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Perceptions of Help-Seeking Experiences Among Female Veteran Survivors of Military Sexual Assault

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Walden University
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Abstract

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Hiza Jackson-Price

MA, Webster University, 2007

BS, Campbell University, 2004

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

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Abstract

The numerous obstacles that female military sexual assault (MSA) survivors face after discharge from military service are well documented in research. However, there is a need for qualitative studies regarding perceptions of female veterans' help-seeking experiences in disclosing MSA to understand how to encourage them to seek help and provide it for them when they do seek help. Based on this scarcity of knowledge, this study aimed to provide a voice to this population as well as provide results that can be used to aid this population. A social constructionist perspective, which postulates that knowledge and experience are constructed by an individual's social, cultural, and economic life, was the conceptual framework used to examine the survivors' help-seeking perceptions. Qualitative data were collected through in-depth interviews of fourteen female veteran MSA survivors who recounted impressions of their lived experiences with the help-seeking phenomenon. Thematic analysis was used to explore and describe the experiences of post-service female MSA survivors by uncovering the shared themes and meanings between all participants. Participants had mixed experiences with their providers during the disclosure process. Some participants had positive experiences with all providers they visited, making them feel comfortable and satisfied with the process. Others reported feeling that their MSA was not taken seriously or that their experiences were not a big deal. This research offers a more comprehensive understanding of help-seeking among MSA survivors to raise practitioner and stakeholder awareness that could lead to advancements in the provision treatment and services for MSA survivors, paving the way for positive social change.

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Dedication

For my mother, Julian Geraldine Boyette, who sacrificed so much for me and my siblings and to whom I am eternally grateful for providing me with the strength and inspiration to stay the course and aggressively pursue my dreams. Thank you for all of the invaluable lessons that you taught me. I wish we had more time together, but I know you are still with me in spirit, and I will carry you in my heart always.

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First, I give thanks to my Lord and Savior, Jesus Christ for sustaining me through this journey, although there were many times when I questioned why I even started it in the first place but was blessed to persevere and reach this point in my academic career regardless. I am eternally grateful for my family—my husband Jamie, my mother Geraldine, my son Raymond II, my daughter Nyesha, and my pet cat Pearl, for their loving encouragement and support through this entire process. A special thank you to my chair, Dr. Stephen Hampe, and second committee member, Dr. Debra R. Wilson, for providing the guidance necessary to allow me to see my doctoral dissertation through to completion. Lastly, many thanks to Rachel, Stephanie, and Tom for lending their valuable assistance to keep me on track, thus making this journey a successful one.

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Chapter 1: Introduction to the Study

Military sexual trauma (MST) refers to undesired sexual experiences, including military sexual assault (MSA) or sexual harassment that occur during military service with both male and female service members (U.S. Department of Veterans Affairs [VA], 2010). Sexual experiences that occurred when an individual was unable to consent, such as if they were intoxicated, also constitute MST, and coercion (e.g., physical force) for sexual activity can be involved in MSA in addition to being unconscious, unaware of what is occurring, or unable to consent (Rape and Sexual Assault Generally, 2017). Additional MST experiences involve the nonconsensual sexual touching or grabbing, unwelcome sexual advances, threatening, and insulting remarks about body or sexual activities. A wealth of research exists regarding the impact of MST on service members; however, there is a knowledge gap in understanding how female MSA survivors perceive their experiences with help-seeking after they discharge from military service. Therefore, this study was conducted to explore the phenomenon of the post-service help-seeking experiences of female MSA survivors.

Chapter 1 addresses the Department of Defense Sexual Assault Prevention and Response Office (DoD SAPRO) MSA prevalence statistics, and a brief explanation of MST/MSA treatment and disclosure considerations is presented. Additionally, details of the societal problem that exists as a result of MSA are highlighted. The rationale for the undertaking of this study as well as the questions that this study answered are also explored in Chapter 1.

Background

Prevalence of MSA

MST includes MSA or sexual harassment that happens during military service and is a growing public health concern, with more than 40% of female veterans and 4% of male veterans reporting MST (Barth et al., 2016). The DoD SAPRO (2016) issued an annual report on MSA in 2016, which provided statistics and analyses of reported MSA as well as policy and program improvements. Approaches and programs for addressing MSA need to consider factors like root causes and various myths as they relate to MSA, military cultural elements that perpetuate sexual assault, and the prevalence of male MSA (Castro et al., 2015).

Treatment for MSA

MST should be a treatment concern for not only VA clinicians, as civilian physicians also need to be aware and able to provide the sensitive care required, given that many veterans also receive some of their medical care in outpatient facilities outside of the VA system (Baltrushes & Karnik, 2013). However, help-seeking barriers impair the well-being of MST survivors and exacerbate depression among active duty servicemembers who did not feel safe from sexual assault (Holland et al., 2010).

Sexual Assault Disclosure

Although many women are receptive to disclosing their sexual assault, they are often not screened, so many sexual assault survivors do not receive the sexual assault resources and support that they need (Berry & Rutledge, 2016). Veterans have reported that they experienced both positive and negative reactions to their initial disclosures; however, nearly all veterans concurred that disclosure was beneficial overall (Jeffreys et

al., 2010). But there is a need to study the disclosure of MSA among female veterans, more specifically how they perceived their help-seeking experiences that involved the disclosure of MSA.

Problem Statement

The traumatic effects of MSA are often suffered well after active-duty service ends. Roughly 41% of female veterans and 4% of male veterans reported MST, and 10% of female veterans and 0.5% of male veterans have reported MSA (Barth et al., 2016). A 2016 survey also indicated that 4.3% of active-duty women and 0.6% of active duty men reported being sexually assaulted in the year before they were surveyed (U.S. DoD, 2016). Comparatively, across the U.S. population, sexual assault occurs at a rate of 0.16% per year (Truman & Morgan, 2016). Though males and females experience MSA, females are affected disproportionately, and although females encompass only 14% of U.S. Army soldiers, they constitute 95% of MSA victims (Dinneen, 2015).

The first step toward healing trauma-related distress is disclosure; however, barriers associated with disclosure during the help-seeking process include fear of potential negative consequences associated with trauma disclosure, lack of trust in a provider, and trauma avoidance (Jeffreys et al., 2010). Other barriers that may impact the help-seeking experiences of female veteran MSA survivors after they leave military service include logistical problems such as lack of transportation and long wait times and stigma-related beliefs such as shame and concerns about the reactions of others (Holland et al., 2015). Those who want to seek help may be subjected to increased distress if they perceive barriers to getting help (Holland et al., 2015). Notwithstanding the physical and psychological trauma of sexual assault, survivors can experience “secondary

victimization," which occurs when service providers fail to adequately respond to survivors and project blame upon survivors when they seek help (Harbottle, 2014, p. 12).

Conversely, concern for medical or physical consequences, direct questioning by a provider, having a knowledgeable provider with a positive attitude, relevance of discussion to the reason for the appointment, and a trusting relationship with the provider can facilitate disclosure of sexual assault history to health care providers (Berry & Rutledge, 2016). Research indicates that most survivors of trauma are responsive to physician questions that are direct and empathic, although they are not likely to volunteer information pertaining to sexual assault (Baltrushes & Karnik, 2013). This speaks to the need for increased awareness of the attitudes and behaviors of health care providers regarding female veteran MSA survivors' disclosure during the help-seeking process.

Research has indicated that female veterans are underreporting MSA, but it is unclear whether that is because of perceived barriers to help-seeking (Barth et al., 2016; Jeffreys et al., 2010; U.S. DoD, 2016). Thus, it is necessary to explore female veteran MSA survivors' perceptions of, and experiences with, seeking help for their sexual assault trauma after they have left military service to better inform community providers and stakeholders on how to provide optimally efficacious treatment for this population. A growing body of literature has acknowledged the various challenges female MSA survivors have after they have left military service (Castro et al., 2015), such as possible barriers encountered by female veterans for access to MST-related care within the VA health care system (Turchik et al., 2014). But a gap exists in the current literature on the perceptions of female veterans regarding their help-seeking experiences after military service in which they disclose MSA or MST. Focusing on female veterans' perceptions

of MSA disclosure experiences using qualitative phenomenology in this study will provide the knowledge necessary to improve provision of care for MSA and increase help-seeking behaviors.

Purpose of the Study

The purpose of this phenomenological study was to explore perceptions of the help-seeking experiences of female veteran MSA survivors after they have discharged from military service, which can provide enhanced insight to practitioners and stakeholders. Positive social change can transpire in many levels of society (Morris, 2017). It is hoped that this study will contribute to the knowledge base on this topic as well as promote the worth and dignity of the female veteran population under study. Gaining understanding of female veteran MSA survivors' experiences and perceptions of help-seeking may enable practitioners to better facilitate disclosure and help-seeking behaviors of MSA survivors.

Seeking to explore the perceptions and understand the help-seeking experiences of this population, a phenomenological research design was determined to be the most practical for my research study because this approach helps to describe people's experiences (Rudestam & Newton, 2015). I conducted semistructured, audio-recorded, virtual interviews with female MSA survivors. Through these interviews, I gained a deeper insight into this topic as participants described and discussed the most salient aspects of their experiences related to the research questions (RQs; McIntosh & Morse, 2015).

Research Questions

RQ1: What are the lived experiences of the post-service help-seeking process among female veteran MSA survivors when disclosing a sexual assault incident?

RQ2: How do female veteran MSA survivors experience the reactions expressed by those persons that they disclosed to?

RQ3: How do female veteran MSA survivors perceive the impact of provider responses on recovery?

Conceptual Framework

A social constructionist perspective was used as the conceptual framework to examine MSA survivors' help-seeking perceptions. This perspective differs from conventional psychological approaches in that it recognizes how knowledge and experience are constructed by aspects of a person's life (Leung, 2017, p. 928). Accordingly, the social construction processes that facilitate the MSA survivors' reactions are influenced by social context through their culture, interpersonal encounters, and availability of support (Leung, 2017). Furthermore, the study of female veterans' perceptions of their post-service help-seeking experiences from a social constructionist perspective coincides with the constructivist perspective's focus on how people understand their experiences (Raskin, 2002, p. 1).

An additional conceptual framework considered in this study was three pertinent help-seeking stages for comprehending the help-seeking processes of intimate partner violence survivors, which was proposed by Liang et al. (2005). This conceptual framework applied to the help-seeking processes of female veteran MSA survivors in that there are three steps to seeking care for sexual assault: (a) problem acknowledgement and

definition, (b) deciding to seek help, and (c) choosing a help provider. These steps are not necessarily linear as female veteran MSA survivors may rotate back and forth between the steps prior to veritably seeking help from a selected provider (Liang et al., 2005). Moreover, barriers may emerge during the help-seeking process that impede female veteran MSA survivors' efforts to obtain care after a sexual assault (Holland et al., 2016). More information about the frameworks will be provided in Chapter 2.

Nature of the Study

The nature of this study was qualitative with a phenomenological approach, which involved participants describing and making sense of their lived experiences from their own perspectives (Pietkiewicz & Smith, 2014). The specific application of qualitative research involved the various ways in which a phenomenon appears and manifests (Vagle, 2014). A qualitative research approach generated information about the research participants' sexual assault disclosure experiences from their own perspectives. In addition, this approach provided essential information that allowed an enhanced understanding of the sexual assault disclosure phenomenon. A significant part of qualitative research was establishing the presence of emerging themes using semistructured, interviews, which allowed for the discovery and comprehension of phenomena that might not have been discovered otherwise (Vagle, 2014). In this study, I used thematic analysis, as Braun and Clarke (2006) outlined, to analyze the data and to generate codes and themes based on the data.

Definitions

Military sexual assault: "Intentional sexual contact, against a military servicemember characterized by use of force, threats, intimidation, abuse of authority, or

when the victim does not or cannot consent. Sexual assault includes rape, forcible sodomy (oral or anal sex) and other unwanted sexual contact that is aggravated, abusive, or wrongful (to include unwanted and inappropriate sexual content) or other attempts to commit these acts" (U.S. DoD, 2013b, p. 93).

Military sexual trauma: "Psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training" (Department of VA, 2010, p. 1).

Second rape: Negative experiences in which "rape survivors are often denied help by their communities, and what help they do receive often leaves them feeling blamed, doubted, and revictimized" (Campbell et al., 2001, p. 1240).

