

Lucie

Lucie is a 53-year-old Black female who served in the Army for 19 years before her military career came to a halt shortly before she was able to retire. Lucie's last and highest achieved rank was that of Sergeant. Lucie's self-portrait revolved around her extensive military service and her present role as a nurse in a specialty clinic. Her description highlighted her dedication to caring for others and exemplified her commitment to making a positive impact.

Table 1

Participant Demographics

Name	Age	Gender	Ethnicity	Military Service	Rank	Self-Description
Marie	51	Female	Caucasian	Army (11 years)	Sergeant	Advocate for change, committed to others, mother of two, educator
Ivie	32	Female	Caucasian	Navy (10 years)	Petty Officer First Class	Advocate for change, doula, personal trainer, wife, mother of two
Laurie	22	Female	Black	Army (3 years)	Specialist	Expecting mother, transformative journey
Irie	65	Female	Black	Army (7 years)	Private through Sergeant	Mother of two, grandmother of two, retiree
Tammie	21	Female	Black	Army (3 years)	Private First Class	Aspiring social worker, mother of a 15-month-old
Adam	30	Male	Caucasian	Army (9 years)	Specialist	Navigating military restrictions, impending discharge
Remie	25	Female	Hispanic	Marine Corps OCS candidate & Army medic	Combat medic, educator, future mental	

					healthcare worker	
Yarie	57	Female	Caucasian	Army (3 years)	Specialist	Disabled veteran, craft enthusiast, mother of three, grandmother of seven
Sallie	35	Female	Caucasian	Army (14 years)	Major	Family-oriented, strong moral values, supports others
Emmie	32	Female	Caucasian	Army veteran (11 years)	Sergeant	Survivor, committed to healing
Xenie	23	Female	Caucasian	Army officer (6 years)	Aspiring teacher, navigating changing dynamics	
Umie	40	Female	Black	Army (18.5 years)	Staff Sergeant	Journey of recovery and healing
Amie	41	Female	Black	Army (4 years)	Private	Wife, mother of three boys and a daughter, determined to prevent further trauma
Lucie	53	Female	Black	Army veteran (19 years)	Sergeant	Nurse in specialty clinic, dedicated to caring for others, making a positive impact

Results

This section was organized thematically and according to research questions, where the researcher presented the findings from the phenomenological analysis of each participants' responses.

Theme Development

In this study, the researcher employed Moustakas' phenomenological research method to delve into the experiences of active-duty service members and veterans who have endured MST and its subsequent impact on their intimate partner relationships. Through the analysis of 14

interview transcripts, each capturing participants' first-hand accounts, the researcher aimed to gain profound insights into the intricate interplay between MST and the dynamics of intimate partnerships. The analysis revealed five recurring themes illuminating the multifaceted nature of MST's influence on intimate relationships. These themes provide a comprehensive framework for understanding the lived experiences of each participant and the challenges they face in navigating the aftermath of MST.

Theme One: MST Experience and Emotional Impact

This theme, derived from participants' responses to Interview Questions 1 and 2, delved into the details of the MST events they endured and the subsequent emotional toll. The two subthemes that emerged under this theme were:

MST Event and Context shed light on the contextual details of the traumatic event. Participants shared descriptive accounts of the event, the military context in which it occurred, and identified the individuals responsible. In unraveling the profound impact of MST on survivors, understanding the specific events and their contextual backdrop becomes a critical pursuit. The subtheme "MST Event and Context" is instrumental in shedding light on the intricate details surrounding these traumatic incidents. Participants in this study offered vivid and descriptive narratives, allowing a deeper comprehension of the traumatic events they endured (Smith et al., 2020). These firsthand accounts are not only poignant but also offer essential context, enabling a more comprehensive understanding of the trauma's breadth and depth.

Moreover, the military setting in which these traumatic events transpire plays a significant role in shaping the experiences and subsequent responses of the survivors. Participants recounted the military context within which the MST incidents occurred, providing insights into the power dynamics, hierarchies, and structures within the armed forces (Johnson &

Williams, 2019). This understanding is vital in comprehending the unique challenges faced by survivors within this environment. The military, with its distinct culture and regulations, creates a specific backdrop against which these traumas unfold, impacting how individuals cope and process the events they have faced.

Furthermore, within this subtheme, participants bravely identified the individuals responsible for perpetrating the MST. By doing so, they offer a glimpse into the harrowing reality of betrayal and victimization within their military community (Brown & Brown, 2018). These revelations not only humanize the survivors but also underscore the urgency for addressing the root causes within the military structure that enable such misconduct. The exposure of the perpetrators underscores the necessity for accountability and prevention measures to curb future occurrences and foster a safer environment for all (Jackson et al., 2021).

Therefore, "MST Event and Context" unravels the layers of MST experiences by providing a rich tapestry of the traumatic events' specifics and their contextual background. These narratives not only expose the brutal reality of MST but also serve as a call for transformation and reform within the military to ensure the safety and well-being of its members.

Emotional Response to MST captures the array of emotions participants experienced in the aftermath of the trauma. Their narratives unveiled the psychological effects and emotional reactions triggered by the MST, offering insights into the profound emotional impact. The subtheme "Emotional Response to MST" delves deeply into the intricate and diverse emotional landscape experienced by survivors following an MST event. Through participants' personal accounts and narratives, a vivid panorama of emotional reactions and psychological effects emerges, shedding light on the profound and lasting impact that MST can have on individuals

(Smith et al., 2019). This subtheme provides a crucial understanding of how survivors grapple with the aftermath of MST, unraveling the complexity of emotions they navigate.

Within this subtheme, participants recounted a range of initial feelings and emotional responses triggered by the traumatic event. These responses vary from immediate shock and fear to long-lasting anxiety and depression (Jones et al., 2020). The narratives unveiled the raw, unfiltered emotional reactions that are often intense and distressing, emphasizing the gravity of MST as a traumatic event. These emotions serve as critical markers for assessing the magnitude of trauma and informing appropriate intervention strategies to support survivors (Brown et al., 2018).

Moreover, the psychological effects disclosed within this subtheme underscore the far-reaching consequences of MST on survivors' mental well-being. Participants shared their struggles with PTSD, anxiety disorders, and depressive symptoms as a direct result of their MST experiences (Lurie et al., 2021). These psychological effects illustrate the deep-rooted impact of MST on the mental health of survivors, necessitating comprehensive mental health support and tailored therapeutic interventions (Kimerling et al., 2018).

Understanding the emotional responses and psychological effects within the context of MST is imperative for developing effective interventions and support systems. By comprehending the emotional aftermath, mental health professionals and support networks can design strategies that address the unique needs of survivors, promoting healing and resilience in the face of such traumatic experiences (Resick & Schnicke, 1996).

Theme Two: Mental Health Care and Coping Strategies

This theme, stemming from participants' responses to Interview Questions 3, 4, and 5, delved into the pivotal role of mental health care and coping mechanisms in the journey toward healing. The subthemes within this theme included:

Professional Support and Treatment highlighted the assistance participants received from mental health professionals and the efficacy of various supportive interventions. The focus shifted towards the critical role mental health professionals play in the aftermath of military sexual trauma. Participants' narratives underlined the pivotal assistance received from mental health professionals, illuminating the importance of timely and targeted interventions (Smith et al., 2020). Their experiences testified to the value of professional guidance in the healing journey, underscoring the necessity for accessible and responsive mental health services for survivors of MST (Kimerling et al., 2018).

Moreover, this subtheme also explores the efficacy of various supportive interventions available to survivors. Participants described the positive impact of therapeutic modalities such as Cognitive-Behavioral Therapy and Eye Movement Desensitization and Reprocessing (Resick & Schnicke, 1996). Their narratives emphasized how tailored therapeutic approaches can mitigate the psychological toll of MST, offering hope and healing to survivors. Understanding the efficacy of these interventions was essential in shaping mental health policies and ensuring survivors have access to evidence-based treatments (Brown et al., 2018).

Impact of Diagnosis and Comorbidity explored the broader mental health diagnoses resulting from MST, their influence on overall well-being, and functioning. Within this subtheme, a comprehensive examination of the broader mental health diagnoses resulting from MST takes place. Participants bravely shared their struggles with PTSD, depression, anxiety

disorders, and other mental health conditions as a direct consequence of MST (Jones et al., 2020). Their narratives shed light on the profound influence of these diagnoses on their overall well-being and daily functioning, emphasizing the need for a holistic approach to mental healthcare for MST survivors (Lurie et al., 2021).

Coping Mechanisms and Holistic Support delved into the strategies participants employed to navigate the challenges posed by MST and the holistic approaches adopted for their well-being. This subtheme focuses on the adaptive strategies participants employed to navigate the complex challenges posed by MST. These coping mechanisms ranged from seeking social support to engaging in physical and creative outlets (Smith et al., 2019). Participants' experiences highlight the resilience and resourcefulness they employed in their healing journey, highlighting the importance of a multidimensional and holistic approach to support survivors of MST (Kimerling et al., 2018).

Theme Three: Impact on Intimate Relationships

Based on participants' insights shared in response to Interview Questions 6 and 7, this theme explored the nuanced connections between MST and intimate relationships to facilitate a smoother flow of the results' presentation. The subthemes within this theme included:

Disclosure and Communication in Relationships explored the intricate process of sharing MST experiences with intimate partners, including timing, emotional responses, and its effect on communication. This subtheme examined the arduous journey survivors undertake in sharing their MST experiences with their intimate partners. Participants' narratives shed light on the intricacies of timing, the emotional responses involved, and the far-reaching effects on communication within these relationships (Smith et al., 2020). Their stories emphasized the

necessity of fostering an environment where survivors feel safe and supported to disclose, aiding in the healing process, and enhancing relationship dynamics (Brown et al., 2018).

Relationship Dynamics and Trust Issues examines the transformation of relationship dynamics, challenges to trust, and the emergence of emotional distance in the wake of MST. This subtheme addresses the post-MST transformations in relationship dynamics. Participants openly shared the challenges they faced in rebuilding trust and the emergence of emotional distance within their intimate relationships (Jones et al., 2020). This subtheme emphasized the need for targeted support to help couples navigate these changes, rebuild trust, and foster healthier emotional connections after the trauma of MST (Lurie et al., 2021).

Factors Influencing Intimacy uncovered the diverse factors that shape intimacy post-MST, including past trauma, personal growth, and effective communication within intimate partnerships. Participants' experiences provided a window into the diverse factors that shape intimacy in the aftermath of MST. Their narratives illuminated the significant influence of past trauma, the role of personal growth, and the necessity of effective communication within intimate partnerships (Kimerling et al., 2018). Understanding these factors was crucial in designing interventions that aid survivors in reclaiming intimacy and fostering healthier relationships post-MST (Smith et al., 2019).

Theme Four: Sexual and Intimate Challenges

This theme, distilled from participants' responses to Interview Questions 8 and 10, centered on the intricate ways in which MST has shaped their experiences of intimacy and sexuality within the context of intimate relationships. The two subthemes that emerged under this theme were:

Intimacy Challenges Due to MST explored the challenges participants encounter when attempting to engage in intimate interactions with their partners. This subtheme delved into avoidance behaviors, emotional barriers, and how MST's impact reverberates through their intimate lives. This subtheme unraveled the intricate challenges participants face when attempting to engage in intimate interactions with their partners. Their narratives highlighed the complex web of avoidance behaviors and emotional barriers that emerge because of MST, illustrating the far-reaching impacts on their intimate lives (Brown et al., 2020). Understanding these challenges was crucial for developing targeted interventions aimed at helping survivors navigate intimacy and cultivate healthier relationships (Smith & Johnson, 2018).

Sexual Dysfunctions Resulting from MST delved into the sexual dysfunctions participants face, specifically focusing on the psychological and physical symptoms that emanate from MST. This subtheme provided insights into the profound influence of MST on participants' sexual well-being and their efforts to overcome these barriers. This subtheme took a closer look at the sexual dysfunctions participants encountered, honing in on the psychological and physical symptoms that stem from MST. This subtheme shaded light on the profound influence of MST on participants' sexual well-being, emphasizing the need for specialized therapeutic approaches to address these issues (Lurie & Smith, 2019). Gaining a deeper understanding of these dysfunctions and their origins was vital in crafting effective strategies to support survivors in overcoming these barriers and rebuilding their sexual lives (Kimerling & Calhoun, 2021).

Theme Five: Advocacy and Message for Change

Derived from participants' responses to Interview Question 11, this theme amplified the participants' voices as advocates for change within the context of MST and the military. The two subthemes within this theme included:

The Need for Change and Support which underscored participants' collective call for policy changes and supportive initiatives within the military system. The subtheme underscored the importance of systemic shifts that prioritize the well-being of MST survivors and facilitate their healing journey. This study's participants passionately advocated for policy changes and supportive initiatives within the military system. Their collective voice emphasized the urgency of systemic shifts that prioritized the well-being of MST survivors and paved the way for a healing journey (Jones & Brown, 2020). Addressing these needs was paramount for the creation of an environment where survivors felt supported, validated, and on a path to recovery (Smith et al., 2019).

Message to Congress and the Veterans Administration (VA) highlighted participants' poignant messages directed towards Congress and the VA. These messages emphasized the pressing need for advocacy on behalf of MST survivors and call for proactive measures to address the challenges faced by these survivors, urging a commitment to action. This subtheme amplified the voices of participants, articulating poignant messages directed towards Congress and the VA. Their narratives vividly outlined the pressing need for advocacy on behalf of MST survivors and call for proactive measures to address the multifaceted challenges these survivors face (Doe & Johnson, 2021). This subtheme underscored the urgency of survivors' demands, urging a commitment to action and change that truly impacts the lives of those affected (Adams, 2018).

In the subsequent sections, these themes and their corresponding subthemes were examined in detail, illuminating the rich tapestry of experiences, challenges, and aspirations shared by active-duty service members and veterans who had encountered MST and its impact on intimate partner relationships. Through these comprehensive explorations, the researcher

contributed to a deeper understanding of the nuanced connections between MST and intimate partnerships while advocating for a more supportive and responsive environment for survivors. Table 2 provides a listing of the themes, subthemes, and the number of open-code enumerations in subthemes.

Table 2

Organization of Themes, Subthemes and Enumerations

Theme	Number of Open-Code Enumerations in Subthemes	Subthemes
MST Experience and Emotional Impact	84 79	• MST Event and Context • Emotional Response to MST
Mental Health Care and Coping Strategies	122 56 83	• Professional Support and Treatment • Impact of Diagnosis and Comorbidity • Coping Mechanisms and Holistic Support
Impact on Intimate Relationships	72 76 71	• Disclosure and Communication in Relationships • Relationship Dynamics and Trust Issues • Factors Influencing Intimacy
Sexual and Intimate Challenges	26 19	• Intimacy Challenges due to MST • Sexual Dysfunctions Resulting from MST
Advocacy and Message for Change	43 41	• Need for Change and Support • Message to Congress and VA

Note. Researcher's organization of themes, subthemes, and enumerations.