Secondary victimization: A concept that involves "a prolonged and compounded consequence of certain crimes; it results from negative, judgmental attitudes (and behaviors) directed toward the victim, [which results] in a lack of support, perhaps even condemnation and/or alienation of the victim" (Campbell & Raja, 1999, p. 262).

Assumptions

It was assumed that participants would be willing to participate throughout the course of the study. This was assumed because an informed consent provided to the potential participants delineated that as volunteers in this study, their identities would remain anonymous with the use of subject codes, their confidentiality would be retained as data access would be limited to only me and those authorized to provide direct guidance to me, and they could withdraw from this study at any time without

consequences. It was also assumed that the participants would answer the questions presented in the semistructured, interviews honestly and to the best of their ability based on their experiences with the phenomenon under investigation. This was assumed because those agreeing to participate might have trouble if an upsurge in the traumatic thoughts, feelings, and memories of the past sexual trauma should occur. Hence, participants were treated ethically and with sensitivity and respect.

Scope and Delimitations

The aim of this study was to address the gap in research pertinent to how female MSA survivors perceive their experiences with help-seeking in which they disclose their MSA. This study was delimited to the participant criteria: female victims of sexual assault, age 18 and over, sexually assaulted during military service, and currently residing in the United States. Results were only generalized to the specific participant criteria noted to describe their perceptions of their experiences with the help-seeking phenomenon in which they disclosed their MSA. The scope of this study, therefore, involved 14 female MSA survivors, who were interviewed with a phenomenological research paradigm to collect thick, rich perspectives. This study presented a limited number of experiences from female MSA survivors who reside throughout the United States and sought help by disclosing their MSA. The sample size of 14 participants limits the degree of generalizability to the larger population of female MSA survivors. Thus, the descriptive data can only be transferable to participants who have experienced this phenomenon as well as those from whom they seek help. However, the study's purpose was to explore the perceptions of the participants' rich experiences and not to generalize the findings to a broader population. The lack of generalizability did not preclude the

application of insights gained from the study to individuals having traits like those of the study participants.

Limitations

The results of this study are limited to adult female MSA survivors who are at least 18 years of age. Adult male MSA survivors were not within the scope of this study, which limited the scope of the study to adult female MSA survivors. Access to female MSA survivors was difficult to establish due to the voluntary and sensitive nature of this research. Moreover, because the privacy and safety of sexual assault survivors was vital, this presented a barrier to identification of the participants. Identification of this participant population was coordinated through rape crisis centers and women's centers, behavioral health counseling practices, women's veteran organizations and the Walden University Research pool.

Additionally, at the time of this research, the United States is experiencing a COVID-19 pandemic, resulting in the necessity to replace audio-recorded, face-to-face interviews with audio-recorded, virtual or phone interviews due to a nationwide executive "stay-at-home" order issued for the physical/social distancing of citizens public health concerns. Therefore, a pool of participants was identified with the goal of locating at least 12 participants to gather a wide range of responses. The sampling of a small portion of the population did not capture each and every possible experience attributable to the population, which presented a limitation in this study that saturation did not occur. Accordingly, the amount of information provided for analysis and the transferability of this information to the broader population of female MSA survivors was limited due to the use of a smaller sample size than that of a study using quantitative data. On the other

hand, the data utilized specific parameters; therefore, it provided a richer, more precise depiction of the phenomenological experience than that of quantitative critical relationship analysis. Because of the scarcity of qualitative studies regarding this phenomenon, any information gleaned from this study can be integrated into treatment approaches and future research.

Although the selection of a distinct population for qualitative research was beneficial, the reporting of experiences using the interview method may be viewed as a possible limitation because of subjective discrepancies in a participant's memory recall. More specifically, because the recounting of the female MSA survivors' experiences is taken at face value, there is the possibility that selective or false memories come into play with a population that is being interviewed post-service about their help-seeking experiences involving disclosure of sexual trauma that occurred during their military service.

Another potential limitation of this study was the consideration that in phenomenological research, the researcher is the instrument through which data were collected. This means that there is a potential for a biased interpretation of the phenomenon under investigation. Frequent reviewing of the audio-recorded interviews to capture the essence of the participants' descriptions of their experiences with the phenomenon under study was done to address this bias. Furthermore, the essence of the participants' experiences as reflected in the data collected was verified through follow-ups with the participants after data collection and analysis to ensure accuracy in the participants' data.

Significance

Military culture has perpetuated an environment in which MSA survivors are discouraged from reporting or seeking help as they believed that nothing will be done about it, or they feared reprisal because of a rigid chain of command and "a perceived code of silence" (Castro et al., 2015, p. 55). The response to a sexual assault and the aftermath of it has been described by both military and civilian survivors as more painful than the sexual assault itself (Castro et al., 2015). But literature on the perceptions of help-seeking experiences among female veterans who disclosed their MSA after military service was scarce. This study expounded on the existing knowledge on MSA with the objective of effecting positive social change through a focus on the lived experiences associated with help-seeking in which female veterans disclose the MSA they suffered prior to their discharge from military service. It is anticipated that the results may eventually lead to positive social change from beneficial changes in policies and procedures by better informing providers and stakeholders.

Additionally, this study, through a phenomenological research methodology, allowed insight to be gained into what perceived barriers to healthcare services were identified by female veteran MSA survivors who disclosed their MSA and how they believed these barriers contributed to their reluctance to seek help. The high MST prevalence among female veterans signaled a need for providers and staff within the Veterans Healthcare Administration (VHA) system to exercise sensitivity to the environment of care for these veterans, especially where their safety and comfort were concerned (Yano, 2010). Moreover, lower patient satisfaction was indicative of health care barriers experienced by veteran patients (Kimerling et al., 2011).

The findings of this study will help make better recommendations to community practitioners, public servants, and other stakeholders such as potential difficulties female MSA survivors may have encountered when talking with clinicians and other providers. Victims of sexual assault commonly experience a broad range of physical and emotional effects like depression, anxiety, posttraumatic stress disorder, sleep and eating disorders, and substance abuse, among other things (Rape, Abuse, and Incest National Network, n.d.). Therefore, the help-seeking experiences of sexual assault survivors, reactions they faced upon disclosure, and the impacts of their providers' responses on their own recovery have considerable significance. It is also hoped that a pathway is established by which future research may lead to the elimination of institutional barriers that impede help-seeking, enhanced clinical treatment reporting and protocols, and improved community outreach and awareness for the optimal treatment of this population.

Summary

This qualitative study was conducted with the goal of helping community providers and stakeholders gain an understanding through the perspectives of adult female MSA survivors regarding their post-service help-seeking experiences when they disclose their MSA and the impact that these experiences have on their recovery. A sample of 14 female veterans who were discharged from military service and who had experienced at least one incident of sexual assault during their military service were selected for this study. Research has suggested that sexual assault survivors are susceptible to secondary trauma because of the negative responses and/or treatment that they may have received from community providers and other stakeholders in response to their disclosures (Campbell & Raja, 2005). A more in-depth grasp of the participants'

help-seeking experiences when disclosing their MSA was important to establish a heightened awareness that may lead to improved provider protocols for optimal recovery outcomes of this vulnerable population. The information yielded from this study might be useful for both the female veterans seeking help for MSA as well as those who provide treatment for this population by equipping them with a better understanding of the prevalent themes and patterns associated with this kind of help-seeking that signal the need for social change. This chapter will be followed by a review of the literature in Chapter 2. Chapter 3 will follow with a description of the research methodology, design, participants, procedures, assessments used and how any information gathered was evaluated.

Chapter 2: Literature Review

Female veteran MSA survivors often suffer the traumatic effects of MSA after the end of their active-duty service. Hence, it was necessary to give credence to this population's perceptions of and experiences with seeking help for their MSA trauma to better inform clinical providers and community stakeholders. A growing body of literature has supported the complexities endured by female veteran MSA survivors after they have left the military service (Castro et al., 2015), including barriers for access to MST-related care within the VA health care system that indicate a need for psychoeducation that is gender targeted (Turchik et al., 2014).

The purpose of this phenomenological study was to explore perceptions of the help-seeking experiences of female veteran MSA survivors after they have discharged from military service, which provides insight to practitioners and stakeholders. I conducted an exhaustive review of that literature, which is presented in this chapter. This chapter provides a discussion and review of existing literature pertaining to MSA and treatment options for survivors as well as a discussion of the conceptual foundation for this study: social constructivist theory.

Literature Search Strategy

A literature search was conducted using the following databases: MEDLINE (EBSCO), SAGE Premier, PsycARTICLES, SOCIndex, Google Scholar, PsycINFO, ProQuest Dissertations and Theses, Inter-University Consortium for Political and Social Research, and PsycTESTS. A keyword search was done online to discover other educational and governmental entities that have pertinent information. Keywords used in this search were as follows: *military sexual assault, military sexual trauma, female*

veteran sexual assault survivors, *sexual assault recovery*, *sexual assault trauma*, *help-seeking experiences*, *help-seeking barriers*, *help-seeking satisfaction*, *help-seeking decisions*, *sexual assault disclosure*, *secondary trauma*, *social constructionist perspective*, *qualitative*, and *phenomenological.* This literature search focused on peer-reviewed research articles and journals from the past 5 years; however, literature from the past 10 years was also included in the search.

Conceptual Framework

A social constructionist perspective was used as the conceptual framework for this study, as it helped explain how MSA survivors are influenced by their social and cultural experiences through interactions and support from others (Leung, 2017). Additionally, social constructivist theories suggest how individuals understand their experiences (Raskin, 2002), which applied to the study of female veterans' perceptions of their post-service help-seeking experiences. Female veterans' perceptions of their experiences correspond with the notion that the composition of reality is a progressive process that is manufactured by people taking actions based on their knowledge and the interpretations thereof (Leung, 2017).

Another conceptual framework was a cognitive theory emphasizing help-seeking in stigmatizing situations, with three pertinent help-seeking stages for comprehending the help-seeking processes of intimate partner violence survivors (Liang et al., 2005). This cognitive theory applies to the help-seeking processes of female veteran MSA survivors. The three steps to seeking care for sexual assault include (a) problem acknowledgement and definition, (b) deciding to seek help, and (c) choosing a help provider (Liang et al., 2005). These steps are not necessarily linear, as female veteran MSA survivors may go

back and forth between the steps prior to seeking help from a selected provider, and barriers may emerge during the help-seeking process that impede female veteran MSA survivors' efforts to obtain care after a sexual assault (Holland et al., 2016). Moreover, a significant consideration regarding the use of this conceptual framework in this study is that like intimate partner violence survivors, female veteran MSA survivors' social support perceptions may directly impact their mental health by diminishing their sense of well-being or by reconciling the connection between abuse and mental health (Liang et al., 2005).

Literature Review

A procedure addressing the treatment and care of MSA survivors was reviewed by the DoD in February 2004 under the direction of the former Secretary of Defense, Donald H. Rumsfeld (U.S. DoD, n.d.). The stance and message of the Secretary of Defense to military leadership was that sexual assault would not be tolerated in the Armed Forces (U.S. DoD, n.d.). The Secretary of Defense also conveyed an expectation that the DoD was responsible for the appropriate provision of treatment and care, to include properly meeting the medical and psychological needs of MSA survivors. To this end, the Secretary of Defense directed military leadership to establish protocol for monitoring the effectiveness of SAPR programs and policies as well as ensure timely response to all MSA-related issues as they arise. However, barriers to the knowledge and comprehension of the SAPR processes remain a significant concern because of the need for enhanced communication between military and civilian personnel and associated medical supports to provide for the timely and optimal care for all MSA survivors (Ferguson, 2008).

Despite DoD SAPR policies and programs that have led to major improvements in the medical care of MSA survivors, there are still many challenges (Ferguson, 2008). One major challenge to providing treatment and care for MSA survivors is the lack of official points of entry in deployment and other harsh environments. For example, remote facilities may lack accessible designated contact persons, or there may be no appointed on-call health care provider available to act as a sexual assault examiner to provide care to the MSA survivor and/or suspect (Ferguson, 2008).