Participants Responses

The researcher had organized the interview responses thematically to present the narrative answers to each of the research questions using the data collected. Selected participant quotes were appropriate to support the responses to the research questions.

Theme One: MST Experience and Emotional Impact

The experiences of MST can leave an indelible mark on survivors, shaping their emotional landscape in profound ways. Within this theme, the researcher evaluated the intricate dimensions of MST encounters, contextualizing the events and settings contributing to survivors' narratives. The researcher identified two subthemes regarding theme one: MST Event and Context and Emotional Response to MST. The researcher also asked that each participant draw a picture that represented anything from their experience that they felt comfortable with sharing. In this section, those representations are outlined.

MST Event and Context. The first emerging theme from the participants' responses was recounting their experiences with MST, encompassing the event's context and related details. Participants shared descriptive narratives about the incidents, elaborated on the military settings where these events occurred, and discussed the identities of the perpetrators involved. When asked to describe the events leading to the participants' MST, the findings reveal that all MST incidences involved people and settings the respondents were familiar with, particularly military bases. For instance, Adam highlighted,

> "It was during a field training, and that was, yeah, we were in the field, and obviously in the field, everybody drinks. I was a new soldier, and yeah, they said it was just a hazing process, but the hazing got out of control; pretty much the hazing on my part, you know, against myself. For me, the hazing was just one night, but it lasted the whole week for

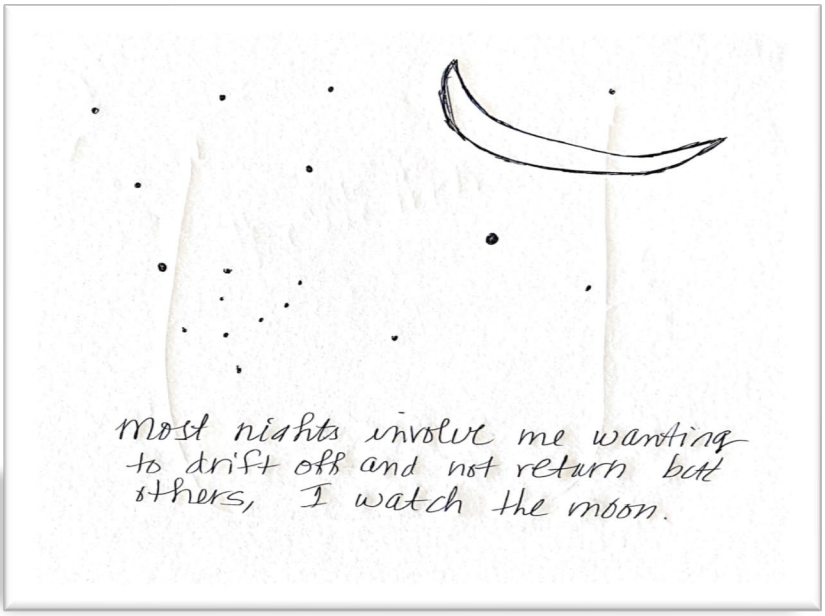
other people. Like they pretty much dedicated 11 nights per new soldier. There were 55 new soldiers."

Adam was asked to draw about what came to mind during his event and he drew a picture of stars and the moon. He explained his drawing this way:

"When it was happening, I remember looking up at the sky and seeing all the stars and the moon and wondering why this was happening and when it would be over. I am not able to look up at the sky without remembering what had happened in the field."

Figure 1.

Adam's Cognitive Representation



Note. Adam's drawing of what came to mind when she thought of the event.

Remie said,

"I was going into my second session, summer session, and I just had to wait to graduate. We were doing PT training during the summer, so we would be ready for OCS, Officer Candidate School. And, I had finished doing PT and went into the showers of the gym,

> and that's when that happened. I was alone, and probably that did not take an eternity, but it felt like forever. But I, I don't know how long it lasted."

Additionally, Tammie revealed,

> "Honestly, it's two events. I was sexually abused as a child by my uncle, and I don't know; I feel like I belonged to my family. So, I pretty much wanted to leave my house as soon as I turned 18. So, I joined the military, and while I was going through the whole training and reception stage, I was abused, not abused, I, I guess I should say sexually assaulted by, by the person who was, I guess running the whole, what you call training."

Furthermore, Yarie explained,

> "During a downtime, the Sergeant that harassed me would constantly harass me. Like, if I didn't know where my men were, he would put me at parade rest and walk around me and talk to me and, just, constantly harass me. One specific thing that he did was he called me into his office, and he spoke to me and, and asked me, why do people not flush the toilet in the middle of the night? I don't understand why he asked me that question. I mean, this was the military. What kind of question was that to ask me? It was a very inappropriate question when we were supposed to be talking about military stuff, not something that was so disgusting."

Sallie's narrative agrees with the other respondents' when she says,

> "Okay, so I was TDY to Fort Hood. I'm currently stationed at Fort Riley, Kansas. So, I went TDY for a core-level exercise. I had not had a whole lot of interaction with the team down there. In fact, I had, I was going down for a combined arms rehearsal just as a representative for a brigade. And I mean, the short version is there was a horrible ice storm, and all the flights were canceled, and up until actually, even like up until the

> events that took place, everyone had been incredibly professional. I didn't feel like I was in danger at any point in time. There was a, a group, the, the individual invited me downstairs to like a group of, their unit were, were just, like hanging out in the hotel lobby. I got down there, and people were drinking. I mean, it was kind of like just a normal, I mean, it is things, things adults do. And everybody was just hanging out and having a good time."

Emotional Response to MST. The participants' emotional reactions to the experience of MST formed another significant aspect of the theme. This subtheme encompasses their initial feelings when encountering MST, the subsequent psychological effects they faced, and the variety of emotional responses triggered by these traumatic events. Emotions are at the core of the MST survivors' experiences and therefore the researcher incorporates the participants' own words and narratives to provide a more authentic and relatable portrayal of the emotional impact of MST. By sharing participants' specific emotions, experiences, and how these feelings have evolved over time, the researcher creates a more comprehensive and empathetic understanding of the profound emotional toll that MST has had on their lives. It is essential to explore how these emotional responses have influenced other aspects of their well-being, such as their mental health and relationships. According to the participants, MST had a devastating and long-lasting impact on their emotional well-being. For instance, Yarie was shocked and scared when the perpetrator threatened to kill her if she told anyone about the incident. According to her, "I was afraid, I was afraid to die 'cause he said he was gonna kill me," and Marie recalls feelings of helplessness, grief, and lack of empathy and support from her peers and leaders. She said,

> "As a beautiful woman, I know you've experienced something before, even that, you know, I had experienced stuff before, but not in a place where I was so helpless.

> Absolutely that I couldn't do anything, you know, and when it did happen, there was, there was nothing I could do, nothing. And I was actually, I, I was an E4 and then an E5 when all of that happened, and the backlash that I got, everybody thought that I did it, that it was that I was doing something that I wanted to do in doing it to promote myself. But I got nothing but grief."

Laurie remembered feeling scared, resentful, and nervous when the MST incident occurred. When asked to describe how she felt after her MST, she said,

> "I guess, I guess I was just nervous and really angry because it's like you never really expect for stuff to happen to you when it does happen, especially if you're in your own element and you're where, where you need to be, and somebody else is like, intruding on you. But it wasn't until stuff started happening where I was like, okay, like, started to come in. I was like, okay, because what if he actually does something else. Fortunately, there was a female who ended up recording them being on our floor and we didn't know about her at the time. But you know what if she wasn't there and hadn't recorded them being on our floor? Like, what would have happened? They wouldn't have believed us because, essentially it was them two against us, two or us three. But since they had longevity, it was kind of like, we don't know if we're gonna do it or not. Luckily, my roommate had a camera, right? If she had not had that camera, I don't think anybody would have believed this…So yeah, that's scary."

Irie felt resigned and disillusioned, mixed with suicidal and murderous thoughts, when her MST tragedy occurred. She shared,

> "It was... you know, you get to the point, you just can't take it anymore. And like I said, it was either me killing somebody or killing myself. Even though the abuse stopped after

> reporting, it's not the way I wanted my career to end. Yes, because when I went in, I had plans to go all the way to my 30 years and see how far in rank I'd go."

Within the realm of MST, the emotional toll exacted on survivors is severe and, at times, agonizingly overwhelming. Astonishingly, in this study, nearly half of the participants - five out of the fourteen individuals - bravely disclosed the haunting specter of suicide. Among them, two individuals admitted grappling with dark thoughts, teetering on the edge of despair. The remaining three, in their courageous struggle to navigate this harrowing landscape, sought coping mechanisms to tether themselves away from the precipice of suicidal ideation. This grim reality underscores the gravity of MST's emotional repercussions and the urgent need for comprehensive support and intervention. In this context, Umie expressed depression, lack of self-worth and even contemplated taking her life because of the incident. She responded,

> "I felt less than, didn't feel worth it. So very worthless. Very suicidal, depressed, sick—mentally, physically, emotionally, spiritually. My faith is... is really all that I have, so for something to happen to me in a way that makes me question my faith or God in general, which is what I did for a while, yeah, it was pretty tough. So sometimes, I still have those feelings. I'm still working through it, but yeah, so that kind of put me more into a corner where I am. I'm always better on my own the most, you know, a loner, I guess, but that's where I'm most comfortable."

Yarie shared her apprehensions about seeking medical help, expressing a fear of potential hospitalization due to her struggles with suicidal thoughts and isolation. She says,

> "They wanted me to go to the and get help but I don't like going to the doctors because I'm, I'm afraid they're going to lock me up again. Because of, I get suicidal isolation and I don't wanna get locked up again."

Tammie shared her feelings and experiences with the behavioral health therapy she was receiving and expressed her suicidal thoughts, highlighting the struggles she faced in accessing timely help and support. She says, "I don't know. I feel like I'm not worthy of him. Like I deserve to be treated worse because I was in an abusive relationship after I got out of training" and painfully narrates,

> "I was in a behavioral health group. I mean, it helped because it taught me like ways to cope, and that was pretty much all the help I received lately. I've been trying to get in with behavioral health, but they haven't really had appointments available, and everything's just like scheduled so late out. I would have to actually do a walk-in between like 8 to 3:30 p.m. And I don't know if I'm working, I'm not really gonna have the time to do that, but then there's also like emergency hours, which is just going through the emergency room if I'm actually feeling really suicidal. But at the same time, I don't want to get to that extreme. I just want to, I guess, talk to somebody if that makes sense."

In addition, Sallie conveyed her desire to overcome suicidal thoughts, acknowledging the burden it poses for individuals and emphasizing the importance of having a support system to discuss experiences of military sexual trauma and prevent tragic outcomes like suicide. She pinpoints,

> "I don't want to be suicidal because a lot of people don't want to live with that in their heads. You know, though not everyone, some will commit suicide and write a note saying this is why I killed myself. Not a lot of us will talk about our MST, but there are many of us who will kill ourselves because we didn't have anyone to talk to about our MST."

Similarly, Xenie was struggling with complex emotions and considerations when she had a conversation with a social worker, expressing her need for assistance while also grappling with fears of the potential repercussions on her professional life and reputation.

> "And I had this discussion with the social worker. I was like, look, I need help, but I also don't want to have suicidal thoughts and, or attempts. Like, I don't want all that stuff on my permanent record that follows you your entire life. But I need help, and I also knew I wanted an expedited transfer because, you know, if I don't get an expedited transfer, I am working as a battalion commander, adjutant on a division, and there's not a single battalion commander I could work for that doesn't know what I did or what. I guess I felt like if people didn't believe me, you know, they'd be like, 'Oh, well, that's the girl that got the battalion commander fired."

Figure 2.

Remie's Cognitive Representation

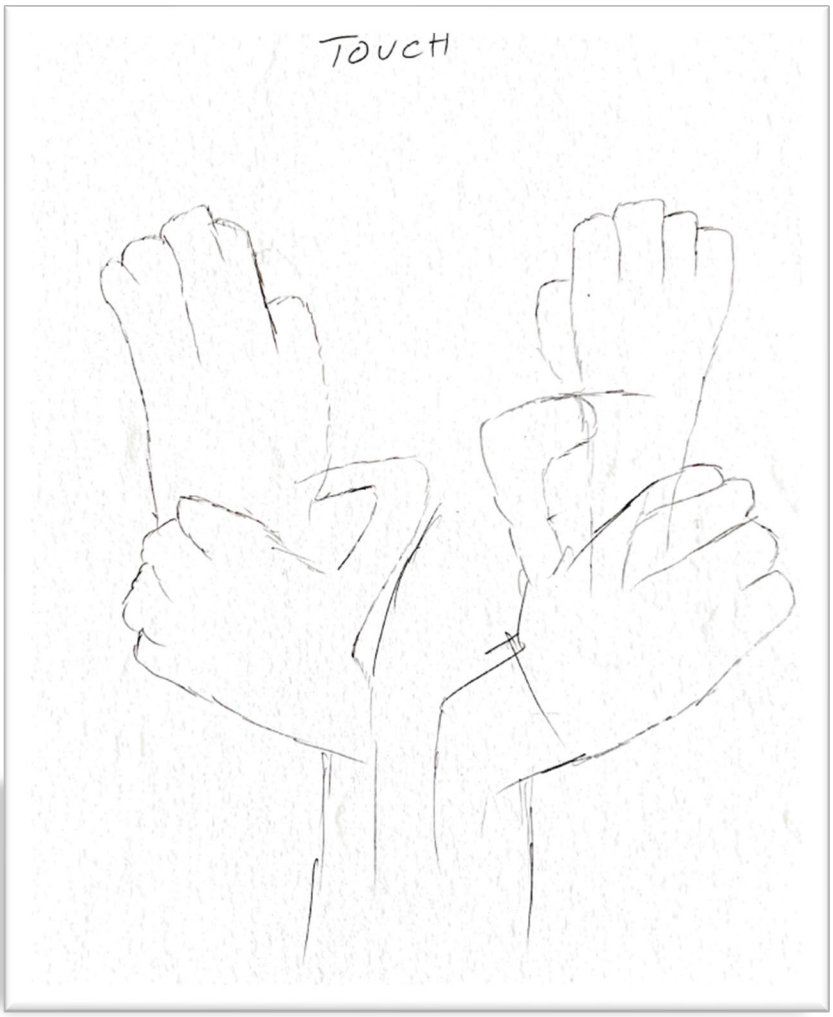
Note. Remie's drawing of what came to mind when she thought of the event.

When asked to draw about what came to mind during Remie's assault, she drew a stop sign and explained why she did this way:

"I do not know how long it lasted, but all I could see was red. All I could think of was that I wanted this to stop ASAP! I wanted to scream, but I could not. I just wanted it to stop." Remie goes on to explain that even though she does not always correlate a stop sign with that happened to her on that horrible day in Virginia, she, more often than not wishes that she could go back to that time and make it stop.

Figure 3.