In response to these challenges as well as allegations that the DoD was negligent in responding to and caring for MSA survivors (Ferguson, 2008), the DoD made changes in how it dealt with reports of sexual assault (U.S. DoD, n.d.). An integral part of the positive change process resulting from the then recently implemented DoD SAPR policy was the option of MSA survivors to choose a reporting method that could either generate an investigation (unrestricted reporting) or that would keep the MSA confidential (restricted reporting), which would allow for the prompt treatment and care of MSA survivors, regardless of reporting option choice (Ferguson, 2008). Other transformative changes included (a) enhanced sexual assault training for servicemembers, (b) the creation of sexual assault response coordinator positions to aid in addressing sexual assault-related issues, (c) the assignment of victim advocates across all the Armed Forces, (d) increased education and training for sexual assault examiners and recognition of those who are trained, (e) utilization of a treatment team approach for MSA survivor case management to follow the forensic and judicial process of the cases, and (f) the design of integrated technology capable of within Armed Forces tracking of sexual assault case numbers, supplying demographic sexual assault case data, and providing the disposition

of sexual assault cases (U.S. DoD, 2005). Research has shown that comprehensive training exposure predicted a decrease in MSA as well as first-rate knowledge, although the function of comprehensive training varied based on military branch, rank, gender, and sexual assault history (Holland et al., 2014). Without effective MSA training in the military, the DoD would not be able to successfully reduce MSA occurrence.

Military Sexual Assault

MSA refers to sexual assault experiences involving the physical assault and sexual battery that happened during military service (U.S. Department of VA, 2018). Although the DoD defines and responds separately to sexual harassment and sexual assault in keeping with the military and civilian criminal justice system distinctions, the clinical considerations are similarly relevant for the treatment of sexual harassment and sexual assault (Stander & Thomsen, 2016). Therefore, both kinds of victimization have been assessed together in the majority of VA research as MST, a label which signified the broader category consisting of both sexual harassment and sexual assault. MST is defined by the VHA (2010) as:

> Psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training. (p. 1)

Current research shows similarity in the consequences of sexual harassment and sexual assault such as poorer general health, mental health disorders (i.e., post-traumatic stress disorder [PTSD], depression), and work and relationship difficulties (Stander & Thomsen, 2016).

The beliefs and attitudes of the public regarding sexual assault result in the complacency and accommodation of a rape culture in the United States, which perpetuates the normalization and tolerance of rape (Lonsway & Fitzgerald, 1994). This acceptance makes for an environment in which it is difficult for both military and civilian sexual assault survivors to get justice and discourages them from seeking help. Thus, MSA is a continuous and prevalent crime that often goes underreported and is difficult to treat because of inadequate or unattainable services (Groves, 2013). The military must establish policies and programs for the prevention of and response to MSA while ensuring that offenders are prosecuted, and care is provided for survivors (Stander & Thomsen, 2016). Moreover, the military community must be better informed if this problem is to be effectively fought. MST has been a problem in the military community, and it is typically associated with female veterans; however, male veterans also experience sexual assault, generally as hazing or a punishment (Hoyt et al., 2011). The U.S. DoD (2013) reported that since women were inducted into the formerly male-dominated combat theaters, MSA has become more pervasive, with most assaults being male-to-female (87%).

Aside from ineffective MSA prevention and awareness programs, barriers to MSA reporting and treatment need to be addressed and curtailed, as sexual assault routinely occurs in military environments and frequently goes unreported despite the zero-tolerance policy throughout the armed forces (Schmid, 2010). According to the 2012 Workplace and Gender Relations Survey of Active Duty Members, 70% of servicewomen were not likely to report because they did not want anyone to know what happened to them, 66% were uncomfortable with reporting, 51% thought their report

would not remain confidential, 50% believed that nothing would come from reporting, and 43% were reluctant to report after hearing of the negative experiences of others with reporting (Rasmussen, 2016). Though some of these reasons signal a lack of confidence in the military justice system, others are not specific enough to draw conclusions about servicewomen's motivations to not report (Rasmussen, 2016), and it is hard to research due to it being a sensitive issue in the military (Steiger et al., 2010). However, research has suggested that reporting calls the survivors' judgment and effectiveness into question, which could diminish the opportunity to advance (Spence, 2017). The consensus of many MSA survivors is that if they want to keep their career, they carry on as if nothing happened. Furthermore, when MSA survivors find out what other female servicemembers endured after reporting their sexual assaults, this serves as additional motivation to not report MSA to avoid the subsequent victim-blaming and re-traumatization (Lucero, 2015).

Two types of unique reporting procedures of the military (restricted and unrestricted reporting) are another problem (Groves, 2013). Restricted reporting allows for the confidential reporting of MSA to a chaplain, health care provider, victim advocate, or a military-affiliated sexual assault response coordinator in addition to treatment for the MSA without prompting an investigation or publicity. Although restricted reporting is more common because it reduces the likelihood of unfavorable feedback, the perpetrator of the MSA, if known, is not brought to justice and the survivor is without recourse. Conversely, unrestricted reporting is most often used by those less affected by reprisal or condemnation such as spouses, civilians, and retired members (Groves, 2013). This kind of reporting allows for a full investigation through local law

enforcement as well as the military justice system, which includes the servicemembers' chain of command and the providers relegated to restricted reporting. Unrestricted reporting, however, can lead to retribution, unfavorable peer regard, shunning, and if conduct is involved such as excessive alcohol consumption, disciplinary action (Groves, 2013). Hence, the choice of either reporting type can potentially render a servicemember vulnerable to stigmatization or being retaliated against.

Prevalence of MSA

There is a high prevalence of MST, with more than 40% of female veterans and 4% of male veterans reporting MST in a population-based survey of 60,000 Operation Enduring Freedom/Operation Iraqi Freedom-era veterans (Barth et al., 2016). Statistics from the 2016 and 2017 DoD SAPR Annual Report speak to the pervasiveness of sexual violence, which indicated the sexual assault of 8,600 females and 6,300 males (14,900 military servicemembers) in 2016 with the rates of penetrative assault remaining consistent with those from 2014 (Protect Our Defenders, 2018). Additional findings indicated that most of these survivors were sexually assaulted multiple times, resulting in over 41,000 sexual assaults in 2016 alone in which over 1 in 4 females and 1 in 3 males were sexually assaulted by someone in their chain of command. The sexual assault of female veterans remains at levels comparable to those among civilians, and intraforce violence of this type is significantly higher than that of other criminal offenses (Wood & Toppelberg, 2017). Female veterans, compared to male veterans, had notably higher prevalence rates than the review of VA records indicated regardless of the kind of victimization event, whether sexual harassment or assault (Wilson, 2016).

Although the VA has established mandatory MST screening processes and increased MST treatment options, the MST prevalence rates obtained through self-report measures and interviews has exceeded the MST prevalence rates documented in VA medical records. These findings indicate that MSA disclosure is less likely during contact with VA providers, especially if the services are not MST-related (Wilson, 2016). Ending combat exclusion for military women and improving their status by improving recruitment, retention, and promotion endeavors as well as increasing the number of women in the armed forces and the percentage of military women in key positions may make the gender line less important, which would help both MSA prevalence rates and MSA reporting rates (Schmid, 2010). Other preventative measures for reducing the prevalence of MST may include maximizing education and legal prosecution of military perpetrators and improving access to mental health services for veterans who have endured MST (O'Brien & Sher, 2013).

Research has also indicated other contributing factors to MSA prevalence and the impact of sexual violence in the military (Turchik & Wilson, 2010). A combination of factors may contribute to MSA, as a significant number of servicemembers are impacted by it. For instance, sociodemographic factors unique to the make-up of the active-duty military environment may affect MSA prevalence, such as a smaller proportion of women; younger persons; more individuals who are high school graduates; fewer people who were college students; fewer Caucasian, Hispanic, and Asian service members; and more African Americans than the general U.S. population according to the U.S. Government Accountability Office (Turchik & Wilson, 2010). MSA has led to impacts such as stress disorders (Fontana & Rosenheck, 1998), and both male and female active

duty servicemembers have had elevated psychiatric symptoms and debilitated functioning because of their sexual harassment or MSA experiences (Turchik & Wilson, 2010).

An understanding of the pervasiveness of MSA, especially in which the female MSA survivors were assaulted multiple times, signals the need to fill a knowledge gap regarding the lived experiences associated with female MSA survivors' perceptions of their help-seeking encounters in which they disclose their MSA. It has been noted with both MSA and civilian survivors that sexual assault response and its aftermath can be more traumatic than the sexual assault itself, which may account for reluctance to report and/or seek help (Castro et al., 2015). Therefore, understanding female veterans' perceptions of their help-seeking seeking experiences in which they disclose their MSA may encourage improvement of sexual assault prevention programs to help decrease the incidence of MSA as well as result in enhanced interventions to increase the likelihood of timely MSA reporting and lead to beneficial help-seeking experiences.

Provider Treatment Considerations

Baltrushes and Karnik (2013) pointed out that MST should be a treatment concern for not just VA clinicians, but civilian physicians also need to be aware and able to provide the sensitive care required, given that many veterans also receive some of their medical care in outpatient facilities outside of the VA system. The authors further advise that primary care physicians bring up the subject by specifically asking the veteran about traumatic experiences and that this should be a routine part of a holistic medical assessment, including MST screening. Accordingly, the primary care provider can play an important role in assisting veterans with transitioning back to their civilian lives and adjustment to their local communities (Baltrushes & Karnik, 2013).

Bell and Reardon (2011) posited that although the provision of care to trauma survivors overall can be formidable, working with sexual assault survivors can be even more complicated in some ways. The authors presented some general guiding principles applicable across any number of roles that providers may have with sexual assault survivors: (a) be aware of the limits of one's own competency and assess the need for referral and/or consultation, (b) consider sexual trauma as a possible factor or explanation for a veteran's presentation, (c) assume a strengths-based approach by providing basic psychoeducation regarding the effects of sexual assault and engage in efforts to normalize the survivors' emotions and other reactions, (d) utilize positive rapport as a tool to build a solid working collaboration by establishing ways to make the therapeutic alliance not only a basis for treatment, but a treatment component as well, (e) acknowledge the difficulties sexual assault survivors face as they struggle with a variety of double binds throughout the recovery process and a part of the clinicians' role is to clarify for the survivor that there are not always clear solutions and that there may be both advantages and disadvantages regardless of the choices made, and (f) make self-care a priority by replenishing self-care activities to help ensure our ability to maintain sufficient emotional endurance, empathy, and perspective that facilitates sound clinical care.

Clinical Implications

Sexual assault survivors suffer from a variety of long-term mental and physical health consequences. They may deal with shame, self-blame, guilt, anger and an inability to trust others in the aftermath of the trauma, they frequently experience psychiatric pathology such as depression, PTSD, other anxiety disorders and substance use disorders.

Consequently, these struggles may lead to homelessness, unemployment, interpersonal relationship disruption, physical illness, more traumatic encounters, and possibly suicide.

An analysis of studies retrieved from major behavioral databases by O'Brien and Sher (2013) revealed a correlation between MST and a rise in mental health illnesses, including PTSD, substance use disorders, depressive and anxiety disorders, eating disorders and suicidality. MST is also associated with an escalation in medical ailments, mainly pain-related symptoms that involve several organ systems, resulting in gastrointestinal, neurological, genitourinary and musculoskeletal sequelae. Unquestionably, MST is a widespread healthcare issue that can affect any veteran and warrants ongoing clinical attention as well as more clinical resources devoted to it (O'Brien & Sher, 2013). Furthermore, Berry and Rutledge (2016) further suggest that healthcare providers exercise vigilance to raise awareness, emphasize sexual assault prevention, and mitigate associated short-term and long-term sequelae.

A key clinical consideration in an investigation by Brignone et al. (2016) was concerned with the question of whether MST exposure evidenced by positive MST screen is a risk factor for post-deployment homelessness and whether this risk factor vary amongst male and female veterans. Brignone et al. (2016) studied 601,892 veterans that were deployed in Iraq or Afghanistan, who were discharged from the military between 2001 and 2011, who had utilized VHA services afterward and screened positive for MST at VHA facilities.

The researchers discovered that positive MST screens were significantly and independently correlated with post-deployment homelessness between male and female veterans, even after adjusting for comorbid mental health and substance abuse disorders.

Furthermore, the association between male and female veterans was significant in the 30-day and 1-year cohorts (30-day: AOR, 1.54; 95% Cl, 1.18-2.02; and 1-year: AOR, 1.46, 95% Cl, 1.23-1.74), which revealed a differentially stronger risk of homelessness among male veterans with a positive MST screen (Brignone et al., 2016). Conclusively, MST is associated with detrimental health results after military discharge as recent research indicated that MST is a clinically significant marker for post service homelessness which further demonstrates the serious long-term adverse effects of both sexual assault and sexual harassment (Brignone et al., 2016).

Sexual Assault Disclosure and Help-Seeking

Nearly two decades ago, Frayne et al. (1999) conducted research on sexual assault disclosure and purported that sexual assault survivors often do not voluntarily disclose their sexual assault experiences to clinicians unless asked and therefore, sexual assault history may go unidentified. The acknowledgment of prior sexual assault history has an impact on the sexual assault survivor's clinical presentation during a medical visit, even years after the sexual assault has occurred. The results of a study of female VA patients revealed a positive correlation among a history of MSA, current physical symptoms, and medical conditions in each area evaluated. Although the psychological damage associated with MSA is well-documented, Frayne et al. (1999) contended that theoretically, MSA could be aligned with a sequence of medical conditions and syndromes such as obesity, peptic ulcer disease, asthma/emphysema/bronchitis, heart problems, arthritis, hypertension, and endometriosis. Furthermore, the exclusive and solitary disposition characteristic of military settings may exacerbate the harshness of the sequelae present after a sexual assault.

A cross-sectional design was utilized to survey a nationally representative sample of female veterans receiving outpatient care at the VA using self-administered mailed surveys (Frayne et al., 1999). These surveys inquired whether the female VA outpatients experienced MSA and solicited information about an array of physical sequela. According to Frayne et al. (1999), they could not definitively establish that female veterans' physical symptoms were a direct result of MSA because of the possibility of identified differences between the two subject groups being the result of unmeasured cofounders. For instance, it was not determined whether female veterans in the MSA group were survivors of other potentially adverse lifetime trauma that occurred before or after military service, it was not known whether a military or nonmilitary person perpetrated the MSA, and female MSA survivors who do not use VA services may differ in their clinical symptom presentation from those who receive VA care. Therefore, Frayne et al. (1999) recommended medical providers screen both younger and older women for a history of sexual assault (Frayne et al., 1999).

Berry and Rutledge (2016) examined women's experiences with sexual assault screening by healthcare providers and found that although many women are receptive to disclosing their sexual assault, they are often not screened and, therefore many sexual assault survivors do not receive the sexual assault resources and support that they need. In this study, the authors discovered that health care officials often unknowingly encounter sexual assault survivors and the environment that they create is thought to be the major facilitator or impediment to sexual assault disclosure. A sexual assault survivor's willingness to disclose their trauma history is highly likely in healthcare settings where the providers are forthright and have cultivated positive alliances (Berry &

Rutledge, 2016). As to the issue of providers' reluctance to inquire about sexual assault because of their own discomfort, Berry and Rutledge (2016) contend that sexual assault survivors are more likely to open up about their sexual assault if asked, regardless of their history and healthcare providers are in a position to close the gap in MST screening by detecting and responding to sexual assault disclosures, which can then help ameliorate survivor burden and cut health care costs.

Holland, Rabelo, and Cortina (2016) conducted a secondary analysis of the 2010 Workplace and Gender Relations Survey of Active Duty Members and investigated the help-seeking barriers to wellbeing of MST survivors and studied how the barriers exacerbated depression among active duty servicemembers who did not feel safe from sexual assault. Hence, it may be safe to assume that if MST survivors experienced help-seeking barriers that contributed to worsening depression and feeling that they were not safe from sexual assault during active duty service, it is a forgone conclusion that their fears and apprehension would remain after they have discharged from service. A secondary analysis of the 2010 Workplace and Gender Relations Survey of Active-Duty Members conducted by Holland et al. (2016) indicated that the barriers most commonly endorsed by active duty MST survivors were that they would be perceived as weak, their superiors might treat them discordantly, and their peers' confidence in them might be diminished. Consequently, they are more prone to suffer adverse psychological symptoms concordant with said help-seeking barriers (Holland, Rabelo, & Cortina, 2016). Finally, the authors propose that to protect mental health among MST survivors and others alike, eradication of barriers such as those involving logistics (e.g., scheduling

enough time for healthcare visits) and stigma (e.g., improving training curriculum for all providers who treat MST survivors) (Holland et al., 2016).

In another study based on statistics from the Workplace and Gender Relations Survey of Active Duty Members, Rosenthal and Korb (2013) argued that dispositional authority from within the chain of command should be removed to "institute a credible and objective justice system" (p. 34). Rosenthal and Korb stated that the military has failed to prove that it can hold MSA offenders accountable from within the chain of command, even after having more than two decades to do so (Rosenthal & Korb, 2013). This assertion is supported by the consistent statistics from 2012 Workplace and Gender Relations Survey of Active Duty Members results that indicate the perpetrator of sexual offenses in the military are often commanding officers and other high-ranking officials. The 2012 Workplace and Gender Relations Survey of Active Duty Members results also revealed that 25% of servicemembers who experienced unwanted sexual contact reported that they were assaulted by someone in their chain of command. Furthermore, an additional 38 percent of servicemembers stated that the offender was not in their chain of command, but they were of a higher rank and paygrade. Cumulatively, 63% of servicemembers who reported MSA on the 2012 Workplace and Gender Relations Survey of Active-Duty Members survey had been assaulted by someone who outranked them (Rosenthal & Korb, 2013).

The history of underreporting MSA is troublesome; however, the VA reportedly intensifies this injustice by requiring that MSA survivors show official documentation of their assault, which often does not exist through no fault of the survivor. Research indicates that servicemembers with PTSD from sexual assault continue to be held to a

more rigorous standard of proof when they apply for benefits through the VA (Rosenthal & Korb, 2013). The authors contend that underreporting is the major reason for this since a large percentage of sexual assaults are not reported, survivors do not have a document trail of proof when they seek care at the VA. Moreover, the VA nor Congress has moved to do away with this documentation requirement for servicemembers suffering from PTSD stemming from MSA, unlike those servicemembers who acquired PTSD from their combat experiences when in 2010, the VA decided to relax the paperwork standards for this group of veterans (Rosenthal & Korb, 2013).

Former President Barack Obama issued a clear directive in May 2013 to Secretary of Defense Chuck Hagel in which he suggested, "to not just step up our game, we have to exponentially step up our game, to go at this thing hard" (Rosenthal & Korb, 2013, p.1). President Obama's directive called for the removal of senior officials/chain of command dispositional authority in sexual assault cases with the aim of keeping with the fair spirit of the Uniform Code of Military Justice (Rosenthal & Korb, 2013).

Turchik, Bucossi, and Kimerling (2014) examined perceived barriers encountered by female veterans for access to MST-related care within the VA health care system. Another goal of this investigation was to explore the question of whether female veterans have gender preferences of clinicians who provide MST-related treatment as well as preferences regarding whether psychoeducational materials are gender-specific. Turchik et al. found that gender-related concerns such as awkwardness with male service providers and a perceived absence of support from a male-dominated environment to be a perceived help-seeking barrier for many female veteran MSA survivors. Additional exploration by Turchik et al. (2014) with the use of qualitative analyses was used to study

data obtained from semi-structured interviews with nine VHA-enrolled female veterans who disclosed MST. Four types of perceived barriers were identified by these female veterans: a) psychological avoidance, b) stigma-related, c) gender-related, and d) lack of knowledge (Turchik et al., 2014). Most of the female veterans expressed a preference for a female clinician and all of them indicated a preference for gender-specific psychoeducational MST literature in comparison to that which is gender-neutral (Turchik et al., 2014). According Turchik et al. (2014), there are a variety of perceived barriers to female veterans seeking MST-related care and the data further emphasize that psychoeducation and treatment for female veteran MST survivors should endorse a gender-based approach.

Jeffreys et al. (2010) used qualitative methods to increase their understanding of factors that are perceived to facilitate and inhibit change in the trauma disclosure process of veterans. The authors examined data from the interviews of 23 veterans (16 male and 7 female) and found that lack of confidence in the provider, fears regarding the possible adverse consequences of disclosure, and trauma avoidance to exist among the potential barriers to trauma disclosure. The providers who encouraged disclosure were those who were perceived as caring and communicating at the same level as the veterans and the providers who came across as uncaring or disinterested hindered disclosure. Jeffreys et al. (2010) offered that veterans experienced both positive and negative reactions to their initial disclosures; however, nearly all veterans concurred that disclosure was beneficial overall. This speaks to the necessity for enhanced patient-provider communications and the provision of settings that promote trauma disclosure to aid healing after trauma.

Vallandingham (2007) outlined recommendations for the DoD's sexual assault policy with the aim of providing a more comprehensive and uniform policy to address the matters of underreporting and to ensure good order and discipline by holding offenders accountable for committing MSA. Primarily, restricted reports of MSA are typically reported with nonidentifying information by a sexual assault response coordinator to a senior commander, whose role is inconsistently defined across the armed forces and therefore needs to be clearly specified to make the MSA policy among the armed forces more comprehensive (Vallandingham, 2007). Vallandingham (2007) asserted that properly defining the roles of senior commanders is especially vital because 15% of the active-duty military consists of women and research indicates women have a greater likelihood of being sexually assaulted and that a female sexual assault victim will be identified within her command level, particularly at small commands or those having few females.

Secondly, Vallandingham (2007) suggested that the scope of confidential reporting contacts needs to be broadened. Research has shown that a greater risk of MSA exists among young servicemembers and that support from their peers and other first responders encourage recognition of MSA as a crime that needs to be reported. Furthermore, by providing lower ranking (E-5 to E-6) initial points of contact who are more readily assessible and less intimidating to refer victims to for support services, a more solid confidential reporting option can be created for commands (Vallandingham, 2007).

Conclusively, Vallandingham (2007) asserted that the incorporation of these three proposals is crucial for a confidential reporting option that is "uniform, practical and

credible" (p. 2). Vallandingham (2007) made these recommendations to increase MSA reporting and disclosure among survivors, as it is difficult for health care providers to properly provide support to survivors without MSA disclosure. Thus, for the DoD to encourage victims to report MSA and receive proper care and support, the DoD must implement these reforms (Vallandingham, 2007).

Summary and Conclusions

According to Jeffreys et al. (2010), the first step towards healing trauma-related distress is disclosure. However, barriers associated with disclosure during the help-seeking process include fear of potential negative consequences associated with trauma disclosure, lack of trust in a provider, and trauma avoidance (Jeffreys et al., 2010). MST can affect veterans of any gender, race, age, ethnicity, or socioeconomic status. It is imperative that clinicians and other stakeholders comprehend the gravity and long-term residual effects of MST and are prepared to appropriately engage survivors with the goal of providing optimal treatment for this vulnerable population.

MST survivors are often distrustful of others and are, therefore, prone to reluctance to disclose their trauma and associated consequences. Clinical providers or stakeholders should ensure enough MST-related training and proficiency by demonstrating an ability to convey empathy, caring, and straightforward communication with survivors. In addition to the significance of interaction, elements of the clinical setting should be created to facilitate disclosure. Settings that proved to be important in supporting provider interactions and facilitating trauma disclosure were those that allowed patient privacy and ensured adequate treatment time (Jeffreys et al., 2010).

Considering the rates of MST prevalence, it is crucial to be prepared to exercise a variety of useful strategies to encourage MST disclosure which can allow for the survivors to receive the proper treatment for subsequent trauma-related sequelae. It is also of vital importance for providers to acknowledge and treat gender-specific physical and psychological problems associated with MST in survivors. According to the Rape, Abuse, and Incest National Network (n.d.), victims of sexual assault commonly experience a broad range of physical and emotional effects; these can include depression, anxiety, posttraumatic stress disorder, sleep and eating disorders, and substance abuse, among other things. Therefore, the help-seeking experiences of sexual assault survivors, reactions they faced upon disclosure, and the impacts of their providers' responses on their own recovery have considerable significance.

Additionally, there are limitations to recent research on the topic. For example, correlational findings do not allow researchers to make causal conclusions, and there may be several possible interpretations of the findings such as the Holland et al. (2016) study of MST and help-seeking behaviors of active duty servicemembers in which no causal relationships between barriers and mental health outcomes could be established from the secondary analysis of cross-sectional correlational data. In a similar vein, a limited sample size in the Leung (2017) study of help-seeking decisions in female sexual violence survivors in Hong Kong introduced difficulty with the analysis of complex data and the sample size was not enough to generalize all the sexual assault survivors' experiences to the broader Hong Kong community. Moreover, limitations of qualitative studies include acknowledgement that the reasons provided may not be the actual causes.