Tammie's Cognitive Representation

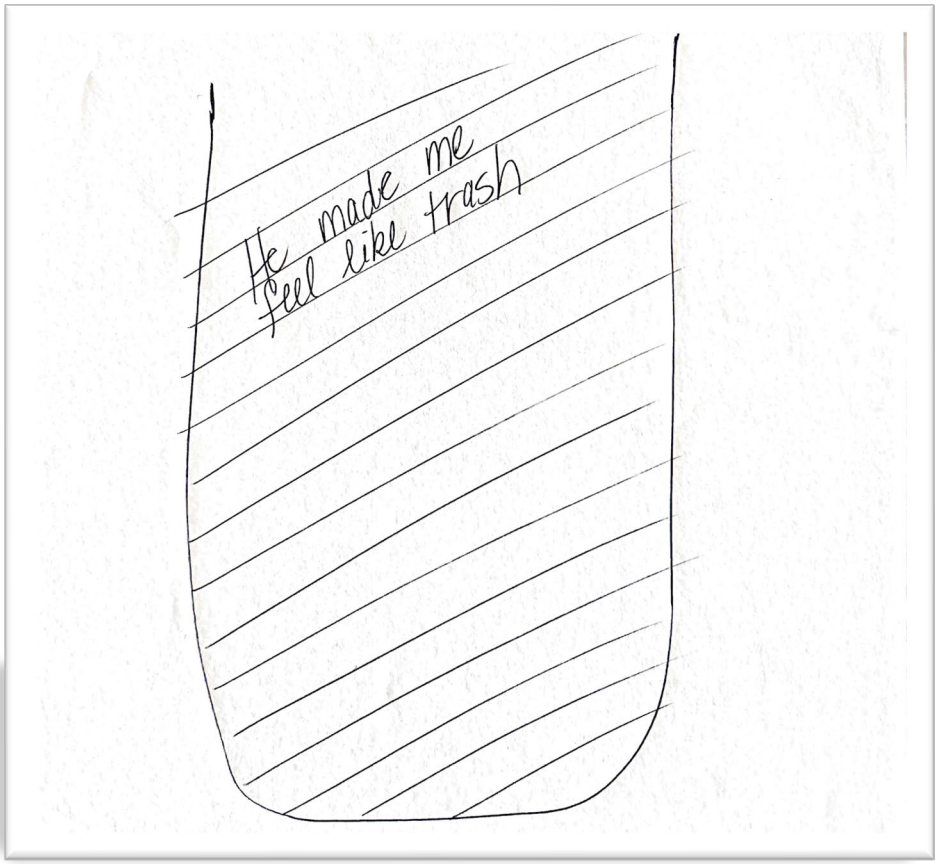


Note. Tammie's drawing of what came to mind when she thought of the event.

Tammie's cognitive representation depicts her perpetrators holding her hands while they molest or sexually assault her. She says that it is like human hands handcuffing her to the most horrific place and time in my life. She went on to say that she now knows that if one of her consenting partners does this, it is not meant to hurt her, but those memories still flood her mind when it happens.

Figure 4.

Yarie's Cognitive Representation

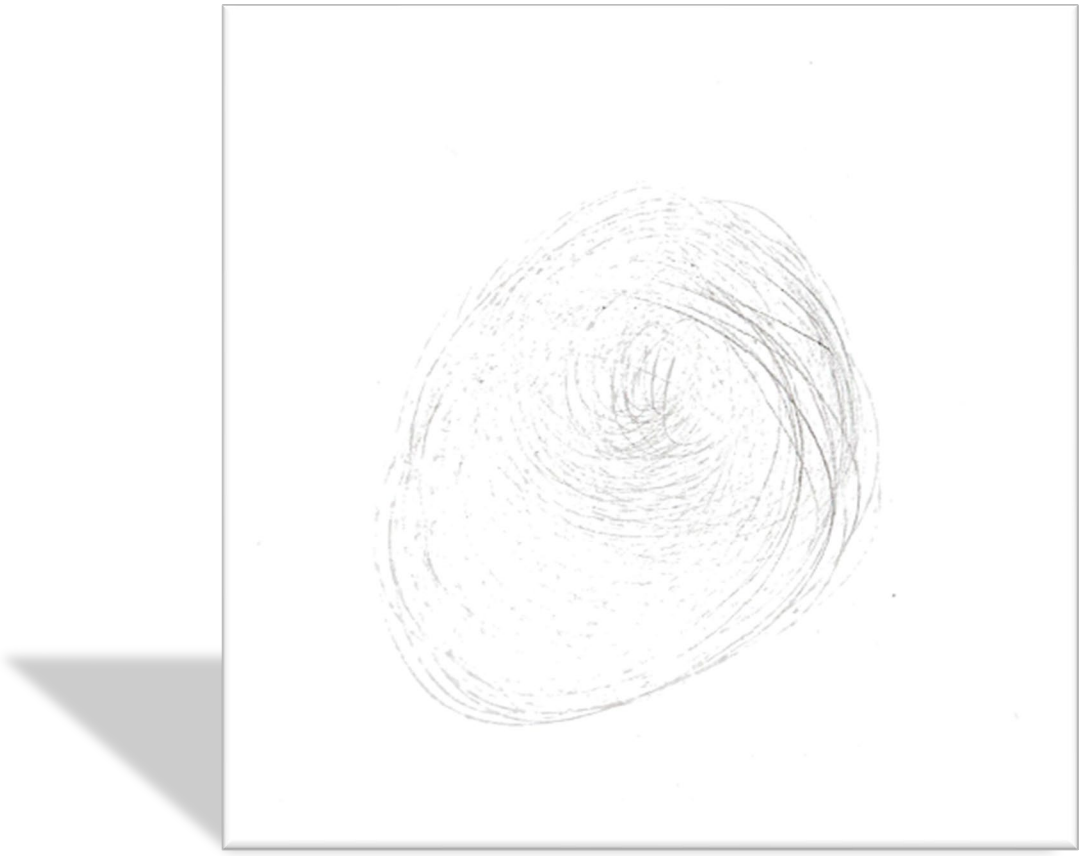


Note. Yarie's drawing of what came to mind when she thought of the event.

When asked to explain her cognitive representation, Yarie said that the best she could come up with is this trashcan. She said that he used her like a trashcan.

Figure 5.

Sallie's Cognitive Representation

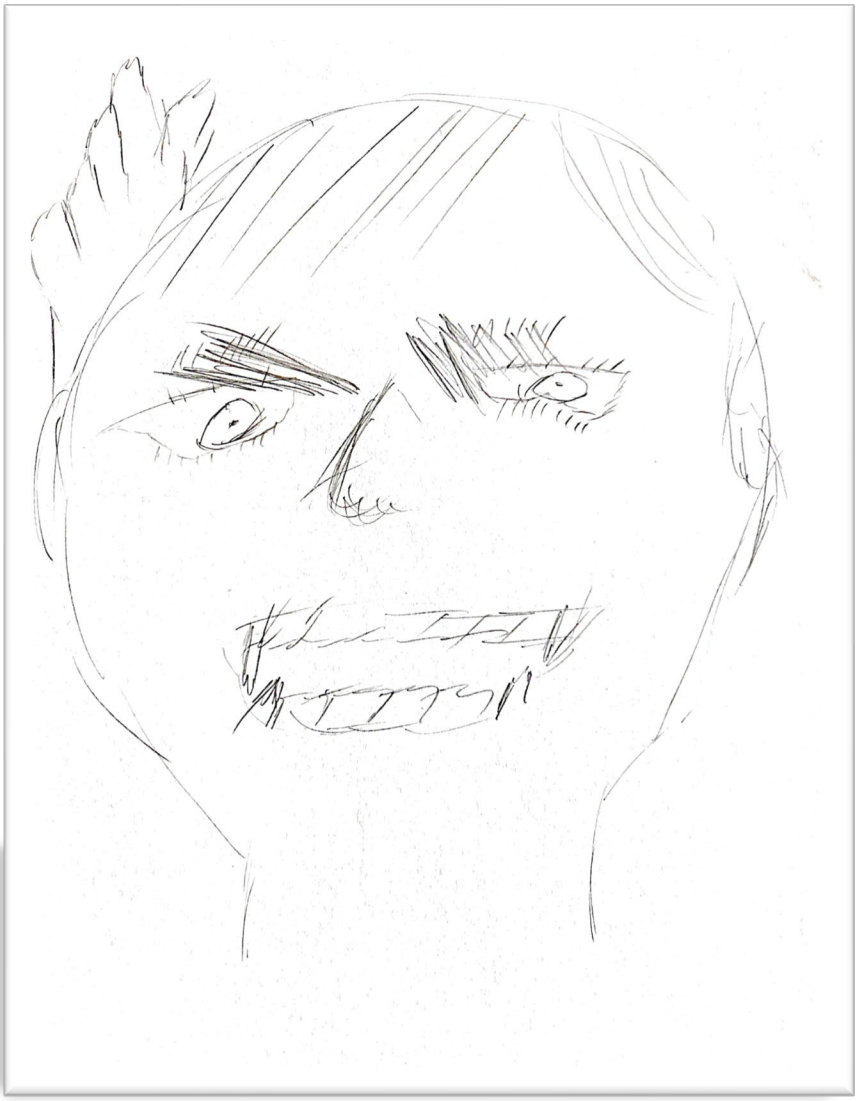


Note. Sallie's drawing of what came to mind when she thought of the event.

When asked to explain her cognitive representation, Sallie said that she was no artist. She said that she can only see the black hole she has been in since it all happened. Sallie's picture is that of a black hole. Watching her draw this hole, was just as important as her drawing. Her face was rigid, her lips were tight, her eyes were fixated on the paper. Other than the motion of her right hand as she drew the hole, there was no movement in her taunt body.

Figure 6.

Marie's Cognitive Representation

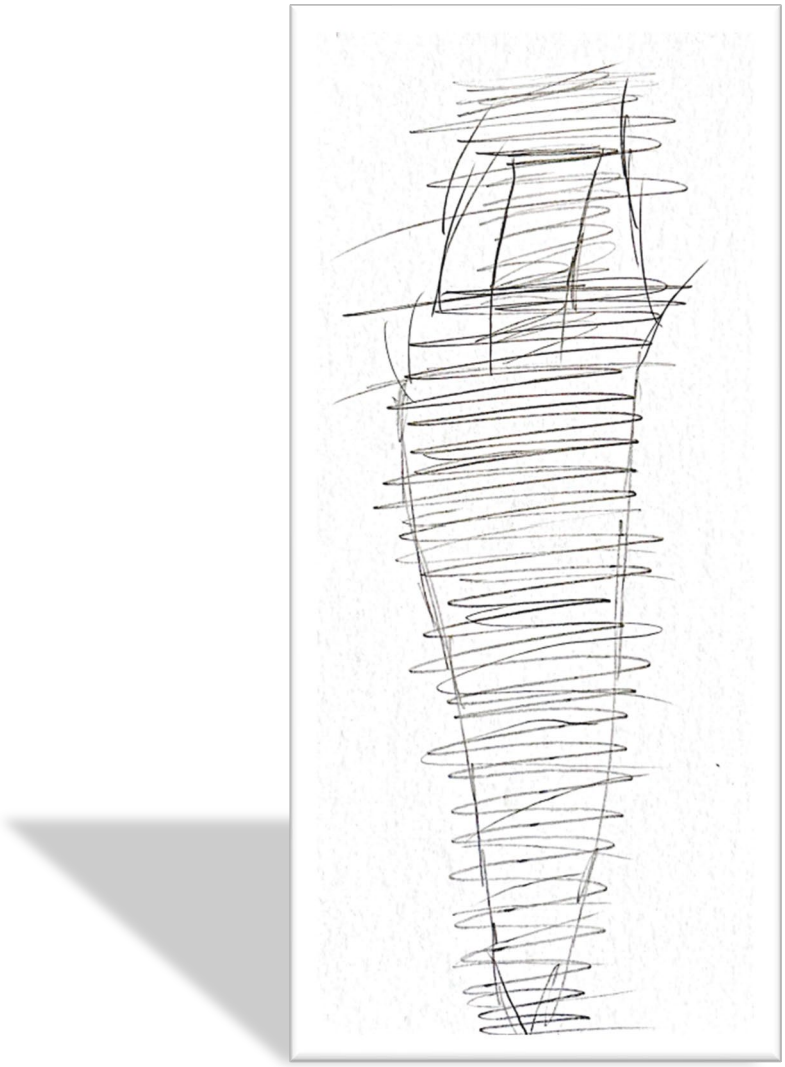


Note. Marie's drawing of what came to mind when she thought of the event.

"The thing in my drawing is the best I could do. There was no good reason for what he did!", Marie explained. "He was a monster." Marie's cognitive representation depicts the anger she felt about her perpetrator and the situation.

Figure 7.

Laurie's Cognitive Representation

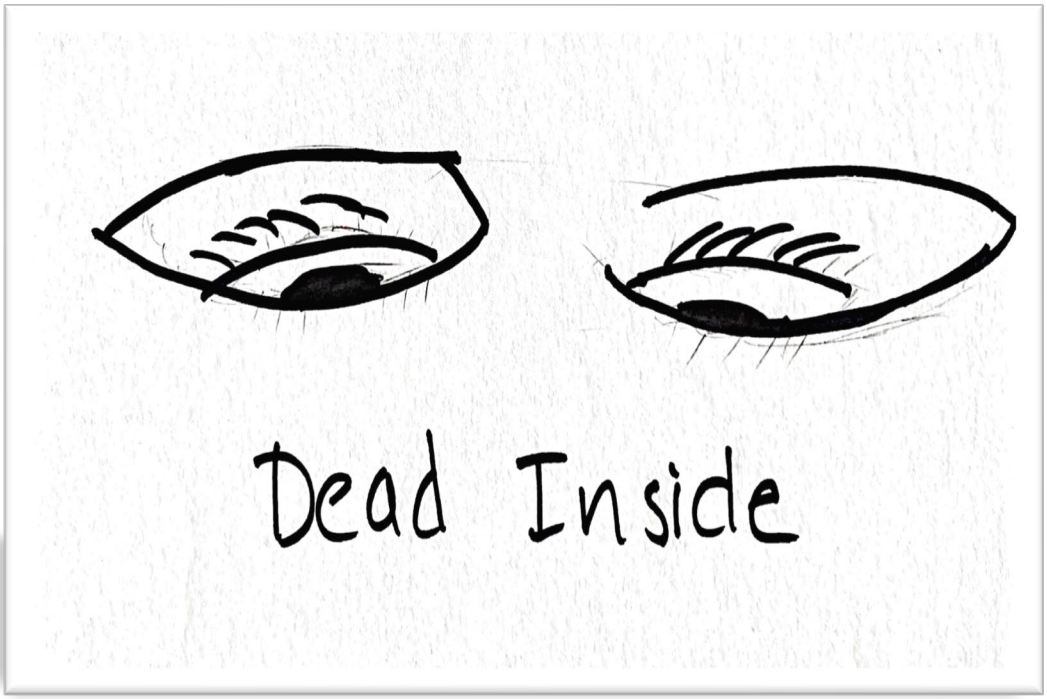


Note. Laurie's drawing of what came to mind when she thought of the event.