Lastly, missing is a study focusing on female veterans' perceptions of the various reactions from those to whom they disclosed their sexual assault trauma during the post-service help-seeking process. Because the research is limited on what experiences female veteran MSA survivors have in disclosing trauma after they have discharged from military service, it is not fully understood how to better encourage them to seek help and how to best provide it for them when they do seek help. Based on this scarcity of knowledge, the proposed study aimed to narrow this gap by providing a voice to, and raising the possibility for, results that can be used to contribute to positive social change.

Chapter 3: Research Method

The purpose of this qualitative phenomenological study was to explore perceptions of the help-seeking experiences of female veteran MSA survivors after they have discharged from military service, which can provide enhanced insight to practitioners and stakeholders. In this chapter, I describe the phenomenological approach I used to better understand this phenomenon. This includes a discussion of how participants were identified and recruited and the processes for data collection and analysis.

Research Design and Rationale

A phenomenological approach in which the participants recount their lived experiences from their own viewpoints was used in this qualitative study (Creswell, 2014). The subjective nature of qualitative research helps to identify meanings people make (Creswell, 2014), providing an in-depth understanding about people, cases, and situations (Patton, 2002). The specific application of qualitative research involved my study of the various ways in which a phenomenon manifests (Vagle, 2014). A qualitative research approach provided information about the participants' sexual assault disclosure experiences from their own perspectives, which yielded essential information on sexual assault disclosure. Establishing the presence of common themes using semistructured, interviews was an integral part of qualitative research, with background questions to broaden understanding of the research problem under investigation and provide the contextualization necessary to comprehend its significance (Vagle, 2014). This approach helped to answer the following RQs:

- RQ1: What are the lived experiences of the post-service help-seeking process among female veteran MSA survivors when disclosing a sexual assault incident?
- RQ2: How do female veteran MSA survivors experience the reactions expressed by those persons that they disclosed to?
- RQ3: How do female veteran MSA survivors perceive the impact of provider responses on recovery?

Role of the Researcher

Phenomenological studies are those in which the researcher acts as an instrument for data collection, making it important for me to be as unbiased and impartial as possible and set aside any preconceptions pertinent to the phenomenon under investigation before data collection and analysis (Moustakas, 1994). I bracketed prior beliefs (Moustakas, 1994), focusing just on the phenomenon (Husserl, 2012) Through bracketing my own experiences, I avoided influencing the participants' comprehension of the phenomenon under study (Chan et al., 2013) as well as my interpretation of their experiences. I asked open-ended, not leading questions about participants' help-seeking experiences and listened carefully to their responses (Chan et al., 2013). Additionally, I ensured that participants' experiences were not misinterpreted during data analysis by implementing Colaizzi's data analysis, a phenomenological analysis that entails the validation of results by following up with the study participants (Chan et al., 2013). I also engaged in reflexivity using reflexive journaling, which can be helpful where bracketing cannot sufficiently address bias (Bednall, 2006). Using reflexive journaling helped me to

understand the impacts of my own thoughts and experiences with this topic on my data collection, analysis, and interpretations.

Another significant consideration in the role of a researcher is the disclosure of any personal and professional relationships that may affect the data collection process. Therefore, it was imperative that I reveal my background with this phenomenon, since I had professional experience as a Navy veteran, victim advocate, licensed clinical mental health counselor, and licensed clinical addictions specialist working with individuals who have experienced this phenomenon. My background with this phenomenon spans over three decades, beginning as an active-duty female servicemember immersed in the military culture and military environments known to perpetuate sexual harassment and sexual assault. My post-service professional involvement with this phenomenon included the provision of victim advocacy services, which included listening to active-duty female servicemembers describe their experience with the MSA they endured while identifying appropriate and realistic options and resources during safety planning to ensure their concerns were acknowledged and addressed. As a subject matter expert, my findings could be biased without the proper oversight.

Although my experience with this phenomenon could bias me toward certain viewpoints and against others, my experience with it has also fashioned me into a better listener. My experience also helped me realize that each person's experience, and the way that they perceive that experience, is different, which allowed me to be open-minded and exercise objectivity while listening as they recounted experiences with the phenomenon. My role as a researcher also required an astute understanding of the vulnerability of the population under study and the necessity to treat participants ethically. I was mindful of

my role as a researcher whose purpose was to gather information and not to act in the capacity of a counselor as a protocol would be established for the therapeutic support of participants as required.

Methodology

Participant Selection Logic

The study population consisted of 14 female veterans who were separated from military service and who had experienced MSA. Parameters for participant selection for inclusion in this study were females 18 years or older who have experienced MSA and who were currently post-military veterans. The sample size for this study was based on literature that outlined a gold standard for establishing the proper sample size for qualitative research. There is no set number for sample size in qualitative research sampling (Patton, 2002). But saturation—the point at which the researcher does not obtain additional data that will produce a change in the data already collected (Guest et al., 2006)—is one way to fulfill a study's purpose. The point at which saturation tends to be achieved depends on the individual study and population being studied.

I employed two kinds of sampling methods, purposive and snowball sampling, to attain a sample size of 14, a well-established sample size for phenomenological research studies based on data saturation (Creswell, 2013; Guest et al., 2006; Patton, 2002). However, this sample size might not have been sufficient to achieve saturation; to support the comprehensiveness of the results and increase the probability of saturation, I recruited as many participants as reasonably possible. Purposive sampling, also known as judgment sampling, is a nonrandom technique in which the researcher purposefully selects participants based on specific traits that the participant possesses without needing

a certain number of participants or fundamental ideologies (Etikan et al., 2016). This sampling technique allowed me to seek out participants who were able and willing through their knowledge or experience to provide rich information about MSA.

Snowball sampling is also a purposeful sampling strategy in which cases of interest are identified through individuals who know persons that possess similar characteristics who know others with those same characteristics (Palinkas et al., 2015). Although the snowball sampling techniques include an emphasis on both similarities and differences, it is better suited for an investigation of correlations (Palinkas et al., 2015). An example of snowball sampling is one in which a researcher solicits recruited individuals to identify other persons for study recruitment (Green & Aarons, 2011). Further, a major consideration of snowball sampling starts with the researcher asking participants who they know who know a lot about the study topic (Patton, 2002, p. 17). I employed this technique in my study as an adjunct to the purposive sampling strategy to increase my chances for yielding the target sample size.

Data saturation occurs when no new information is found with continued interviewing (Guest et al., 2006). Further, having no new themes means there are no new data and subsequently, no new coding (O'Reilly & Parker, 2013); hence, saturation is the point where there are no new data as well as new themes (Fusch & Ness, 2015). Though data saturation cannot be directly tested, an effort was made to recruit as many participants as reasonably possible with a minimum of 12 to increase the probability of saturation. Although the aim was for the data to be saturated with 12 participants, there is a lack of consensus as to what constitutes the ideal number of participants to reach data saturation (Morse et al., 2014). Because study designs are not universal, no one-size fits-

all method for reaching data saturation exists (Fusch & Ness, 2015). Thus, a lack of saturation may be a limitation of this study.

Instrumentation

The data for this research study came from audio-recorded, semistructured interviews conducted with female MSA survivors who are consumers of VA health care and other community providers and who have experienced help-seeking following their discharge from military service that involves disclosure of their MSA trauma. A standard interview protocol guided the data collection for this study, and the semistructured, audio-recorded interviews to collect the data included five main interview questions that align with the RQs. The study participants were offered a $10 virtual Amazon e-gift card as an incentive at the conclusion of the initial interview, which was deemed important for recruitment for participants who might not otherwise participate in this research study, or those who might be wavering in whether they want to participate. After the debriefing session during which they reviewed their respective interview transcripts, the participants were provided with contact information for the Veterans Crisis Line where they could speak with a qualified responder for confidential counseling if needed.

Procedures for Recruitment, Participation, and Data Collection

Recruitment

Participants were recruited through rape crisis and women's centers, behavioral health counseling practices, and women veterans' organizations throughout the United States in addition to the Walden University Research pool. A request for permission to conduct research along with a copy of my research proposal was submitted to each agency before requesting institutional review board (IRB) approval from Walden

University. After obtaining IRB approval to conduct human subjects research and securing permission from the agencies to conduct my study, I scheduled meetings by email and phone with the agency directors and other chief points of contact to request the posting of research participant solicitation flyers on the collaborating agency websites and/or premises announcing the study.

Participation

Prospective research participants contacted me directly through my academic institution email address and/or a phone number established specifically for this study. Each prospective participant was briefed about the nature of the study, the purpose of the study, and what was expected of potential participants. Additionally, the prospective participants were explained the informed consent and assured of their ethical treatment and protection from harm.

Fourteen women who agreed to participate in this study were selected and scheduled for an audio-recorded, virtual interview lasting 60 to 90 minutes each. Prior to being interviewed, each participant was emailed an informed consent form to read and acknowledge by replying “I consent” in their email response to me. The potential participants were emailed information on the purpose and nature of the study for their reference and were asked to consider inviting other post-military women they knew of to participate in this study. The audio-recorded virtual interviews were followed by a brief post-interview debriefing session, about 30-60 minutes in length, scheduled later to allow the participants to review their transcribed interviews for accuracy. At the conclusion of the debriefing session, each participant was provided with information for the Veterans

Crisis Line for 24/7 confidential counseling in case they experience any emotional difficulty.

Data Collection

After approval by Walden University's IRB (approval no. 03-11-20-0338132), I conducted semistructured, virtual, audio-recorded interviews lasting approximately 60 to 90 minutes during various times over a 2-month period. The interviews began with a review of informed consent before the collection of demographic information followed by the interview questions. I documented my impressions and reactions in handwritten notes recorded on the interview protocol questionnaire to note any personal bias that I discovered as I interviewed each of the study participants. Each participant was encouraged to use the Veterans Crisis Line for free 24/7 confidential counseling and further advised that they need not be suicidal in order to make use of this important resource if needed to address any difficult feelings that they might be struggling with after their interviews. The participants were also offered a $10 Amazon e-gift card at the end of the interview as a compensatory incentive for participation in the study.

Data Analysis Plan

Qualitative research can yield large amounts of textual data. Analysis of the data for this study was accomplished with the use of Braun and Clarke's (2006) Thematic analysis. Thematic analysis follows a six-step approach to data analysis that, much like Vagle's phenomenological analysis, proceeds with the goal to uncover the shared themes and meanings between all participants. Braun and Clarke (2006) further advised that their six-step approach to data analysis should not be viewed as a linear model, but rather the analysis is conducted as a recursive process with these six steps (Braun, Clarke, & Terry,

2014). In the first step, the researcher reviewed transcripts for familiarity with the contents. Step two occurred when the researcher moved line-by-line through the transcripts and assigned passages of text relevant to the RQs with short codes. In step three, the researcher reviewed all codes generated in step two to look for similarities, grouping similar codes into larger thematic categories. Step four entails the researcher reviewing all thematic categories from step three, further reducing categories into larger categories based on similarity, as necessary. In step five the research defines and gives names to the themes, or categories, that were generated based on the review of these categories. Step six involves the researcher presenting the results of the findings. Fusch and Ness (2015) posit that when information is adequate to replicate the study, when the ability to acquire new information has been exhausted and when further coding is no longer possible, data saturation has been achieved. Although saturation cannot be tested directly, the researcher will attempt to gather as large a sample as reasonably possible with a minimum of 12, to increase the probability that saturation is achieved.

I commenced the data analysis process by preparing myself to see each participant interview with a brand-new perspective, bracketing out any previously held beliefs, biases, and judgements. After all the participant interviews were conducted and each interview transcribed, the transcripts were entered in NVivo 11 (QSR, 2017) for data coding and analysis. NVivo 11 was used to organize and store my data and assist me with data analysis. The use of the NVivo software package to manage, organize, and store my data, made it an ideal tool for my qualitative research study. Furthermore, it allowed me to monitor and track any changes that I made to my data, thus helping me to identify any data that might have been incorrectly entered.

I started the process of thematic analysis to reveal the shared themes and meanings between all participants once data entry, sorting, and categorization had been accomplished. To gain an intimate understanding of the raw data content, I took the liberty of hand coding transcripts to review and compare it to the NVivo coding to glean a more profound comprehension of the thematic outputs. An amalgamated and cogent statement was then created from a synthesis of the essences captured from the rich structural and textural interpretations of the phenomenon (Moustakas, 1994). It is important to consider however, that this statement is not entirely exhaustive since the potential for an illimitable number of prospective insights yet to be discovered exists.