Laurie's cognitive representation was a little confusing at first glance, but once explained, it became clear. At the end of the hallway was her and her roommate's door to their room. The person who put her through so much terror that evening walked down that hallway to their door. She said that when she thinks of the event, she remembers the hallway the most.

Figure 8.

Irie's Cognitive Representation

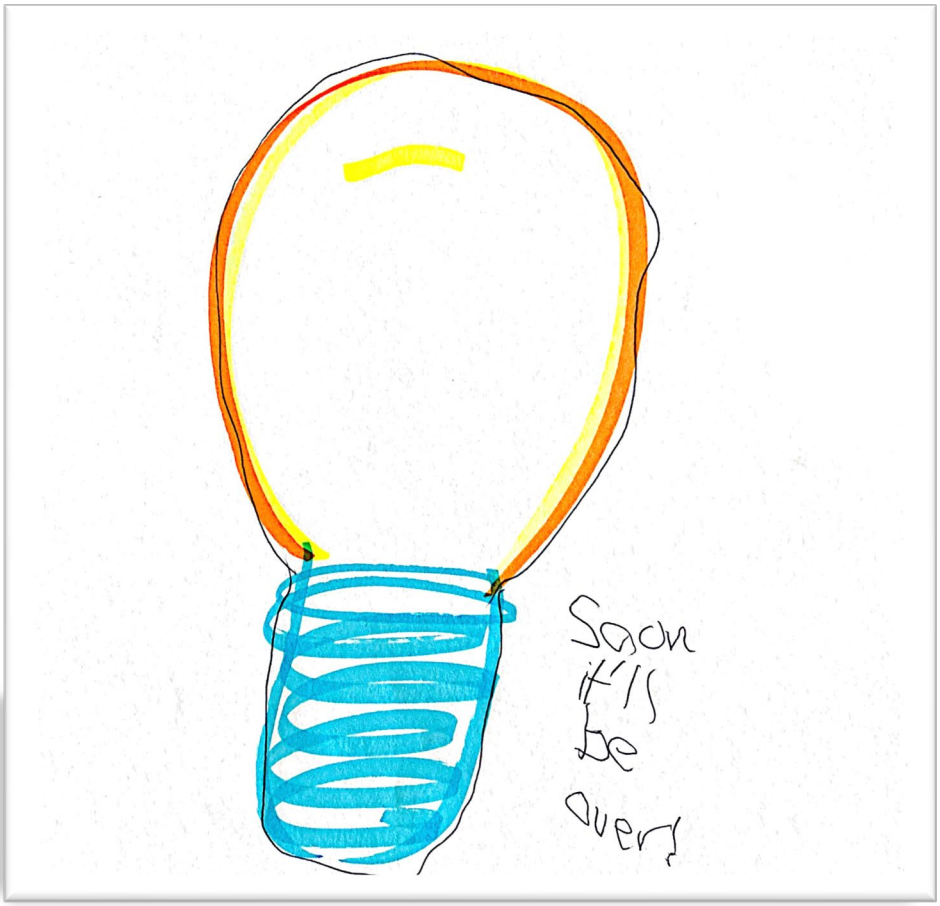


Note. Lucie's drawing of what came to mind when she thought of the event.

When asked to describe her cognitive depiction, Lucie just drew two eyes. When asked why she drew just eyes, she said that the eyes hold the life and soul of a person, So for the person who took some part of her from her life and soul away, they had to be dead inside. She then labeled her picture "Dead Inside".

Figure 9.

Umie's Cognitive Representation



Note. Umie's drawing of what came to mind when she thought of the event.

As silly as it sounds, Umie said, "I could remember vividly a light bulb. There was no shade or globe over it, just a light bulb hanging from a string.". I asked what that light bulb now represents, and she said, "I was hoping that when the light bulb goes dim, it would be over."

Figure 10.

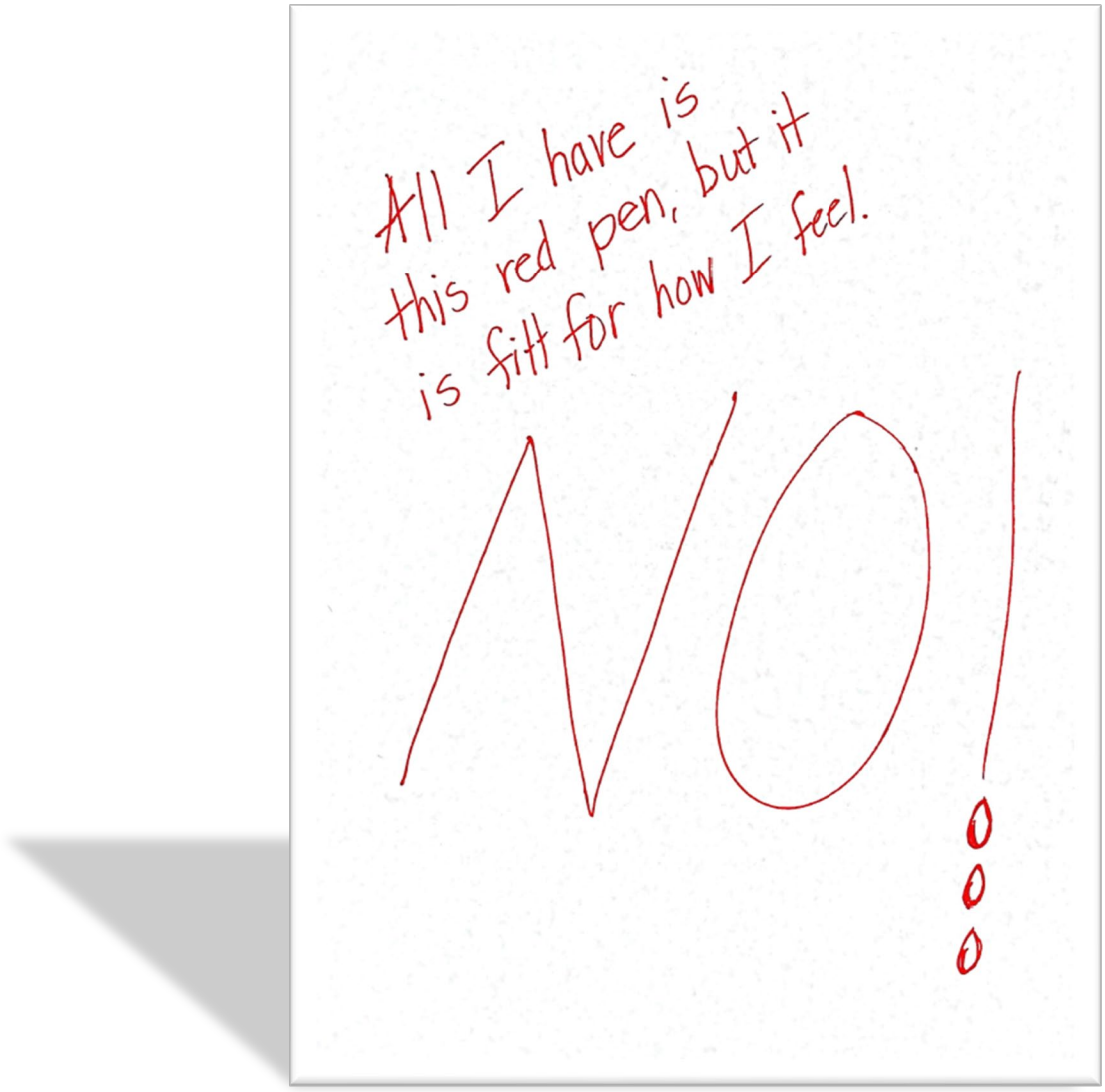
Ivie's Cognitive Representation

Note. Ivie's drawing of what came to mind when she thought of the event.

Ivie explains her cognitive representation using simple words. She said that she is in pain. Her heart hurts, her head hurts, and sometimes her body hurts when she is reminded of what happened to her. She describes the black dots on the page as the tears she has cried. She said that if she could draw a billion tears it would not be enough tears to illustrate how many she has cried over the years. She says that the tears are not just for her but they are also for the thousands of other service members and veterans who have gone through what she has gone through, and no one has helped them through the pain.

Figure 11.

Amie's Cognitive Representation



Note. Amie's drawing of what came to mind when she thought of the event.

"If I could have yelled no, would it have helped?", is what Annie said when asked to describe what she felt then. She states that she was not able to say anything at the time because she was not sure how or why what was happening to her, was happening to her. I asked what the red dots were at the end of her page, and she told me that they were tears. She says that she too, cries so much when what had happened to her resurfaces.

Figure 12.

Lucie's Cognitive Representation

Note. Lucie's drawing of what came to mind when she thought of the event.

Much like Marie's drawing, Lucie's drawing shows a human figure. She too, reminded me that she is no artist, but could only see the person who assaulted her as a disfigured person. She said. "I drew him as a monster, because that is what he was. He was a monster1" The more and more she looked at the picture she drew the more frustrated she became with what she was being asked to relive, so we stopped the interview and decompressed.

In summary, the first theme enabled the researcher to capture the lived experiences of the respondents because of MST and its impact on their emotional well-being. The first subtheme examined the pivotal aspects of MST events, shedding light on the intricate contexts in which they transpire. The second subtheme revealed the emotional responses that MST elicits, offering insights into the immediate feelings, psychological consequences, and emotional reactions that survivors grapple with. By dissecting the emotional trajectories of the participants, the researcher uncovered the intricate interplay between MST experiences and their lasting emotional impact, a cornerstone in understanding the complex ripple effects of MST on intimate partner relationships.

Theme Two: Mental Health Care and Coping Strategies

MST's aftermath often involves grappling with a spectrum of mental health challenges. Theme Two delved into the critical facet of survivors' well-being, exploring their encounters with mental health care and their strategies to cope with the aftermath of MST. This theme comprised three subthemes: Professional Support and Treatment, Impact of Diagnosis and Comorbidity, and Coping Mechanisms and Holistic Support.

Professional Support and Treatment. The participants shared insights into their experiences with seeking mental health care. This subtheme addressed the assistance they received from mental health professionals and the various supportive interventions that played a role in their healing process. Sadly, the respondents reported the MST incidents but did not receive the help, including medical assistance that they needed after being victimized. Irie recalls,

> "The next day after the last MST incident, I went down to my command, and I don't know why I did because they never believe you before. And it's like, you know, it... and

> by then they knew I was gay by then because I was like, shut myself off pretty much from everything. And, instead of doing something, they gave me a Chapter 13."

According to Ivie,

> "For the first and the last one, there were investigations. The first one went all the way to a court-martial. And then the second one, my command decided to drop it because there wasn't enough evidence. And the last one, not at all, the last one was the one that was dropped. The second one I didn't report, so there was never an investigation because there was not enough evidence. So, in the moment after the first court-martial was over and they were, they were both acquitted. I spent a lot of time working towards an appeal process. And after a couple of months of doing that, I realized that I was kind of torturing myself."

Marie narrates,

> "He, he got moved out of my platoon and got moved to the battalion, and he got moved, and I got moved into his slot. Yeah, as an E5. Yeah. That stopped it. But I still dealt with a lot of fallout, you know, people, you know, still giving me shit about it. And I mean, as a female in the military, it never really stopped, you know, I, I always had, you know, other, although as I got promoted, it stopped some, but, you know, it never really stopped. I mean, for as long as I was in the Army…"

Impact of Diagnosis and Comorbidity. Participants' narratives highlighted the impact of mental health diagnoses and comorbid conditions on their overall well-being. This subtheme explores the presence of related disorders, the interplay between different diagnoses, and how these factors influenced their mental health journey. The findings show that the respondents were diagnosed with various mental disorders like PTSD, depression, anxiety, and borderline

personality due to MST. Emmie shared, "My anxiety came first, that came from my first trauma, and my major depression came from my second trauma," and Amie stated, "Just basically PTSD, it is my major depressive disorder," and Xenie revealed,

> "I assume PTSD. You know, when I was talking to a social worker, they mentioned some of the symptoms I said. Most symptoms indicated PTSD but, and I don't know if this is just my care managers or if it's everyone's, but they don't tell you what you're diagnosed with."

Umie narrates,

> "So, I have. From that, I've had half, half. They would say half and sickly agree, but whatever, you know, eating disorder, PTSD, anxiety, severe depression. And there's been, I think, about four times now that they tried to chop me out of the Army parade."

According to Yarie,

> "I have a panic disorder. My mom is dying of cancer right now; any day she could pass away. And I have been fainting. I've had two episodes where I fainted, and the doctor called it a vasovagal symptom or syndrome that I have. And the reason I've been fainting is because of past trauma."

Coping Mechanisms and Holistic Support. Descending further into the participants' coping strategies, this subtheme delved into the therapeutic approaches they embraced to navigate their mental health challenges. It encompasses insights into their treatment plans, the effectiveness of various coping mechanisms, and their pursuit of holistic well-being beyond traditional interventions. The participants revealed engaging in various therapeutic and coping strategies for their MST trauma. Lucie highlights,

> "That's therapy. I also have a psychologist as well as a psychiatrist to help with the medication part of it. My psychologist helps with the medication part of it. My sociologist gives me different therapies to help, you know, to help when my mind is in that place again and when I'm viewing everyone that I encounter as untrustworthy or basically waiting for the betrayal. So, I think between, I don't too much care for my psychologist, but between my sociologist and my therapist, you know, they're really helping me to cope with what I dealt with for so many years, not knowing that I was dealing with anything. I just thought something was wrong with me."

According to Umie, "So, I have, like, the wellness checks. So, I have a therapist I talked to, psychiatrist, behavioral health, and the outpatient therapy program that I'm in now. And the traveling, of course, yeah," Remie expressed, "Like I said, I was seeing the MST provider on post, and then I was sent to – I'm waiting, being able to restart seeing her again. It's just a matter of having an appointment to open up."

On a different note, Adam revealed that he was put on different remedies to curb the effects of MST. However, he expressed dissatisfaction and pointed out that his coping mechanisms of talking to his peers and writing about it seemed to be most effective. He says,

> "So, they tried. They tried doing the group therapy, but that didn't really work. I just thought it was too awkward. They tried doing the regular therapy, but I never had a consistent therapist. Like, every time I would go, it was with a different person. So, I had to restart and start over every single time, and that actually made it worse. It made it a lot worse. So, right now, I just kind of put everything on pause. Now, what helps me with my mental diagnoses is I write about it a lot, and I talk with other soldiers a lot – like, just

> naturally talking with close friends or battle buddies – and just kind of, you know, we just relate with each other."

Medication is another valuable measure of dealing with MST and related effects, as revealed by participants' responses. Amie says, "Not really, nothing. I'm just, I get mental health services, and they have me on medicine, of course. I'm on 33 different medications. I take Wellbutrin in the morning with others."

Tammie revealed,

> "Since I'm moving, I'm not really in therapy because they're scheduled out, but I am supposed to be taking these pills to help me with my chronic pain and also my mood swings. At least I haven't been able to take them because I still breastfeed my son throughout the night. He will not sleep if I don't breastfeed him. So, I'm not able to take that because I'll just, you know, get all drowsy, and I'm not sure how that will affect my progress."

In summary, the second theme enabled the researcher to examine the mental healthcare services provided by the military to MST survivors. In addition, this theme uncovered the coping strategies employed by the respondents to deal with MST and related traumas. The first subtheme focused on the role of professional support and treatment, examining the pivotal contributions of mental health professionals and supportive interventions. The second subtheme delved into the profound impact of MST diagnosis and comorbidity, unraveling the web of related disorders and their influence on survivors' overall well-being. Additionally, the third ventured into coping mechanisms and holistic support, elucidating the therapeutic approaches, treatment plans, and comprehensive strategies survivors employ to navigate their healing

journey. This theme bears the intricacies of seeking and sustaining mental well-being following MST experiences.

Theme Three: Impact on Intimate Relationships

Intimate partner relationships often bear the weight of MST survivors' experiences, presenting unique challenges and opportunities for healing. Through Theme Three, the researcher traversed the terrain of how MST reverberates within these relationships.

Disclosure and Communication in Relationships. Drawing from the interview questions, this subtheme delves into participants' experiences sharing their MST experiences within their intimate relationships. It explores the intricate process of disclosure, the timing of these conversations, and the emotional responses evoked by such discussions. The findings reveal that most participants did not or were uncomfortable revealing past MST incidences to their spouses. For instance, Emmie says, "My first one, no, but I told my next one." Within the domain of "Disclosure and Communication in Relationships," a notable revelation emerges—the pervasive fear of burdening their spouses looms large among MST survivors. Strikingly, three out of the 14 respondents exposed this anguishing silence in their responses, shedding light on a deeply ingrained struggle within intimate relationships impacted by military sexual trauma. According to Marie, she did not tell her spouses because her greatest fear was them not understanding exactly what she went through. She reveals,

> "My current boyfriend is curious, but he's like, 'I know what happened.' I'm like, you don't know what happened. You will never know what happened because you were not there. And even if I were to tell you, you still wouldn't know, and because you weren't there, you weren't the 22-year-old with me, with the husband going through chemo and wondering how the fuck did I end up here? My ex-husband, my first husband, that it

> happened while I was married to him, he never knew. I don't tell him. No, I never told him. Oh, he had enough going on with chemo and radiation, and he didn't need my drama on top of that. My second husband, he knew some of it, but he didn't know again all the ins and outs of it."

Tammie feared burdening her spouse; he was also undergoing difficult moments, and therefore, she did not tell him about her incident. She said,

> "No, I didn't tell my husband. I mean, he knows that it happened, but like he doesn't know how much it affected me. We pretty much just brush it off. I didn't tell him the impact it had on my mental health. No, I just didn't feel the need to tell him, especially if I guess I may be overreacting to it. I haven't really told him, but honestly, I'm not sure how he's going to react because he's actually been accused, like he's been on the other side of this, he's been accused of sexual assault, he hasn't done it. There's been like their own military investigation. He hasn't done it. It's just, he's just going through a whole custody battle right now, and the ex is trying to use everything he can to, you know, stall the court, I guess, the case."

Similarly, Adam never told his significant other because he did not want to burden his spouse with his issues apart from not wanting to appear "weak." he highlights,

> "I never have revealed my situation. Talking about it probably makes me seem weak and we were and I, I wouldn't want to put that burden on someone else. I just wouldn't want to bring it up like it's not their problem. Like I, I don't want to make my problem someone else's problem."

On a positive note, Ivie has talked to her husband about the ordeal and takes pride in the fact that communication is a key element in the healing process. She says,

> "Yes, I think, I mean, I've, I think I've had challenges with all of my partners. The one person that I'm currently with has been by far the most supportive and like the healthiest relationship I've ever had. After my first MST, I was actually married at the time, and our relationship didn't last because I was so broken. I think he had a really strong desire to support me and like work it out, but it was just like I was too young and I was kind of too broken, and I kind of just exploded everything."

Similarly, Laurie shared,

> "Like, even my partner, when I started telling him about the stuff that happened to me, he started watching what he did. And like, I had explained to him like, it's different if you do something because I trust in you and I trust you enough to, I've told you what I've been through and I've explained to you how it makes me feel. So, I know like you're not gonna do it and if you do do something, it's not intentional, and sometimes he does, like, catch himself or he'll apologize or whatever the case is, but it's just having the support system and having people to fall back on when you're down."

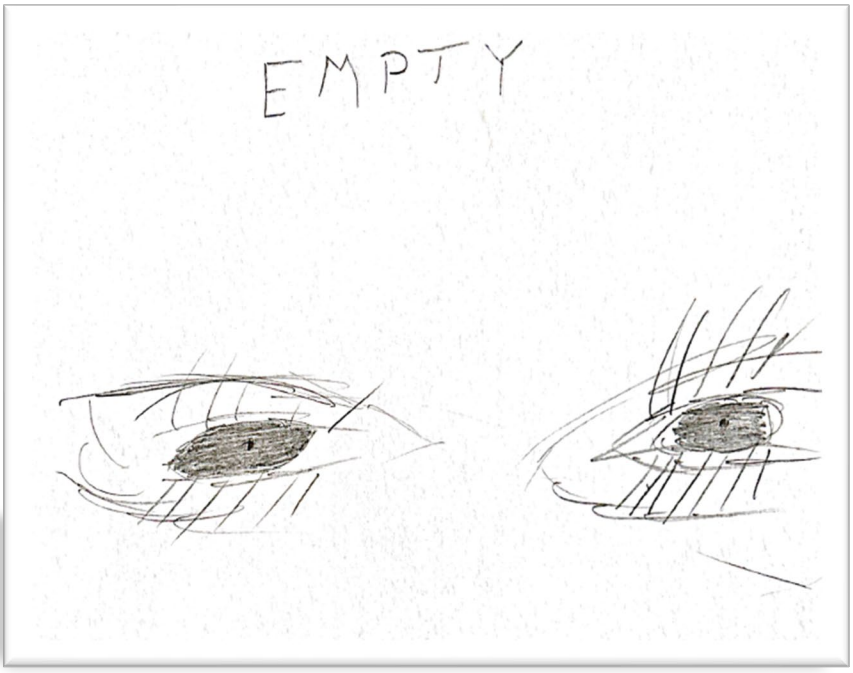
Relationship Dynamics and Trust Issues. Participants' narratives shaded light on the transformations that MST brought to their intimate relationships. This subtheme explores the dynamics that changed due to their experiences, the emergence of trust issues, and the emotional distance that often accompanied these challenges. The findings show that MST leads to adverse effects on relationship dynamics. Xenie responds, "I trust him a lot less and this is kind of not on, this isn't on the topic of sex…" According to Marie,

> "It affects my relationships and the people that I want to love, questions behind that you don't have enough answers. I just, I've never wanted to name names, you know, we

don't, even though I say mine more often, I don't, I don't verbalize his name, but I say it so often in my head because I can see exactly what happened when it happened."

Figure 13.

Xenie's Cognitive Representation



Note. Xenie's drawing of what came to mind when she thought of the event.

There are many interesting and correlative themes throughout this study, but the drawing of eyes were by far the most for the researcher. I asked Xenie who's eyes were they and she said, "They are mine." In Irie's cognitive representation the eyes were of her perpetrator. Xenie reports that these eyes are hers and she sometimes feel empty inside.

Tammie portrayed a strained relationship with her partner faced with trust issues due to the traumatic effects of MST. She says,

"I don't know. I feel like I'm not worthy of him. Like I deserve to be treated worse because I was in an abusive relationship after I got out of training. And it was hard for me to break away from the relationship because I don't know, I was just thinking in my head,

this is what I deserve. I'm not gonna get any better than this. When I do get somebody that does better, I'm just thinking if there's like an ulterior motive, if that makes sense."

Remie painfully narrates,

"I reached out to the person who I was with at the time that it happened. I called him and I kind of sort of told him what happened, and he didn't really take it well. We ended up just ending the relationship, which made me feel like the breakup amplified the feelings that I had of guilt and the feeling of being dirty. It just amplified it more, and it just made me feel like maybe, you know, I'm just not meant to be with anyone."

Other than messing up her intimate life, Yarie notes that MST effects have profoundly impacted her ability to show affection to her children. She narrates, "The MST has ruined my life for everything. My kids didn't know what it's like to be hugged by their mother. I can't hold a relationship down. I have social anxiety like you wouldn't believe."

Factors Influencing Intimacy. Exploring factors that influenced participants' capacity to engage in intimate relationships post-MST, this subtheme delves into elements such as past trauma, personal growth, and communication skills. It examines how these factors either facilitated or hindered their ability to navigate intimacy. According to the participants, MST has taken a toll on their love life as far as sexual intimacy is concerned. For instance, Yarie responds, "I do not like to have sex very often. That, that's about it." In exploring the dynamics of "Factors Influencing Intimacy," a prominent and distressing factor emerges: the pervasive influence of PTSD flashbacks. Remarkably, five out of the 14 participants shed light on this relentless presence, revealing it as a formidable obstacle preventing them from engaging in intimate or sexual interactions with their spouses. This revelation underscores the profound and enduring impact of trauma on the complex fabric of personal relationships. Sallie notes,

> "I think the hardest thing is like getting, like, being present mentally, because initially after the event, my libido kind of nosedived. And I think if I was in a different point of my life, I would have become very self-destructive in my sexual behavior. If that makes sense. But my husband is very supportive. But it's very easy for me to talk clinically about what happened. It's easy for me to kind of detach myself from what happened. What is difficult is like, while we were being intimate, it's like things are pleasurable, things are good, and then all of a sudden, if he does something that this other person did, it sucks me back into that moment."

Similarly, Ivie reveals,

> "My MST sometimes manifests when I want to be intimate with my partner. It does, sometimes. I would say that it's. I could not recollect a time where we would need to, like, stop intimacy because of, like, a memory or a feeling. But like, there are times when it's like, I'm not feeling like I don't want to be touched at all. But I think that we have, like, developed a good way of communicating that. And not many people communicate with their partners about, you know, their past traumas sexually. And because we don't talk enough, we create this whole problem that doesn't need to be created when we keep that, you know, those things to ourselves."

Emmie reveals,

> "I have flashbacks when I am physically intimate with somebody, and physically, I'm dry down there, so it's painful. And it's been painful for some time. I did have medication for it, which did help significantly. But again, I guess he didn't remember that. I told him that I was doing fine with it. But it's mainly the mental that I get into that block and get that flashback because it was a year of abuse."

Figure 14.

Emmie's Cognitive Representation

Note. Emmie's drawing of what came to mind when she thought of the event.

Emmie was one of the most open and funny participants the researcher had the honor of interviewing. Though the topic was very hard to talk about, and the researcher asked many personal questions, Emmie managed to keep it light. I asked her to explain her cognitive representation and she said, "I love the zoo. At that moment, I would have rather been at the zoo in the aquarium section watching the jellyfish."

Marie bitterly recalls,

> "Well, like I said, I've been at times completely asexual. Didn't want anybody to touch me at all, and I. It definitely has something to do with it. Umm, he wasn't very understanding, my ex-husband, you know? He had multiple affairs, which of course ended us. Yeah, we are no longer married because he had multiple affairs, and I don't know if that was just a direct result of that. Because he was not the best person in the world for me to marry regardless, but I'm sure it didn't help, right? You know, but it didn't help. But I'm not going to say that it was the cause of it. But we definitely had intimacy issues for a while. And then we didn't. And then we did, and then we did, you know, so. I don't. My boyfriend now knows."

In addition, Laurie says,

> "So it's like not all of them because, well, before I met them, and if I don't like, see it going anywhere, it just, I just don't. I usually don't. I do tell them like, things I'm uncomfortable with, or if we are intimate. But other than this, I would rather not say anything because for some reason when I learned that a lot of men don't know how to take, how to react when you tell them something like that. Or some men have it in their mind that, 'Oh, like she's not clean' or whatever the case may be. And I just sometimes did not wanna go through that."

In summary, the third theme enabled the researcher to circumnavigate the implications of MST and related disorders on people's intimate relationships. The first subtheme uncovered the challenging and delicate yet vital process of disclosure and communication, unraveling the complexities of sharing MST experiences within intimate relationships. The second subtheme unraveled the intricate dynamics of relationships, spotlighting the erosion of trust, emotional

distance, and other transformations stemming from MST's aftermath. The third subtheme ventured into the factors that sway intimacy, shedding light on the interplay of past trauma, personal growth, and communication in intimate relationships. By unpacking these dimensions, the researcher illuminates how MST affects individuals' lives by weaving its threads into the fabric of intimate connections.

Theme Four: Sexual and Intimate Challenges

MST's impact transcends emotional and psychological spheres, often extending to sexual intimacy. Through Theme Four, the researcher navigated this sensitive terrain, dissecting how MST experiences intertwine with survivors' sexual lives. As a result, Intimacy Challenges due to MST and Sexual Dysfunctions Resulting from MST subthemes emerged from this theme.

Intimacy Challenges Due to MST. Based on insights from the interview questions, this subtheme explores the complex challenges participants encountered in fostering intimacy post-MST. It addresses the themes of avoidance, emotional barriers, and the profound impact that MST had on their ability to engage in fulfilling intimate relationships. According to Umie,

> "But mentally, when I think about something sexually, I don't relate it to anything good. It's not like a positive experience to me. I'm very real with my daughter when I talk to her about these things. And that, hey, sex was created by God and supposed to be a beautiful thing, but sometimes it's not, and the evil in the world that we are in has turned that into something that's not what it was meant to be. So I don't have anything good that I associate it with."

Xenie shares,

> "MST made me doubtful, made me distrust, you know, intimately it's, it wasn't good for it, but it also made me feel less trustful because, you know, when we talked about it, he

was like, well, I don't stick up for you because, you know, I know that like, this sounds really bad."

Emmie revealed that she experienced intimacy challenges with her former partner and is afraid that the same problem might reoccur with her next one. She says,

"I don't know yet because I am on a dating site. Am I nervous? Absolutely. Because I don't know if he is gonna be like my previous partner and be very sexual and very intimate. I would like to have a person that understands what I've been through and not be pressured because I did feel pressured by him to have sex and everything like that. And I told him that, and he was like, well, I'm not trying to pressure you and everything. I'm like, but your body language tells me that you wanna have sex. So, and at that time I didn't want him to leave. So, I basically said yes, even though I didn't want to."