Issues of Trustworthiness

Trustworthiness involves the following elements: (a) credibility; (b) transferability; (c) dependability; and (d) confirmability (Amankwaa, 2016). Data saturation, as proposed by Lincoln and Guba (1985) is the production of information-rich cases in which data are accumulated to the point of redundancy, where no new information is emerging from new data. This can ensure adequacy of data and the use of a combination of sampling strategies can help accomplish this goal (Morrow, 2005). Clearly, adequacy of data is essential to the issue of credibility, however, Morrow (2005) maintained that what was of greater significance than sample size was the quality, length, depth of interview data, and variety of evidence in sampling procedures.

Trustworthiness in qualitative research is dependent upon the preciseness of the information obtained wherein the important question of whether the data collected from participant interviews are representative of the intended purpose of the study. The issue of trustworthiness in this study was addressed with the use of established methods to

substantiate the authenticity of the results germane to the qualitative correlates of reliability and validity. This was delineated in elements such as credibility, transferability, dependability, and confirmability. Credibility addressed the issue of whether the results of this study are authentic and plausible and involved member checking on the part of both the researcher and member to ensure accuracy of the data collected. This process also included an accurate review of all audio-recorded interviews and handwritten documentation in addition to the proofreading of transcripts multiple times for preciseness against interview audio recordings.

Afterward, virtual audio-recorded debriefing follow-up sessions were scheduled with each of the study participants to complete the transcript verification process, during which time they reviewed their respective transcripts to check them for correctness, clarify any mistakes that may have transpired during the interview and to address any final questions they had regarding the study. The participants also had an opportunity at that time to add any commentary they believed pertinent but was overlooked during the initial interview. Upon verification of the transcript information, the data was entered in NVivo 11 and reviewed once more for exactness against current data sources. The credibility checks continued regularly throughout the duration of the data analysis process to assess the estimated extent of data saturation, and validity of the study was increased utilizing triangulation, which was accomplished in this study through the use of semi-structured audio-recorded interviews, transcripts of the interviews and review of the transcripts with the participants for data validation. An additional step to ensure validity in the results of this study was achieved during data analysis through collaboration with an external auditor (Schwandt, 2014, p.12). The rationale for the use of an external auditor was also supported

by Denzin's (2009) assertion that there is no one single method, theory, or observer that can grasp all that is significant or pertinent. Accordingly, triangulation is the method through which a researcher "must learn to employ multiple external methods in the analysis of the same empirical events" (Denzin, 2006, p. 13) and it is "the way in which one explores different levels and perspectives of the same phenomenon. It is one method by which the validity of the study results is ensured" (Fusch, Fusch, & Ness, 2018, p. 26). Moreover, Schwandt (2014), purported that triangulation is a means to check the integrity of one's inferences and:

> It can involve the use of multiple data sources, multiple investigators, multiple theoretical perspectives, and/or multiple methods. The strategy of triangulation is often wedded to the assumption that data from different sources or methods must necessarily converge or be aggregated to reveal the truth. (p. 298)

Next, to address the quandary of transferability, I applied rich, detailed descriptions of participants' experiences to the phenomenon being investigated. Qualitative studies tend to have small sample sizes, thus making it a challenge to generalize findings to other populations and locales. Rich detail, including direct quotes from participants in addition to a description of how participants talk about the phenomenon of MSA, enhanced transferability by providing more information for future researchers upon which to determine transferability. Dependability was demonstrated in this study through the process of ascertaining if similar findings would come to light should the study be replicated. Accordingly, a thorough accounting of all procedures was recorded in a research log, in step-by-step fashion like a recipe, to facilitate the replication of this study in the future with other populations using the same research protocol. Lastly, confirmability guaranteed that

study results accurately reflected the experiences of the participants and not the researcher's judgements or biases. A social constructionist framework and bracketing promoted the impartiality of this study. I accomplished bracketing through use of a reflective journal, in which I described and reflected upon my personal and professional biases that existed at that time as well as those that arose during the data collection and analysis processes. Additional audits ensured my own neutrality while I investigated this phenomenon, as confirmability of the data was augmented by a continual check and recheck process. The question of confirmability was addressed in this study using an audit trail consisting of documentation detailing the decisions I made during throughout the research process, to include sampling, reflective thoughts, research team consultations, research materials used, development of study findings, and data management information, all of which would allow the auditor to evaluate the transparency of the research path (Korstjens & Moser, 2018).

Ethical Procedures

Sanjari, Bahramnezhad, Fomani, Shoghi, and Cheraghi (2014) postulated that anonymity, confidentiality, and informed consent are some important ethical issues that should be considered while conducting qualitative research. Prior to conducting any research for this study, approval was be obtained from Walden University's IRB, after which the requirements for informed consent and confidentiality were adhered to. The informed consent forms that were electronically acknowledged through email response by each participant prior to conducting their interviews supplied the following information: (a) an explanation of the study, (b) information about this researcher, (c) the study's purpose, (d) data collection process, (d) the autonomous nature of the study, (f)

the study's risks and benefits, (g) the right to privacy, (h) publication of the study results, and (a) the right to withdraw at any time from the research.

Research participants were apprised by emailed informed consent that a professional counselor, victim advocate or other qualified responder would be made available to them should they experience any adverse effects due to the sensitive nature of this study. Additionally, confidentiality was thoroughly reviewed with each of the participants to include the participants' right to privacy of information divulged during the interview process. The confidentiality agreement detailed the protocol that was in place to guarantee the protection of participant information along with the notification germane to the legal consequences for the researcher if unauthorized disclosure of said information should occur. Participants were informed that all audio recordings and transcripts would be anonymously coded in lieu of participant name labeling and they were advised that these data sources would be stored in a locked firebox in the researcher's residence for a five-year period. The participants were further informed that the study data would be stored on my password-protected laptop computer and the data would contain no personally identifiable information; rather, subject codes would be used in lieu of names. Additionally, all data would be removed from my laptop and stored on a disc with participant files in the locked firebox upon conclusion of the research.

Summary

The phenomenon of interest in this study was the perceptions of female veterans during their help-seeking experiences in which they disclosed MSA. Accordingly, I used a phenomenological research design because such designs are especially good for collecting and analyzing data when the goal is to understand perspectives on a

phenomenon. Through this, the aim was to provide valuable insight into this phenomenon to educate practitioners and stakeholders, as well as to address gaps in the literature, by adding to the knowledge base where the research is scarce on this topic. Using in-depth interviews allowed me to investigate participants' experiences that provided a rich perspective on the phenomenon itself and its effects on the recovery of participants. Braun and Clarke's (2006) Thematic analysis guided analysis of the transcribed interviews and aided comprehension and interpretation of the female veteran MSA survivors' perceptions of their help-seeking experiences which are currently not adequately documented in the literature. Ensuring data trustworthiness through member checking by providing each participant with the opportunity to review their transcribed interviews for accuracy via Zoom and by conducting a thorough review of the audio recorded interviews, handwritten notes, and interview transcripts enhanced the credibility of the study. In the next Chapter, the results of this research study are presented with supporting information.

Chapter 4: Results

The purpose of this phenomenological study was to explore the perceptions of female veteran MSA survivors regarding help-seeking experiences after they have discharged from military service. To do this, I sought to answer three RQs that addressed the lived experiences of female veteran MSA survivors, especially regarding the reactions of those they disclosed to and the impact of provider responses on their recovery. I collected data through semistructured interviews via Zoom, during which each participant provided a detailed account of their help-seeking experiences and perspectives on those experiences. I analyzed data using a thematic analysis developed by Braun and Clarke (2006). In this chapter, I present the study setting and participant demographics to provide context for the presentation of results as well as how I collected and analyzed data. Finally, I present and describe the themes created from the thematic analysis.

Setting

There were three hermeneutic RQs that focused on the post-service, help-seeking experiences of female veterans in this study. Data were collected through semistructured, audio-recorded interviews using Zoom, a web-based video conferencing tool that possesses audio-recording only capability, and an interview questionnaire instrument. The data were repeatedly analyzed and studied for themes and incorporated into tables to address the RQs.

Demographics

A total of 14 female veterans who met inclusion criteria participated the study. To be eligible for inclusion, women had to be over 18 years old, experienced MSA, and not be on active duty. The mean age of the participants was 36 years old (range 25-55), and

the following branches were represented in the sample: Air Force, Army, Marine Corps, and Navy. Seven participants identified as being married, three divorced, and four as single/never married. The education level of the participant is as follows: four had doctoral degrees, four had master's degrees, four had bachelor's degrees, one had an associate's degree, one had some college but no degree, and one had completed high school with no college. The participants resided in the following states: Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Maryland, Missouri, New Mexico, South Carolina, and Texas.

Data Collection

I instructed interested female veterans via recruitment flyer to contact me at my university student email address or by a phone number established for the research study. After 14 prospective participants made contact, I emailed them a description of the study along with the informed consent to review and asked them to reply to the email by typing "I consent" in the subject line of their email as an acknowledgement of the informed consent and to consent to participate in the study. Upon receipt of consent, I coordinated a convenient date and time for the interview with each participant via email. Participants exercised their option to use the device of their choice and were afforded autonomy in the selection of an interview environment suited to their comfort level through which to participate in the interview process.

Semistructured, audio-recorded interviews were conducted with 14 female veteran participants with Zoom and an interview questionnaire instrument (see Appendix). An advantage of using an interview questionnaire is that it serves as a guiding protocol for the interview and ensures that participants address each of the identified RQs

in depth (Wengraf, 2001). The interview questionnaire consisted of personal demographic questions followed by open-ended interview questions designed to avoid the presentation of leading questions that could potentially skew participant responses (Hsieh & Shannon, 2005; Rubin & Rubin, 2012; Wengraf, 2001). Background questions were also included about health care and community providers from whom help was initially sought and to whom MSA disclosures were made after military discharge. Additionally, background questions were included related to help-seeking decisions, provider reactions, and subsequent participant impressions of the help-seeking visit as well as one final question regarding the impact of the help-seeking encounter on the participants' recovery and likelihood of sustained help-seeking efforts in the future. The interview questionnaire was used to document any participant impressions noted during the interview.

Each interview was opened with a review of the informed consent and the collection of demographic information followed by the interview questions. Participants were asked to turn off their cameras prior to the recording of the Zoom interview to prevent the recording of their likenesses to safeguard their privacy and maintain confidentiality. The semistructured, audio-recorded interviews were typically between 30 to 60 minutes and were conducted over 3 months. I emailed a debriefing statement reiterating the study purpose, Veterans Crisis Line information, and sexual assault prevention resource information to each participant in addition to a $10 Amazon e-gift card token of thanks at the conclusion of their interviews.

Some variations in the data collection for this study, such as the use of Zoom for virtual interviews in lieu of face-to-face interviews and increase in the geographic area of

recruitment to nationwide arose out of a necessity due to the COVID-19 pandemic. Although the onset of COVID-19 changed the trajectory of participant recruitment area and data collection plan, I believe the opportunity to virtually interview participants nationwide afforded an advantage for the robustness of this study.

Unusual circumstances were also encountered in data collection for this study, which involved the discovery of a participant falsely presenting themselves as someone who met criteria for inclusion in this study. This issue came to light after the initial encounter during an interview in the data collection phase. Aside from a thick accent, the participant had difficulty with the comprehension of some key demographic interview questions, particularly the questions regarding what military branch they served in and what state they resided in. A reverse email lookup revealed that this person lived and worked in Nairobi, Kenya; considering the possibility that this person did not meet inclusion criteria, I decided to exclude this individual from the study. Although this study initially contained a prescreening protocol that was removed due to the IRB, this circumstance suggests that some kind of prescreening process should be included in future studies to avoid interviewing those who do not meet study inclusion criteria.

Data Analysis

After I collected data from participants, I had the interviews transcribed by a professional transcription service. When I received the transcripts, I uploaded them into NVivo 12, a qualitative computer data analysis program designed to assist researchers with qualitative data analysis and organization. After uploading all transcripts into NVivo, I began the thematic analysis by following the steps Braun and Clarke (2006) outlined in their approach. In the first step of thematic analysis, I familiarized myself the

contents of all interviews by reading each of them thoroughly to gain a sense of each participants' complete experience.