Sexual Dysfunctions Resulting from MST. This subtheme delves into the profound effects of MST on participants' sexual well-being and functioning. Drawing from participants' responses, it examines the emergence of intimacy issues, the development of psychological barriers, and the manifestation of physical symptoms that hindered their sexual experiences. Ivie notes that MST drove her to an unusual sex life leading to interactions with sexually violent individuals. She highlights,

"So, in between 2012, which was my first MST, and 2015 when I moved to Washington, I find it difficult for me to call all of it sexual dysfunction because I think that in some ways, it was something that I kind of needed to survive. And I also consented within it the entire time, but I engaged really heavily in the BDSM and kink community while I was stationed in Hawaii during that time. So, I chose to engage in pretty violent, like

> sexual partnerships and like engagements pretty much that entire time. That was my entire sex relationship with sex the entire time."

Marie reveals that her MST messed up her sex life to the extent that she does not want to be touched by her partner. She says,

> "I mean, the sexual times, like when I don't wanna be touched at all, I mean, not at all, you know, don't like just don't even fucking touch me. You know, we can talk, we can have a good time, don't fucking touch me, right? There are a lot of times like I'm in that zone right now where I don't want anybody anywhere near me, and I wasn't like that before."

Similarly, Ivie narrates,

> "My MST sometimes manifests when I want to be intimate with my partner. It does, sometimes I would say that it's, I could not recollect a time where we would need to like, stop intimacy because of, like, a memory or a feeling. But, like, there are times when it's like, I'm feeling like I don't want to be touched at all."

In summary, Theme Four enabled the researcher to investigate the adverse sexual implications of MST on the intimate lives of survivors. Subtheme one probed into the challenges MST survivors face in intimacy, illuminating the barriers and avoidance mechanisms that often arise. Subtheme two delved into the interplay between MST and sexual dysfunctions, highlighting the psychological barriers, emotional hurdles, and physical symptoms that impact survivors' sexual well-being. In this theme, the researcher uncovered the nuanced ways in which MST's effects permeate survivors' intimate and sexual experiences, presenting a complex landscape of challenges and potential avenues for healing.

Theme Five: Advocacy and Message for Change

The voices of MST survivors are potent catalysts for change, sparking advocacy efforts to transform policies and support systems. Theme Five sheds light on survivors' critical role in driving change and fostering support for fellow survivors. The researcher uncovered pertinent potential solutions to dealing with MST from first-hand recommendations provided by the respondents. These recommendations were categorized into two subthemes: A Need for Change and Support and a Message to Congress and the VA.

A Need for Change and Support. Derived from insights from Interview Question 11, this subtheme emphasizes the pressing need for policy changes and supportive initiatives to address the issues MST survivors face. It highlights participants' calls for comprehensive changes that can better protect and aid survivors in their journey towards healing. The fact that all participants were motivated by the urge to share their stories, touch other survivors' lives, and voice the MST and its related problems illustrates a need for change. When asked why she was interested in participating in the study, Marie said,

> "To help other female veterans and survivors. I thought it might help other people and that's why I agreed to do it," and Lucie heartily says, "To tell my story and because my best friend asked me to thank you before we begin."

Laurie shares,

> "So, within the military, there's a lot that goes on that, like, a lot of people don't know about and like people who are on the outside that don't know about and like, in this day and culture, you see, it's so easy for people to have like their opinions, but nobody really knows what survivors or survivors actually go through. A lot of people are afraid to speak up, they're afraid to be retaliated against or like just things like that. So, I feel like it's

> always good to, like, spread what happened, what has happened so that other people have a chance to see, you know, how this affects others and what they have gone through and also like their road to getting back to how they were before the trauma happened."

Irie hopes that participating in this study will not only help other MST survivors but also contribute to her healing process. She highlights,

> "I'm participating to try to help others. I think it may help what I'm going through just, I'm just now starting to face it, and I think it may be key for my rehab. I guess you could call it or my therapy."

Tammie adds,

> "I honestly just wanted to pretty much see how much of an impact it really did have on my relationship and just get my story out there. Because I want to make a change and speak out so it is not normalized."

To put the record straight, Remie states,

> "I would like to share my experience in hopes of helping others who've gone to a similar situation and also help counselors get insight on how to go about helping/ understanding. I went back and forth with it first. I was like, no, because it, I wasn't comfortable to talk about stuff like that, but then I talked about it with my significant other. And, yeah, he gave me his opinion. He's like, well, you know, like, you know, this could help someone or, you know, depending on whoever ends up seeing this. Like, it could help counselors go about things differently. And he's like, ultimately, it's your choice. And I thought about it, and I was like, you know, he's right, like, you know, I want this to potentially help someone else who's in my shoes or, you know, you know, someone like a counselor

or something, like, go about things a different way because they see they're able to see this and able to, like, do things from a different perspective."

Message to Congress and the VA. Within this subtheme, participants' responses guided a focused exploration of their advocacy efforts directed at Congress and the Department of Veterans Affairs. By illuminating their messages, this subtheme underscores the urgent need for proactive measures and interventions that prioritize the well-being and rights of MST survivors. According to the respondents' narratives, there was a call to action for Congressional intervention to deal with MST and its effects on military personnel's current and future intimate relationships. Sallie calls for actions geared toward protecting survivors and effective policies advocating for accountability by responding to the question asking if there was anything she would like for the researcher to pass on to Congress. She recommended,

> "I think like one of the most important things for our congressional representatives and just leaders of this country to know is that for every opportunity that they have to address something, that if they do not address it, they are just as bad as the perpetrator. This is about accountability. There is a stark difference between being a good person and a good soldier. But I would argue that in moments of MST, it violates both of those things. So, it is unacceptable to have perpetrators in our military, leading soldiers, leading America's sons and daughters. I would ask for accountability. I would ask for support for those who have been victimized in a way that does not re-victimize them at every opportunity. Compelling survivors to testify, whether it's a board of inquiry, a separation board, or a court martial, may be beneficial to some who are ready to take that step. But there are many who are unwilling to participate for personal reasons, and it should be respected. And so, I would just ask for their discretion in policymaking and how it impacts

> individuals, not just in the military, but for a lifetime. And it's going to continue to impact how people who have experienced MST talk about the military. In the midst of a recruiting crisis and a retention crisis, something should be addressed. They need to do something different with the policies, most definitely, and the support. Some of us just want to get it out and have someone on the other end not judge us for what happened to us."

Similarly, Marie points out,

> "I mean, this person controls every part of your life and, especially for women, or in some cases, young men in a situation where you have no one, no one. You are in a place where you have just been stuck, and you have nobody there. And these people are supposed to care for you. If they're not caring for you, what are you supposed to do? Who are you gonna tell? This is your boss, this is, and his boss is his best friend. Who are you gonna tell? And you're in a place where, you know, nobody, it's a powerless situation, and I know, I know many women that have and some young men that have the same story that I do. So, anyone who could make a difference, like the chain of command, like Congress, anyone who makes the rules, even the rest of us, empower our soldiers to do male, female, women, right? Speak out about this, and you can say no; you can get those people who have done such a heinous thing to be held accountable."

Adam urges lawmakers to develop and implement policies that protect MST survivors, including men, by creating safe places. He says,

> "I, I think that, I think that sexual assault in MST is like a social and a community and a cultural issue. It's like it's not going to be solved by putting more posters up on the walls. And that was always kind of like an issue that I had of like a person doesn't go to a bar

> and see like a poster on the wall and be like, oh yeah, maybe I shouldn't drink and drive like they, if they've made the decision to do that already, like nothing that we like put on the walls or even pass in a law is really gonna change their behavior. We need to create spaces where men can be vulnerable and handle their own trauma and talk about how like our cultural standards have changed, like the way that we perceive like masculinity, and like, I know that I know that there already aren't enough safe places for women. But I think that there we need to create more safe spaces for men to talk about how hard it is to be male in our culture too."

The final theme allowed the participants to speak out about potential solutions to the problem of MST by providing recommendations in their responses. Subtheme one emphasized the urgent need for systemic change and comprehensive support mechanisms, emphasizing the call for policy amendments and supportive initiatives. Also, subtheme two directed attention to survivors' messages directed at Congress and the VA, revealing their fervent advocacy for fellow survivors and a call to action to address the pressing challenges. Within this theme, we witness the metamorphosis of MST survivors into advocates, championing transformative shifts that hold the potential to reshape the landscape for current and future survivors.

Summary

This chapter presented the findings of this phenomenological study after the researcher conducted 14 interviews and analyzed participants' responses. This comprehensive research endeavor shed light on the profound impact of military sexual trauma on intimate partner relationships, unraveling a tapestry of experiences, emotions, and coping strategies. The exploration of the themes and subthemes has uncovered a multifaceted landscape that underscores the far-reaching effects of MST on survivors' lives.

The first theme, "MST Experience and Emotional Impact," provided a poignant window into the lived experiences of respondents in the wake of MST. Subtheme one investigated the contextual intricacies of MST events, while subtheme two revealed the emotional responses that MST triggers. This exploration unearthed the intricate interplay between MST experiences and their enduring emotional repercussions, offering valuable insights into the complex emotional undercurrents that shape survivors' intimate relationships.

Figure 1 illustrates the hierarchical relationship between themes and subthemes according to the qualitative analysis of participants' responses. The organizational chart represents emerging themes as the main sections and subthemes as the corresponding sub-sections.

In the second theme, "Mental Health Care and Coping Strategies," the researcher focused on survivors' mental well-being. Subtheme one illuminated the role of professional support and treatment, highlighting the contributions of mental health professionals and supportive interventions. Subtheme two unraveled the connections between MST diagnosis, comorbidity, and survivors' overall well-being. Subtheme three traversed the terrain of coping mechanisms and holistic support, unveiling the strategies survivors employ on their healing journeys. Through this exploration, the theme underscored the importance of addressing mental well-being in the aftermath of MST.

The third theme, "Impact on Intimate Relationships," casts a spotlight on the intricate ways MST reverberates within intimate partner relationships. Subtheme one navigated the delicate process of disclosure and communication, while subtheme two delved into the shifting dynamics and trust challenges that arise. Subtheme three unearthed the factors influencing intimacy, revealing the interplay of past trauma, personal growth, and communication. This

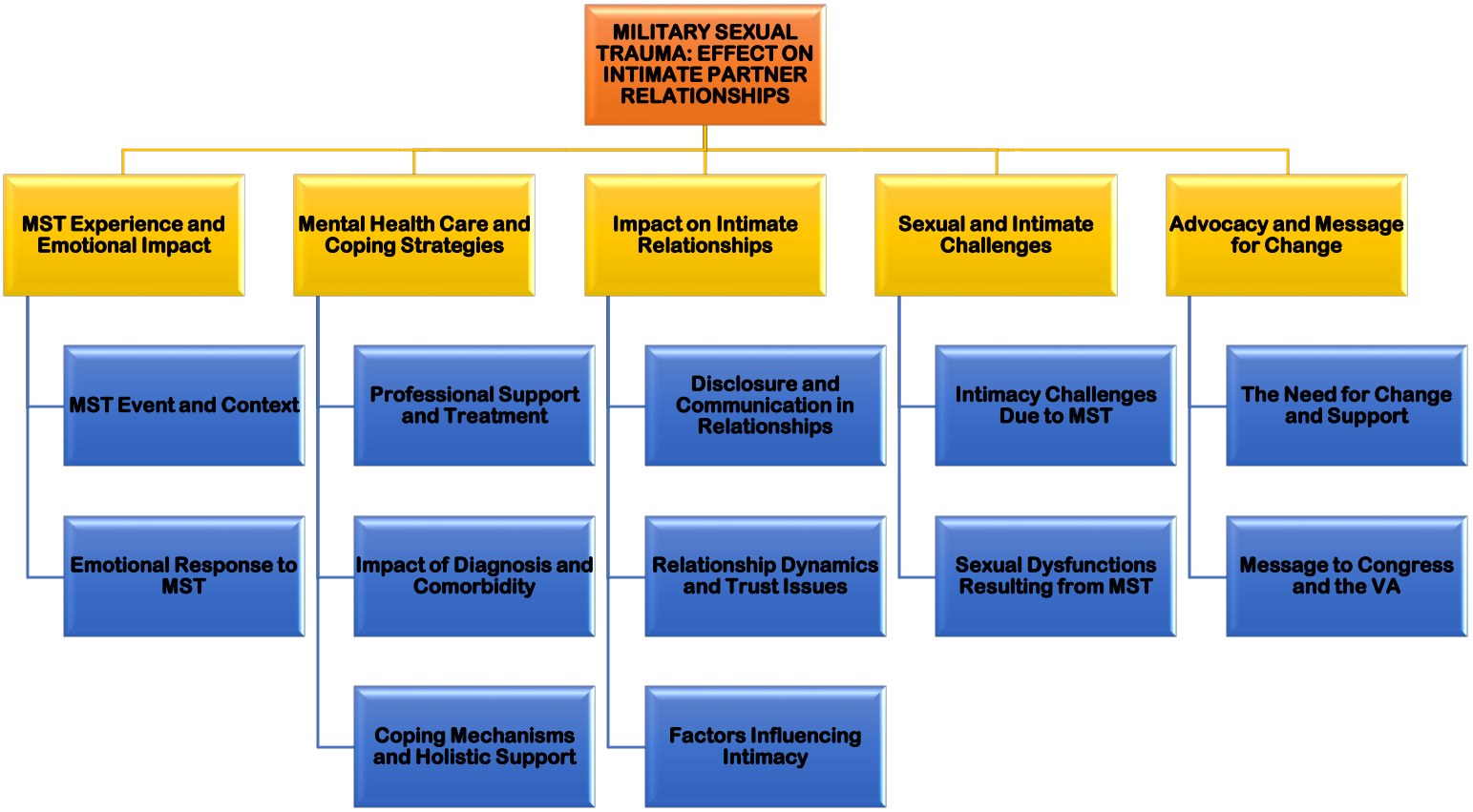
theme emphasized the intricate dance between personal histories and shared connections in the context of survivors' intimate relationships.

Theme four, "Sexual and Intimate Challenges," delved into the often-overlooked realm of sexual intimacy following MST. Subtheme one elucidated the challenges that survivors encounter in this sphere, while subtheme two revealed the impact of MST on sexual well-being, encompassing psychological and physical dimensions. Through this exploration, the theme highlighted the intricate intersections of trauma, trust, and intimacy within survivors' intimate lives.

The final theme, "Advocacy and Message for Change," highlighted the resilience of MST survivors as advocates for systemic change. Subtheme one underscored the urgency for comprehensive support mechanisms and policy amendments, emphasizing the call for transformative shifts. Subtheme two spotlighted survivors' impassioned messages directed at Congress and the VA, demonstrating their commitment to improving the landscape for fellow survivors. This theme vividly portrays the transformative journey from victim to advocate. In conclusion, this study's results contribute to a deeper understanding of the intricate web of emotions, challenges, and triumphs that characterize the experiences of MST survivors and their intimate partner relationships. Through the lens of these themes and subthemes, we gained profound insights into the complexity of MST's effects, illuminating pathways for healing, advocacy, and change.