In the second step of thematic analysis, I coded the interview transcripts. To do this, I started with the first interview and in NVivo highlighted passages of text—either words or phrases—salient to the RQs. After highlighting the passage to be coded, I was able to to type in a brief title of the passage of text, called a code. In assigning a code to the passage of text, NVivo stores the passage of text at a *node* in the program, which is group of information similar to a physical pile. Each new code I created was stored at a new node, and passages that were assigned to codes I had already created were stored at the node for that code. That is, the node for a code contained all associated textual passages, which allowed for easy retrieval and visualization of these data and provided a count of the number of passages associated with that code and the number of participants who had contributed passages to that code. This is similar to taking printed copies of transcripts, cutting out all passages coded with the same code, and placing them into the same pile. I followed this coding process for all transcripts, ending with a list of codes. Throughout this process, I noted codes that seemed to indicate different experiences and variation among participants as possible discrepant cases for further examination. I added a *dc* to these codes in NVivo, to denote possible discrepancies. An example of codes and coded passages is included in Table 1.

Table 1

Codes and Coded Passages

Code	Passage of Text
Discomfort with therapeutic technique	"It's the rapid eye movement therapy. But, she had me like ... She was tapping on my hand. That was very distracting.

	Then, she had me watch a clock. I just remember being very uncomfortable and she would not try any other types of therapies with me. This was the only way she was going to do it. I was not receptive to it, and it was very uncomfortable for me." (Mary)
Feeling in control	"Yeah, I just feel more in control now." (Kara)
Sense of comfort with provider	"I felt comfortable being able to talk to both of them, if anything had occurred or I was having a severe PTSD day or an attack." (Brianne [Bam])
Convenience of provider	"The first community provider, I literally just looked for one with a good review who took my insurance and went with them." (Martha)

In Step 3 of thematic analysis, I searched for themes among the codes. I reviewed the list of codes I generated in Step 2 and started compiling related to codes into larger categories. I did this in NVivo by creating a new code as I did in Step 2 for the coding process. However, in Step 3, I used the new codes I created as larger categories, or themes, and I dragged and dropped the codes from step two into these newly created themes. Like with the codes in Step 2, I gave these themes a title reflective of the codes they contained. At the end of this process, I was left with several themes containing the codes generated in Step 2. In this step, I also explored those codes marked with the *dc* described in Step 2. I noted, for example, that many participants described something related to trusting the providers they disclosed their MSA to, but one participant expressed distrust in her provider. In instances where I found discrepant cases, I included them in the larger theme related to trust, leaving the *dc* in place to denote the discrepancy or variation. These discrepant cases are discussed at the level of theme or subtheme in the Results section of this chapter. The themes and their associated codes are presented in Table 2.

Table 2

Themes and Supporting Codes

Theme	Codes
Feelings Surrounding MSA Incident	Blame and responsibility, blocked assault from mind, broken-down feeling, everything was a blur, felt embarrassed, like a ball of stress, low self-esteem, panic attacks, second-guessing self
Intuitively Knew the Right Time to Seek Help	Felt she had to do something, affecting career, affecting relationships, alcohol abuse, wanted understanding of incident, no longer afraid, PTSD, suicidal ideations, triggering event
Finding the Right Provider	Convenience of provider, inconvenience of provider (dc), comfortable with VA-assigned provider, uncomfortable with VA-assigned provider (dc), found own provider, immediate help seeking (dc), waited to seek help, referral from VA to provider
Disillusionment with VA in Help-Seeking Process	Bitterness, resentment, feeling betrayed by institution, frustration with VA system, wanted to stop going to VA, VA provider minimized experience, VA felt too clinical
Satisfaction with Provider in Disclosure Process	Felt provider was effective, felt better talking about incident, learned valuable coping skills
Feeling Supported During Disclosure Process	Feeling heard, provider lacked empathy, feeling validated, made to feel she was not alone, sense of comfort with provider, provider accused her of attention-seeking (dc), provider said something that shut her down (dc)
Feeling Empowered Through Disclosure Process	Feeling active in own disclosure process, feeling in control, feels free, move slowly through trauma therapy
Not Getting What She Needed from Provider	Discomfort with therapeutic technique, mad about questions provider asked, felt provider did not address her concerns
Trusting the Disclosure Process and Provider	Trusts provider, lack of trust (dc)
Ongoing Help Seeking	Continues seeking help, would continue seeking help, would not continue seeking help (dc), would continue seeking help with qualifications, does not feel she needs more help, nervous to seek help after negative experience

I explored these themes in greater depth to determine if other relationships existed between them. In NVivo, I made a mind map of these themes to explore how they related

to one another and if some themes were perhaps subthemes of others. I noticed that the themes *feeling supported during disclosure process*, *trusting the disclosure process and provider*, *feeling empowered through the disclosure process*, and *not getting what she needed from provider* all related to participants' satisfaction with their provider. Reflecting this, I determined that these themes were subthemes, and I moved these themes underneath the theme *satisfaction with provider in disclosure process* using the drag and drop process to move all associated codes in NVivo. This left me with five themes and associated subthemes.

In Step 4, I reviewed the themes and subthemes created in Step 3 of thematic analysis. I did this by returning to the data in NVivo to ensure that all data within each theme helped address the RQs and told a cohesive and comprehensive story. This is done easily in NVivo by double-clicking on the node for the category under scrutiny, as doing this pulls up all associated passages of text for easy review. I checked to ensure proper placement of codes and categories and took this opportunity to move around codes and categories that, upon further review, fit better in a different place. I noticed that the theme *not getting what she needed from the disclosure process* was also a facet of *satisfaction with provider in disclosure process*, so it became a subtheme.

The fifth step of thematic analysis entailed the final titling and defining of themes. I made sure that the titles of the themes captured the story the theme told and conveyed an understanding of phenomenon. I also ensured that the themes and titles addressed one of more of the RQs. In the sixth step, I present the results of the thematic analysis, as the Results section of this chapter shows. The final thematic structure is as follows:

- Theme 1. Feelings surrounding MSA incident

- Theme 2: Intuitively knew the right time to seek help
- Theme 3: Finding the right provider
- Theme 4: Disillusionment with VA in help-seeking process
- Theme 5: Satisfaction with provider in disclosure process
    - Subtheme 1: Feeling supported during disclosure process
    - Subtheme 2: Feeling empowered through disclosure process
    - Subtheme 3: Trusting the disclosure process and provider
    - Subtheme 4: Not getting what she needed from disclosure process
- Theme 6: Ongoing help-seeking

Evidence of Trustworthiness

Credibility, transferability, dependability, and confirmability are concepts that ensure trustworthiness in qualitative research (Elo et al., 2014; Lincoln & Guba, 1985; Shenton, 2004). Credibility pertains to the study's internal validity, meaning that the study design will measure what it is intended to measure. The participants had the opportunity to review their respective interview transcripts through member checking to ensure accuracy of the data collected. Additionally, a detailed review of all audio recorded interviews, handwritten notes, and interview transcripts was employed to increase validity and uphold credibility in the study. After the participants completed the review of their interview transcripts, the data was entered in NVivo 11 and reviewed again for preciseness using the interview transcripts and handwritten documentation. Credibility checks were conducted throughout the course of the data analysis process to evaluate the extent of data saturation and triangulation was achieved through

collaboration with an external auditor using all data sources to ensure validity in the study results (Schwandt, 2014).

Transferability refers to how applicable the study results are to other populations and therefore, firm adherence to study participant inclusion criteria was maintained. Rich, detailed descriptions of how the participants talked about the MSA phenomenon, including their direct quotes about their help-seeking experiences facilitated transferability in this study by providing a breadth of information for future researchers to determine generalizability. Dependability was addressed in this study by determining if similar findings would come to light should the study be replicated. This was accomplished by recording a thorough accounting of all procedures in a research log, in step-by-step fashion like a recipe, to facilitate the replication of this study in the future with other populations using the same research protocol.

Confirmability guarantees that the results of the study accurately reflect the experiences of the participants and not the researcher's judgements or biases. A social constructionist framework and bracketing promoted the impartiality of this study. Bracketing was accomplished through use of a reflective journal, in which I described and reflected upon my personal and professional biases that existed then and those which arose during the data collection and analysis processes. A continual check and recheck process with the assistance of an external auditor was performed to help ensure my neutrality during my investigation of this phenomenon. Additionally, an audit trail consisting of detailed notes recorded on each unit of analysis (Appendix A) about the decisions I made during the data collection and analysis process, provides assurance to future researchers "…that the

work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher" (Shenton, 2004, p. 72)

Findings

Through Braun and Clarke's (2006) approach to thematic analysis, I identified six themes, one of which had four associated subthemes. Results are presented by theme to show the relationships between them.

Theme 1: Feelings Surrounding MSA Incident

Theme 1 is about the feelings that participants experienced related to their MSA incidents. This theme was created to provide a background understanding of the perspectives of participants on their experiences and what led them to disclose their MSA incidents. Understandably, participants experienced a mix of negative emotions about their MSA. Five women described the feeling of second guessing themselves and their feelings. Beth was concerned that when she disclosed her MSA, people would not believe her. "I had a part of, will they believe me?" Beth recalled.

Kara and Jenna, on the other hand, seemed to second guess the severity of their incidents. For Kara, this appeared to be related to her status as a veteran and seeing other soldiers with obvious physical traumas to which she compared her own. Kara questioned herself and her assault during a PTSD group meeting:

> I just felt like everybody there because I…I don't know. I knew there were female combat veterans and people in Iraq and Afghanistan. Of course, I knew that. But I felt like talking with these guys, that some of them had limbs missing, that I didn't deserve to be there, or that they all were looking at me like, "What's this 30-year-old girl doing here? What's going on?"

Jenna also second-guessed the severity of her MSA. She said she felt like "I didn't have the worst kind of sexual trauma" despite knowing that her MSA fit the legal definition.

Mary and Sasha second guessed their very worth as humans after their MSA. Mary began questioning whether she could make decisions on her own and questioned "every friendship I made." She described no longer feeling sure if she was "a good or bad person," Mary said. She continued, "You literally second guess everything in your life," which she attributed to the "emotional violation" she felt as a result of her MSA. Similarly, Sasha described the feeling that she was "the scum of the earth…the worst person in the world." Sasha believed the MSA happened "because of something that I did."

Participants also used the word *blur* to describe the time surrounding their MSA. Beth, who spent time involuntarily hospitalized, said, "It was such a blur since I was first Baker Acted in September. My whole military service from there, everything was such a blur." Beth's involuntary hospitalization was directly related to her MSA and her emotional state following the incident. Grace (Gonzo) used this term as well:

> I disclosed my entire everything to them and they made notes and everything, and then that's how I was able to go and see the other therapist. So, I'm not even entirely sure what their positions were. It was a very blur type of time for me. But yeah, definitely, I had to tell two different women.

Participants experienced a range of emotions beyond second guessing themselves and feeling that the time around their MSA was a blur. Beth was angry and directed blame toward her leadership when she was still active in the military. "When I had my leadership treat me the way that they did, I wanted to blame them and I tried to blame

them," Beth remembered. She realized, with the help of a therapist, that blaming her leadership was not fruitful. Kara, in addition to questioning her own trauma and PTSD, found herself feeling paranoid and wondering if she was "that much of a pain in the ass" to those around her at the time, including those from whom she sought help. Sasha felt "embarrassed" about the incident, and Mary said she had panic attacks because "you get broken down," as Mary explained.

Women experienced a range of emotions, predominantly negative, about their MSA incidents. Though there were some commonalities to these experiences, most women described multiple negative feelings, including emotions and behaviors strong enough, in some cases, to lead to hospitalization. These feelings were complex, and participants described multiple feelings coexisting together at times. Ultimately, the negative emotions participants felt led them to the sense that it was the right to time to disclose their MSA and seek help, which is described in Theme 2.

Theme 2: Intuitively Knew the Right Time to Seek Help

Building from Theme 1, Theme 2 is about how women made the decision to disclosure and seek help after their MSA. Overwhelmingly, participants identified that they knew it was time to seek treatment, often for similar and multiple reasons. In some cases, something specific happened that made participants seek help. In others, participants recognized ongoing problems they had that led to help seeking.

Four participants described a specific triggering event that led them to seek help. Some of these participants were more forthcoming about the specific event than others. Alice experienced the death of her brother by suicide. In the aftermath of Alice's MSA, this event was an added trauma that led her to seek help. Alice explained:

> We had found out after that he had died that he had went through some horrific things when he was younger. That wasn't talked about or dealt with, and it had just kind of opened up the floodgates. So, I sought counseling again at that point. And at that point, it felt like it was more of a receptive... Definitely way... Just like a 360, a way more receptive environment, and was able to get some help that I needed at that point.