Figure 15

Hierarchical Diagram Depicting Thematic – Sub-thematic Relationships



Moving from Chapter 4, where the results of this research had been presented and analyzed, we embarked on a journey into Chapter 5: Discussion, Implications, Recommendations, and Conclusion. In Chapter 4, the focal point was unveiling the intricate and nuanced findings derived from the participants' narratives. This included themes and subthemes that encapsulated their experiences and perceptions regarding military sexual trauma and its profound impact on intimate relationships, mental health, and more. Chapter 5 serves as a

platform for interpreting and discussing these results in the broader context of existing theories and empirical literature. Furthermore, it provides a space for exploring the implications these findings have on the theoretical, empirical, and practical domains. Recommendations for future research and policies are proposed, aiming to guide the way forward in addressing the critical issues surrounding MST and its aftermath. Finally, this chapter culminates by summarizing the comprehensive study, encapsulating the essence of the research journey and its potential to contribute to a deeper understanding of MST's impact on intimate partner relationships and mental health in military settings.

CHAPTER FIVE: CONCLUSION

Overview

The purpose of this phenomenological study was to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. Not only did the study achieve that goal, it also gain a comprehensive understanding of the effects of military sexual trauma on intimate partner relationships among active-duty service members and veterans. Incorporating Bowlby's (1969) attachment theory into the context of sexual assault and threatening sexual harassment during active duty, the study sought to gain a deeper understanding of the experiences of MST survivors, specifically focusing on its potential impact on intimate partner relationships. Drawing from Bowlby's attachment theory, which centers on the profound significance of early emotional bonds and attachments, this research aimed to illuminate the intricate dynamics between attachment patterns and the consequences of MST.

Attachment theory posits that individuals form emotional bonds and attachments in early childhood that significantly influence their interpersonal relationships (Bowlby, 1969, 1973, 1980). In the case of MST survivors, the disruption of these attachment patterns due to traumatic experiences can have lasting effects, potentially affecting their capacity to form secure and healthy intimate partnerships. This study delved into how MST may disrupt or alter attachment styles, leading to potential challenges in forming and maintaining intimate relationships. Focusing on attachment theory, this study aimed to shed light on how a sexually traumatic event experienced while serving in the military could impact survivors' emotional bonds and relational behaviors, thus contributing to a more comprehensive understanding of the consequences of MST and the potential avenues for support and healing for those affected. This concluding

chapter summarized the journey to explore the intricacies of MST's effects on intimate partner relationships.

Summary of the Findings

The purpose of this phenomenological study was to describe active duty and military veterans' experiences with intimate partner relationships after a sexually traumatic event. This section provided a concise overview of the key findings from the previous chapter. The intimate challenges and sexual dysfunctions stemming from MST were highlighted, along with the victim's journey towards advocacy and the need for systemic change.

The research questions were explored through the participants' narratives, providing insights into the intricate web of consequences that military sexual traumatic events impose on intimate partner relationships, mental health, and attitudes toward the military institution. The study offers a comprehensive portrayal of the far-reaching effects of MST, contributing to a deeper understanding of the challenges faced by survivors and the implications for their lives and relationships.

Central Research Question: How do MST survivors describe how their sexual traumatic event impacts their intimate partner relationships?

The study's findings provided a nuanced understanding of how military sexual traumatic events significantly impact intimate partner relationships. Survivors described complex challenges arising from the aftermath of such events, encompassing emotional responses, intimacy barriers, and sexual difficulties. The results highlighted how the trauma from MST can ripple through the fabric of intimate connections, altering dynamics and posing obstacles to healthy relationships.

Sub-Question One: How do participants describe the impact their MST, and other associated mental health diagnoses because of their MST, have upon their ability to have a healthy intimate partner relationship?

The study's findings shed light on the intricate interplay between military sexual traumatic events and mental health. Survivors' experiences of emotional distress, psychological distress, and PTSD emerge as significant outcomes of MST. The results emphasized these impacts' persistent and cascading nature, affecting the victim's overall well-being, and contributing to the complexities of intimate partner relationships.

Sub-Question Two: How do participants describe their experience with sexual dysfunction as the result of their MST?

In response to this sub-question, the study revealed that military sexual traumatic events influence intimacy which can leave the survivor rethinking many aspects of sex. One participant felt blessed that they were in a loving relationship because there could have been a strong chance that they would have explored high risk sexual behaviors. Another participant discussed the difficulty they were having becoming intimate with anyone since the MST occurred. The dysfunction was not just a mental roadblock, but a physical one as well.

Sub-Question Three: How do participants describe their experience of relationship dissatisfaction once they have shared their MST with their partner?

Perhaps one of the most difficult parts of the study was to discover that when a survivor discloses their MST to a potential or current intimate partner, that partner does not offer the love, trust, and support the survivor needs. This in turn gave the survivor more justification for not sharing their experience with their intimate partners. It also left them feeling lonely and alone in this struggle to find peace in what has happened to them. The withdrawal does nothing more than

assist in harboring feelings of mistrust and resentment that may not have been there before the disclosure, which may ultimately lead to relationship dissatisfaction.

Discussion

This section comprehensively discussed the research findings, connecting them to the existing literature and theoretical framework. The section explored the implications of the findings for intimate partner relationships, mental health care, and victim advocacy.

Examining the study findings in the context of attachment theory offers a more comprehensive understanding of the effects of military sexual traumatic events (MST) on intimate partner relationships, mental health, and attitudes toward the military. By adopting attachment theory as a guiding framework, we gain new insights into the empirical and theoretical literature surrounding MST's impact. Attachment theory emphasizes early emotional bonds' significance and enduring influence on individuals' relationships and psychological well-being. When applied to the study's findings, attachment theory provided a fresh perspective on how MST could disrupt attachment patterns and contribute to challenges in forming and maintaining intimate partner relationships. It also sheds light on the potential influence of MST on individuals' mental health and their attitudes toward the military.

Impact on Intimate Partner Relationships

The effects of MST take a critical perspective through the lens of Attachment theory. In alignment with existing empirical research, the study's findings affirmed the intricate ways MST can profoundly disrupt and transform intimate relationships. This resonance with prior investigations underscores the urgency of addressing the challenges MST survivors and their partners face within these relationships.

The study's findings resonated with previous research, highlighting the intricate ways in which MST impacts intimate partner relationships. Empirical literature underscores survivors' struggles in communicating about their traumatic experiences with their partners (Smith et al., 2019). The present study corroborates these findings, revealing the complex disclosure process and the subsequent challenges to trust and intimacy. Within Attachment theory, these difficulties in sharing MST experiences can be seen as disruptions in attachment bonds and the formation of secure emotional connections (Bowlby, 1969). The fear of judgment or stigma that hinders disclosure can be understood as an attachment-related barrier to seeking support and comfort in intimate relationships.

A notable theme emerging from the study was the formidable obstacle survivors encounter when attempting to communicate their traumatic experiences with their partners. This finding resonated with the empirical literature, particularly the work of Smith et al. (2019), which highlights survivors' struggles in openly discussing their MST experiences within their relationships. This struggle to disclose traumatic events is multifaceted and can be attributed to various factors, such as the fear of judgment, the stigma associated with victimization, and concerns about potential negative impacts on the relationship. Attachment theory suggests that these difficulties may stem from early attachment experiences and how they influence an individual's ability to seek comfort and support from their intimate partners. The alignment of these findings with Attachment theory underscores the significance of understanding how early attachment experiences can shape an individual's ability to form secure emotional bonds and communicate effectively within intimate relationships. Interventions informed by Attachment theory principles could potentially address and ameliorate these attachment-related challenges,

fostering improved communication and emotional well-being within intimate relationships affected by MST.

What sets this study apart was its comprehensive exploration of the diverse facets of how MST impacts intimate relationships. By delving into emotional barriers and intimacy challenges faced by survivors and their partners (Jones et al., 2020), the study provided a more nuanced understanding of the complexities that arise in the aftermath of MST. This depth of analysis contributes to the field's knowledge base by shedding light on the interplay of emotional responses, attachment dynamics, and relational behaviors within intimate partner relationships affected by MST, as viewed through the lens of Attachment theory.

Mental Health Implications

In alignment with prior research, the study established a significant association between MST and adverse mental health outcomes, including emotional distress, psychological distress, and symptoms of post-traumatic stress disorder (PTSD) (Kimerling et al., 2018). This alignment could be understood through attachment theory, which emphasizes the role of early emotional bonds in shaping an individual's emotional well-being and psychological resilience. The study's findings extend our understanding by illuminating the intricate interplay between these outcomes and their detrimental effects on survivors' overall well-being, shedding light on the enduring psychological toll MST exacts on mental health.

Exploring mental health implications within the context of MST underscores a critical dimension of the study's findings. The consistent linkage between MST and adverse mental health outcomes resonates with prior research, emphasizing the urgent need to address the mental health challenges MST survivors face and to develop effective interventions to support their well-being. Attachment theory suggests that disruptions in early attachment bonds can leave

individuals more vulnerable to emotional distress and psychological difficulties later in life, reinforcing the importance of recognizing and addressing the mental health needs of MST survivors.

The study's alignment with the theoretical underpinnings of cognitive processing therapy (CPT) took on added significance within the framework of attachment theory. CPT posits that individuals' cognitive distortions can exacerbate trauma-related symptoms (Resick & Schnicke, 1996). When viewed through the lens of attachment theory, these cognitive distortions could be understood as emotional responses influenced by early attachment experiences. The study's identification of the vital link between MST and adverse mental health outcomes reinforces the validity of the theoretical framework, providing empirical support for the idea that disruptions in attachment dynamics can contribute to psychological distress and its persistence over time.

Moreover, the study's findings transcend prior research by delving into the complex interplay between adverse mental health outcomes and their far-reaching effects on survivors' overall well-being. This comprehensive analysis underscores MST's enduring psychological toll on survivors, amplifying the call for comprehensive and targeted mental health interventions to address these challenges. Attachment theory suggests that healing and recovery can be facilitated by establishing secure emotional bonds and support systems, emphasizing the importance of addressing the long-lasting effects of MST on multiple facets of survivors' lives.

In essence, this study's results both confirmed and extended previous research by providing a detailed account of the multifaceted impacts of MST on intimate partner relationships and mental health, as seen through the lens of attachment theory. By delving into the intricate nuances of these impacts, the study offered a novel contribution to the field,

shedding light on the complex ripple effects of MST and advocating for comprehensive support mechanisms and policy changes to address the challenges faced by survivors.

Implications

This section discussed the potential implications of the study's findings through the lens of attachment theory, highlighting the relevance of attachment dynamics in understanding and addressing the impact of MST and how this understanding can inform therapeutic and support efforts in military and civilian contexts alike. The purpose of this section was to address the theoretical, empirical, and practical implications of the study. This included theoretical, empirical, and practical implications of this research.

Theoretical Implications

The attachment theory emphasizes the significance of early emotional bonds in shaping individuals' cognitive and emotional processes. In this context, the alignment of the study's findings with attachment theory underscored the importance of attachment dynamics in the context of MST. The empirical evidence presented in this study corroborates the foundational principles of attachment theory, emphasizing that disruptions in attachment patterns can contribute to trauma-related symptoms and complex cognitive processes influenced by early attachment experiences.

Moreover, the study's resonance with attachment theory deepens our understanding of how attachment dynamics influence survivors' disclosure patterns and trust issues. Attachment theory posits that disruptions in attachment bonds can lead to difficulties in seeking support and forming secure emotional connections, which aligns with the study's findings regarding survivors' challenges in sharing their experiences and trust-related issues.

Additionally, when survivors' altered perceptions of themselves and the world are viewed through the lens of attachment theory, it underscores the enduring impact of early attachment experiences on individuals' cognitive schemas. Attachment theory suggests that these disruptions in attachment can lead to distorted self-perceptions and mistrust of others, which are consistent with the study's findings.

These theoretical implications highlight the practical application of attachment theory in addressing MST survivors' mental health and intimate partner relationship challenges. By recognizing the role of early attachment bonds in shaping individuals' cognitive and emotional responses to trauma, interventions informed by attachment theory may provide valuable insights and strategies for supporting MST survivors in their healing journey. This shift in theoretical perspective opens new avenues for understanding and addressing the complex dynamics of MST and its aftermath.

Empirical Implications

The empirical implications of this study, when considered through the lens of attachment theory, contribute significantly to the growing body of research on MST and its multifaceted impact. This perspective underscores the importance of understanding how early emotional bonds shape individuals' responses to MST and the implications for their intimate partner relationships, mental health, and attitudes toward the military.

Firstly, this study fills crucial gaps in the empirical literature by delving into the lived experiences of MST survivors from an attachment theory standpoint. It provides valuable insights into how MST disrupts attachment patterns and affects individuals' abilities to form and maintain secure emotional bonds, which is central to attachment theory's framework. By

highlighting the role of attachment dynamics, this study expands our understanding of the complexities inherent in the aftermath of MST and the enduring impact on survivors' well-being.

Moreover, the alignment between the study's findings and previous research within the context of attachment theory underscores the consistency and validity of these themes across diverse populations of MST survivors (Smith et al., 2019; Kimerling et al., 2018; Barnes et al., 2020). Attachment theory emphasizes that early attachment experiences can have lasting effects on individuals, and this alignment reinforces the importance of recognizing the role of attachment in the MST survivors' experiences.

The study's comprehensive exploration of survivors' emotional barriers, coping mechanisms, and intimacy challenges extends empirical knowledge about survivors' strategies to navigate the aftermath of MST (Jones et al., 2020). Attachment theory suggests that early attachment experiences may influence these strategies and that interventions tailored to attachment-related challenges may be especially effective in supporting MST survivors.

Practical Implications

The practical implications of this study extend to clinical practice, policymaking, and support services for MST survivors. The in-depth understanding of survivors' experiences offered by this research equips mental health professionals with insights to tailor therapeutic interventions rooted in the attachment theory. The study's revelations about communication challenges, emotional barriers, and intimacy issues provide clinicians with a roadmap for addressing the multifaceted impact of MST on intimate partner relationships. Additionally, identifying coping mechanisms and holistic support strategies empowers mental health practitioners to develop comprehensive treatment plans encompassing survivors' emotional, psychological, and relational needs.

Policymakers can draw on the study's findings to advocate for systemic change within military institutions, offering survivors improved avenues for reporting, healing, and seeking justice. The empirical insights about attitudes toward the military shed light on cultivating institutional accountability and cultural transformation. These practical implications highlight the urgent need for collaborative efforts between clinicians, policymakers, and military institutions to provide comprehensive support for MST survivors and effect lasting change within the system.

Delimitations and Limitations

This section acknowledges the scope and boundaries of the study, addressing the delimitations that might have influenced the research outcomes. Additionally, the study's limitations will be openly discussed to provide a clear understanding of the study's potential constraints.

Delimitations

This study intentionally delimited its participant pool to include only 14 individuals who have experienced military sexual trauma. The selection of this limited number of participants was grounded in exploring the nuanced and individualized experiences of MST survivors in depth. Previous research on qualitative studies supports that a small sample size can yield rich and detailed insights into participants' lived experiences (Guest et al., 2017). Additionally, the decision to focus exclusively on active-duty service members and veterans participating in ethnographic interviews aimed to provide a deep and contextual understanding of how MST impacts their intimate partner relationships. This ethnographic approach aligns with the study's phenomenological design, allowing for a comprehensive exploration of participants' subjective experiences (Borrego et al., 2021).

The rationale behind limiting the participant pool to 14 individuals was to ensure a rigorous and in-depth analysis of MST survivors' lived experiences within the study's scope. The research aimed to uncover the intricacies of these survivors' experiences through detailed narratives and insights, which a smaller participant pool allowed (Guest et al., 2017). By narrowing the focus to active-duty service members and veterans, the study sought to understand how MST specifically impacts individuals within the military context. This specificity enabled the exploration of unique factors associated with military culture, which could influence survivors' attitudes, coping mechanisms, and interactions with their intimate partners.

Limitations

One notable limitation of this study is the sample composition, which consisted of 13 female participants and only one male participant. This gender imbalance may have introduced potential bias and limited the study's ability to fully capture the diverse experiences and perspectives of MST survivors. While the study aimed to explore the experiences of both male and female survivors, the predominantly female sample may have skewed the findings toward female perspectives, potentially missing out on the nuances of male experiences (Braun & Clarke, 2019).

Another limitation stems from the focus on military participants exclusively. While this focus aligns with the research's primary aim of exploring MST's impact within the military context, it does not encompass the broader spectrum of survivors who may have experienced MST outside the military setting. This limitation could restrict the generalizability of the study's findings to a broader population of survivors who have encountered MST in different contexts (Creswell, 2017).

Lastly, conducting an interview of members of the armed forces from all services could shed additional light on the concerns surrounding MST. Each service has its unique manner of dealing with victims of MST and perpetrators of MST. Though all services are under the same umbrella of the Uniform Code of Military Justice and works under the auspice of the same laws, some services conduct investigations of MST differently than others, therefore, researching the limitation of the services chosen in this study would broaden our understanding by representing other services in future study.

Recommendations for Future Research

Drawing from the study's outcomes, this section offers suggestions for future research directions. These recommendations aim to contribute to a more holistic understanding of MST's effects and the development of targeted interventions for survivors and their intimate partner relationships.

This study deliberately delimits its scope to include a small number of participants and focuses on active-duty service members and veterans to ensure a thorough examination of their lived experiences. However, the limitations arising from the gender composition of the sample and the exclusive military focus underscore the need for cautious interpretation of the findings and consideration of their applicability to a broader range of survivors and contexts. Based on the study's findings, limitations, and delimitations, several recommendations and directions for future research can be suggested. These recommendations aim to build upon the current study's insights, address its limitations, and explore new relationships between MST and its impact on intimate partner relationships.

Diverse Participant Samples

Given the gender distribution of the current study's sample, future research should prioritize a more diverse participant composition, including a balanced representation of male and female survivors of MST. This will allow for a comprehensive understanding of all genders' unique challenges and experiences in the military.

Exploring Cultural Variation

Inclusive of a more extensive demographic representation, researchers should investigate the influence of cultural backgrounds on the impact of MST on intimate partner relationships. A cross-cultural study could reveal culturally specific coping mechanisms, resilience factors, and challenges, thus contributing to a more comprehensive framework. Though this study did include Caucasian, African American, Hispanic, and mixed-race representations, there were not enough participants in each racial category to make intelligent assumptions about each of them.

Longitudinal Studies

Employing longitudinal designs can provide valuable insights into the trajectory of MST's impact on intimate partner relationships over time. Researchers can capture the evolving nature of their relationships and mental health by long-term tracking participants' experiences, changes, and coping strategies.

Comparative Studies

Conducting comparative studies between survivors who have accessed different types of mental health support and those who have not can shed light on the effectiveness of these therapeutic approaches. Such studies could reveal which interventions are more conducive to enhancing survivors' overall well-being and relationship dynamics.

Mixed-Methods Approach

Integrating quantitative methods with qualitative approaches could offer a comprehensive view of the associations between MST, mental health outcomes, and intimate partner relationships. This combination would allow for exploring broader trends and patterns while capturing rich narratives and individual experiences.

Partner Perspectives

Future research could also explore the perspectives of partners of MST survivors. This would provide a holistic understanding of the challenges survivors and their partners face, shedding light on the dynamics of support, communication, and intimacy within these relationships.

Comparative Military and Civilian Contexts

Comparing the impact of MST on intimate partner relationships in military and civilian contexts can provide insights into the unique challenges posed by the military environment. This comparison would allow researchers to discern whether particular challenges are specific to the military culture or are more universally experienced.

Online Support Networks

Investigating the role of online support networks and virtual communities for MST survivors could reveal how digital spaces contribute to their coping strategies and healing processes. Such platforms might provide anonymity and a sense of belonging for survivors to share their experiences.

Intersectionality

Recognizing the intersectionality of identities, such as race, sexual orientation, and socioeconomic background, is crucial. Future research should explore how these intersecting

identities interact with the experience of MST and its subsequent impact on intimate partner relationships.

By pursuing these recommendations and directions, researchers can further advance the field's understanding of MST's multifaceted impact on intimate partner relationships and contribute to developing more targeted interventions and support systems for survivors.

Summary

The concluding section of this chapter provides a concise summary of the entire research journey, reiterating the study's key findings, insights, and contributions to the field of military sexual trauma and intimate partner relationships. As the final chapter of this research, the conclusion captures the collective insights gained, fosters connections to existing knowledge, and underscores the significance of understanding the complex dynamics of MST's impact on intimate partner relationships.

This phenomenological study delved into the intricate and often uncharted territory of the impact of military sexual trauma on intimate partner relationships among active-duty service members and veterans. Guided by John Bolby's attachment theory, the research aimed to uncover how MST shapes survivors' intimate connections, mental health, and attitudes toward the military. The study's findings underscored the pervasive impact of MST on survivors' lives, providing a comprehensive view of the challenges they face within intimate partner relationships and their mental well-being. The implications of this research are multifold and have significant theoretical, empirical, and practical implications.

The study's alignment with the theoretical framework, particularly the attachment theory, deepened our understanding of how distorted cognitive patterns, trauma reappraisal, and altered perceptions influence survivors' experiences. These implications underscore the relevance of

these theories in guiding interventions that address distorted cognitions and promote healing. The findings corroborated previous research, highlighting the complexities of survivors' experiences. The study extended existing knowledge by uncovering the intricate layers of MST's impact, encompassing emotional barriers, intimacy challenges and mental health struggles. This contributes to a more holistic understanding of the ramifications of MST on multiple dimensions of survivors' lives.

The study's insights have practical implications for support systems, intervention strategies, and policy changes. Recommendations for diverse participant samples, longitudinal studies, and comparative analyses offer valuable guidelines for researchers, clinicians, and policymakers to enhance interventions that facilitate healing and foster healthier intimate partner relationships among MST survivors.

Key Takeaways

Complexity of Intimate Partner Relationships. The study highlighted the intricate process of disclosing MST experiences within intimate relationships, shedding light on the erosion of trust and emotional barriers that often follow. This underscores the importance of targeted interventions to facilitate effective communication and support for survivors and their partners.

Enduring Psychological Toll. The study emphasized the persistent mental health implications of MST, echoing previous research while revealing the profound interplay between trauma-related symptoms and survivors' overall well-being. This highlights the need for comprehensive mental health support services tailored to MST survivors.

An illustrative anecdote from the findings exemplifies the study's key takeaways: Remie, a victim of MST, disclosed her trauma to her partner, who struggled to comprehend the depth of

her experiences. This led to a breakdown in communication and emotional distance within their relationship. Remie's experience mirrors the broader findings of the study, highlighting the need for interventions that address communication challenges and emotional barriers, fostering resilience and healing within intimate partner relationships.

In conclusion, this study uncovers the intricate nexus of military sexual trauma, intimate partner relationships, and survivors' mental health. By aligning with established theories, building upon empirical evidence, and offering practical recommendations, the research illuminates the path forward to better support MST survivors and foster healthier and more resilient intimate partner relationships within the military.

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Appendix A

Demographic Questionnaire

The purpose of this study is to investigate how a military sexual traumatic event can impact an intimate partner relationship. This questionnaire is intended to capture demographic information, gather limited information about military sexual events, and confirm participants' willingness to participate in the study.

Thank you for your participation.

1. Please provide the following (*Required):
    a. *First and Last Name: _____
    b. *Email Address _____
    c. *Gender: _____ *Age: _____
    d. *Race/Ethnicity: _____
    e. *Branch of Service: _____
    f. *Length of Service: _____ years
    g. *Rank (at the time of the assault): _____

2. Did you know your assailant?	Yes	No
3. Did the assault happen while you were deployed?	Yes	No
4. Did you report the assault?	Yes	No
5. Was there an investigation?	Yes	No
6. Were you satisfied with the results of the investigation?	Yes	No
7. Did you seek mental healthcare after the assault?	Yes	No
8. Were you diagnosed with MST?	Yes	No

9. Do you have any other mental health diagnosis as the result of your MST?

Yes No

10. Were you in a relationship at the time of the assault? Yes No

11. Are you currently in a relationship? Yes No

12. Does your current partner know of the assault? Yes No

13. Have you experienced sexual dysfunction since the MST? Yes No

14. Have you experienced relationship dissatisfaction since the MST?

Yes No

15. *Explain why you are interested in participating in this study.: _____

_____

_____

Appendix B

Recruitment Flyer

Research Participants Needed

A Phenomenological Study on Veterans' Military Sexual Trauma and Its Impacts on Intimate Partner Relationships

- Are you a Veteran?
- Are you a survivor of MST?
- Are you interested in sharing your story?

If you answered **yes** to each of the questions listed above, you may be eligible to participate in a research study.

The **purpose** of this research study is to investigate how a military sexual traumatic event can impact intimate partner relationships. Participants will be asked to share their experiences about how their MST and how has impacted their intimate partner relationships.

Benefits include contact information of a qualified professional who can assist with any questions concerning military sexual trauma. Participants will also receive the utmost privacy, my eternal gratitude, and a **$50 Visa gift card** for participating.

If you would like to participate, please complete the MST Demographic Questionnaire or contact the researcher at the phone number or email address provided below.

Should you be chosen for the study, a consent document will be sent to you one week before the interview.

Jaretta Buckholtz, a doctoral candidate in the Department of Community Care and Counseling, School of School of Behavioral Sciences at Liberty University, is conducting this study.

Please contact Jaretta Buckholtz at [redacted] for more information.

Liberty University IRB – 1971 University Blvd., Green Hall 2845, Lynchburg, VA 24515

Social-Media Recruitment

Facebook

ATTENTION FACEBOOK FRIENDS: I am conducting research as part of the requirements for an EdD in Community Care and Counseling – Traumatology at Liberty University. The purpose of my research is to investigate how a military sexual traumatic event can impact intimate partner relationships. To participate, you must be a veteran 18 years of age or older who have experienced a military sexual traumatic event. Participants will be asked to take part in an interview via Zoom, which should take 60-90 minutes to complete. If you would like to participate and you meet the study criteria, please complete this form. If you prefer to speak with me about the study, I can be reached at [redacted]. A consent document will be emailed to you one week prior to the scheduled interview. Participants will also receive the utmost privacy, my eternal gratitude, and a $50 Visa gift card for participating.

Twitter

Are you a veteran, 18 years of age or older, who has experienced a military sexual traumatic event, and is interested in taking part in a study on how a military sexual traumatic event can impact intimate partner relationships? Direct message me for information about the research study.

Appendix C

IRB Approval Letter

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

June 22, 2023

Jaretta Buckholtz
James Kasten

Re: IRB Exemption - IRB-FY22-23-1750 A Phenomenological Study on Veterans' Military Sexual Trauma and Its Impacts on Intimate Partner Relationships

Dear Jaretta Buckholtz, James Kasten,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2. (iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,
G. Michele Baker, PhD, CIP
Administrative Chair
Research Ethics Office

Appendix D

Interview Questions

Rapport Questions

1. Can you please introduce yourself and tell me a little bit about who you are?
2. Is there any topic or question you are uncomfortable discussing during this interview?
3. What motivated you to participate in this research study?
4. Before we begin, do you have any questions for me, specifically about this study?

Questions Related to the MST

5. Please describe the events that led up to your MST.
6. Please describe what you were feeling before your MST happened.
7. Please describe what you were feeling during your MST.
8. Please describe how you were able to stop the action.
9. Please describe what you were feeling after your MST happened.
10. Did you communicate with the perpetrator after the event, and if so, what was discussed?
11. Who did you notify anyone in your chain of command of your MST?
12. Tell me about the investigation if you reported it to your chain of command.
13. What was the outcome of the investigation and was it handled to your satisfaction (If reported)?
14. Since your MST, have you had interactions with other survivors of sexual trauma? How did those conversations go?

Questions Related to Mental Health Diagnoses

15. Describe what assistance you received from a mental healthcare professional that you felt helped you process what happened.
16. What other mental health diagnoses have you received because of your MST?

17. What assistance did you receive or are you receiving to help you with the subsequent diagnoses?
18. How have the new diagnoses impacted your intimate partner relationship(s)?

Questions Related to Sexual Dysfunction

19. What sexual dysfunction(s), mentally and/or physically, are you experiencing because of your MST?
20. Are there any other experiences or factors that have influenced your approach to intimate relationships after the trauma?
21. Have you ever felt unable to be intimate with your partner because of your MST? If so, can you tell me more about that?

Questions Related to Relationship Dissatisfaction

22. How do you disclose your MST to your romantic partner(s)?
23. How have your romantic partner(s) responded to the news of your MST?
24. How has your MST impacted your current (or most recent) relationship?

Closing Questions

25. Is there anything else you would like to share?
26. I am hoping to forward my research to members of Congress and the Veterans Administration. Do you have a message for them that you would like me to pass on?

Appendix E

Recruitment Follow Up

Dear Potential Participant:

As a graduate student in the Department of Community Care and Counseling, School of Behavioral Sciences at Liberty University, I am conducting research as part of the requirements for a doctoral degree. Last week an email was sent to you inviting you to participate in a research study. This follow-up email is being sent to remind you to complete the survey if you would like to participate and have not already done so. The deadline for returning the survey is **7/31/2023.**

To participate, you must be a veteran, 18 years of age or older, who has experienced a military sexual traumatic event. Participants will be asked to take part in an audio- and video-recorded interview via Zoom, which should take 60-90 minutes to complete. Names and other identifying information will be requested as part of this study, but the information will remain confidential.

If you would like to participate and you meet the study criteria, please complete the MST Demographic Survey. If you prefer to speak with me first about the study, I can be reached at [redacted].

A consent document is attached to this email. The consent document contains additional information about my research. If you choose to participate, you will need to sign the consent document and return it to me at the time of the interview. Doing so will indicate that you have read the consent information and would like to take part in the study. Participants will also receive the utmost privacy, my eternal gratitude, and a $50 Visa gift card for participating.

Sincerely,

Jaretta A Buckholtz,

Doctoral Candidate