Alice described this event in her life as opening the floodgates and leading her to help. Sarah's experience was somewhat similar in that an event in her life triggered her and led her to seek help. Sarah described how the trauma she experienced following her MSA manifested itself and became increasingly "overwhelming," according to Sarah. When Sarah had a baby, she noticed that things changed. Sarah described:

> I had a baby, but I did not get help for this until couple of years after having him, and it's the fear of trying to prevent anything like that a from happening to him…I worry about him being a victim because I also was a victim advocate and worked in staffers, so I'm very well-educated about male victims. But also, a feeling of needing to educate him so that he knows what is not acceptable. It's just a lot of stress and trauma from that.

Jenna's experience was somewhat different, as her triggering event was something that happened repeatedly year after year. Jenna still worked as a federal employee and had to receive sexual harassment training every year, which retraumatized her with each training. Jenna said,

> So, every time we receive the training because the trauma was so close to me, I would either dismiss myself from the training or stay as long as I could or

> sometimes, I would be more vocal. It just depends on the year that it was. And so there would be counselors afterwards or during it that would step out with me and I would talk to those counselors during that training as an example...So they would have the coordinators associated with training the program and then the counselors with that would step out and make sure that whoever stepped out was okay. And so, I would just explain that I don't want to be reliving whatever session or whatever was going on in there because I didn't want to be a part of it. And so whatever counselor afterwards would talk to me…But I felt re-traumatized year after year as I had to continually take this training every year as a federal employee…And so that's what I struggle with because I see it every year. And yet it continues to re-traumatize people and yet they continue to do it. And I don't know how to overcome that and reconcile it.

Jenna had to relive her MSA every year during this training, despite trying her best to avoid the training and accompanying trauma. Sarah, Alice, and Jenna could recall in detail the triggering events leading them to seek help. Latrice was somewhat different, however. While she could recall the single triggering event, this clearly evoked such painful and traumatic memories for her that she could not elaborate on this during her interview. Latrice's triggering event happened when she saw a man who looked like her attacker. After 20 years spent repressing the memories of her MSA, Latrice's memory was triggered when she saw someone who looked like this man, and she went to the VA to seek help.

Brianne (Bam) and Mary knew it was time to seek help when they were no longer afraid of what might happen as a result of their disclosure. Both were concerned about

repercussions related to their careers in the military if they had disclosed their MSA sooner. Brianne (Bam) said she made the decision to disclose and seek help when she knew "I wouldn't be chastised, and I wouldn't have the fear of it permanently damaging my career." Brianne (Bam) was concerned that, if her MSA was revealed beyond the clinical setting, her unit might chastise or ostracize her, and this fear prevented her from seeking help until after her military discharge. Mary, similarly, sought help when she was no longer afraid. However, in Mary's case, she said, "I felt like I was protected in a way from the distance that I received from getting out of the military." Brianne was no longer afraid because she knew she would not be ostracized by her peers in the military, while Mary was less specific about the reasons why she was no longer afraid, simply stating that the distance from the military helped alleviate her fear.

Feelings of depression also led participants to seek help for their MSA. Grace (Gonzo) said she was "very depressed" after detaching from the military. Grace (Gonzo) attributed this depression to no longer having the routine of the military, which may have helped her avoid thinking about the MSA because of the structure a specific routine provided. Without this, she experienced depression, which led her to seek help. This was the case with Latrice, too, who sought help for "depression" that she associated with her MSA. When Martha ran out of her medication, which she was taking to help her with her MSA, she reported that she "got very depressed and suicidal," and these feelings led her to seek help.

Participants also recognized they needed to seek help when they recognized how their MSA was negatively impacting their lives. Beth recognized that, when she was discharged from the military, she struggled with the pace of life, which was very different

from life in the military. “After getting out…getting moved in with my sister, it took me a time where I needed to really decompress because things just were moving so quickly…I knew it was imperative that I continue with treatment,” Beth recalled of the time. Grace’s separation from the military and period of transition to civilian life was also when she recognized that she needed help. Grace explained,

> Because my entire first year and a half away from the military is when I realized that I had not dealt with what had happened to me in a healthy way, in any way, shape or form, because I just wouldn’t talk about it. And it was affecting my family life, my person, just everything in my life. And I felt like if I spoke to someone about it then maybe they could help me get myself back on track so that I could continue going to school and achieve all my goals without that weighing on me…When I got out and it was all about me finding out who I now was, is when I realized that I had never dealt with that, and I could barely get out of bed. I began drinking heavily. My personal relationships, even with my own siblings, were hurt because they were just worried about me, but I didn’t want to let them help me. And so, it was affecting a lot.

Grace recognized she had never fully dealt with her MSA and made the connection between this and her relationships with others. This also led Grace to abuse alcohol, which she said further contributed to relationship problems. As Grace said, she had time to find out who she was when she left the military, which was a similar situation to the one in which Marie found herself. Marie said that, upon leaving the military, “I finally had time to focus on my mental health, and I knew it was something that needed to be worked on.”

Sasha struggled to complete daily tasks after leaving the military, and she attributed this to her MSA. This daily struggle led her to seek help. Sasha recalled that it took her "a little while to seek help, and the reason was because I was embarrassed." When her MST "was causing me problems with functioning," as Sasha said, she sought help. Though Sasha said she did not have trouble getting out of bed in the morning, "it was hard for me to focus on my daily activities," Sasha said.

Participants knew themselves and knew when it was time to seek help for their MST. Some women referred to specific triggering events that led them to seek help, like seeing a person who looked like their abuser or experiencing another trauma. Women also recognized that unresolved MST crept into their lives after they left the military and did so in ways that impacted their relationships and ability to complete their daily tasks and routines. For some, multiple reasons led to help seeking for MST. Theme 3 describes the process of help seeking that participants went through.

Theme 3: Finding the Right Provider

Following the recognition that they needed to seek help for MST, participants described their experiences seeking help. The women sought help from providers at the VA and in the community, and the providers they saw included doctors and psychiatrists, psychologists, social workers, and clergy from their churches. Women saw male and female providers, all from a variety of ethnic backgrounds. Their experiences with these providers varied but there were commonalities of experience, which is the focus of this theme.

Most participants did not immediately seek help following their detachment from the military, though there was a range in terms of length of time that women waited.

Jenna, Martha, and Sasha waited less than a year to seek help. Sasha sought help about six months after she left the military, and Martha waited about three months. Jenna waited about two months, but she was not the one who initiated the help-seeking process. Rather, she got a call from the sexual assault response coordinator office two months after she was discharged from the military inquiring about her MSA. Jenna remembered, "I had been about four years removed from [the incident], or three years removed from it, and that was when I had that bitter exchange with them." Jenna felt that nobody had really helped her immediately following her MSA incident and so, when the sexual assault response coordinator office called her years later, it was "a day late [and a] dollar short," according to Jenna. Eventually, she sought help from her pastor, who helped her with the trauma and the bitterness she felt in the wake of that phone call.

Other women waited about 18 months to seek help. Alice was one woman who waited a year and a half before seeking help, and when she did it was through a women's clinic. Marie also waited a year and a half to seek help. When Marie was discharged from the military, she had a newborn baby, and felt she "didn't really have the time to focus on myself." When the time came and she did have time to focus on herself, she sought help. Grace also waited about a year and a half, for reasons similar to Marie. Though she did not have a newborn, Grace was in California when she was discharge, and felt that seeking help would worry and hurt those around her. She decided to move across the country so she could "get away from the people that I felt I was hurting and fix things on my own," and immediately after moving, she got settled and sought help from the VA.

Still other women waited years for help. For Latrice, who had suppressed so many of her memories of her MST, the wait was 20 years. Mary "suffered in silence" for nine years before seeking help. For Rachel, the wait was three years, and for Sarah, seven.

To keep the help seeking process as simple as possible, many participants described selecting their providers based on convenience. Martha (Mariah) made this easy for herself and shared, "The first community provider, I literally just looked for one with a good review who took my insurance and went with them. I didn't know anything; [I] was just trying to get in with someone as soon as possible." This was also the approach that Marie took to finding a provider. Marie did not know anything about her provider before she sought help and said choosing the provider was simply "[the provider] being in a convenient location," Marie said.

Rachel explained that the VA was the most convenient option for her when finding a provider. She said,

> I chose behavioral health at the VA because that's part of my medical benefits. And with all the publicity with the VA behavioral health, and PTSD, and all those other things, they have a really good reputation lately. I thought about talking to them because that's where I seek medical treatment – at the VA. VA is like a one-stop shop. You can go there for everything. So, I decided to talk to behavioral health because of that.

Kara, on the other hand, had a slightly different view of the VA, and found it inconvenient, unlike Rachel. Kara was not entirely a discrepant case here, as she tried to find a provider based on convenience like other women, but her experience of the convenience of the VA was different from others' experiences. Kara found the VA

inconvenient because they would send her letters about appointment scheduled for the following day, which frustrated her. “I have a job. I can’t just tell them, ‘I have an appointment tomorrow’,” Kara said. “When you try to call to reschedule, [the people at the VA say], ‘Okay, we can see you in three months’,” Kara continued. The experience left her frustrated because of the lack of flexibility at the VA.

Sarah also tried to find a convenient provider using telehealth, but this did not work well for her. She felt that the telehealth provider tried to meet her needs, so she was satisfied with their level of service, but her life and lifestyle did not appear well suited to teletherapy. “I need to be in person,” Sarah said, “It’s nearly impossible for me to carve out time in my home because I have a husband. I have three dogs and a toddler. And so, [teletherapy] didn’t feel the same…And so, for me, the telehealth was just not a good fit.”

Participants waited to seek help after they left the military, for months or years, in some cases. For Jenna, seeking help required the prompt of a phone call, which she did not appreciate but perhaps spurred her into action. Women chose convenience, either in location, timing, or comfort, when they sought help from providers. Some women had better experiences with the convenience than others. Those women who were unable to find a provider that offered greater convenience kept searching for providers until they found the right fit for them.

Theme 4: Disillusionment with VA in Help-Seeking Process

As participants were all formerly military, many sought at least some form of initial help through the VA, which was a convenient provider option for them and one they trusted could help them. Unfortunately, nine participants expressed disillusionment

with the VA or other military-related entities during the help-seeking process. This disillusionment is the topic of Theme 4.

One way that this sense of disillusionment manifested was in feelings of bitterness and resentment. Jenna felt that the VA was not available for and supportive of her following her MST and discharge from the military. Her bitterness seemed centered around that and the fact that she believes women in the military now get better care than she received. Jenna explained,

> I was so bitter at the time…it was just this growing bitterness, so I never did seek a counselor or therapy [at the time] …Now they have, it's bitterness, now they have these systems in place where you can request to leave the unit and you can get out of there. That wasn't in place when I was there. And so I'm grateful that they have these things and it doesn't mean that people don't have feelings and people still don't talk but it's just like…it's almost this jealous for the way things work now…That growing bitterness…yeah, it's like a growing bitterness.

Jenna had a difficult time making sense of the help available to soldiers now that was not available when she was in the military and used the term *bitter* repeatedly to describe her feelings about this. Kara used the term *resent* to describe her feeling of disillusionment with the VA and lack of care she felt they gave her. "Sometimes I, I guess, resent that…I have to pay $600 a month for something that the VA should be dealing with," Kara said, "That's how much I detest the VA." Kara resented that she should be able to receive care from VA providers, as this was a service afforded to veterans, but instead, her experiences with the VA were so bad she was forced to pay for her own insurance so she could seek help from a provider with whom she was happy.

Participants also used the term *frustrated* to describe their disillusionment with the military and the VA after they were discharged. Martha said the clinicians at the VA made her feel like she was not sick enough to be treated at the VA. Martha shared, "[I felt] very frustrated, because I also suffer from eating disorders. And one of the reasons, because I was not drug-seeking or alcohol-seeking, I wasn't sick enough. [The VA] didn't count eating disorder as a seeking-like behavior." Martha's frustration appeared to come from not being taken seriously and from being treated as though her MST was not worth treating.

Rachel also felt frustration with her experience at the VA. Rachel was able to see a provider, but the provider was an intern and made Rachel feel that she was going through the motions of the disclosure process rather than actually making measurable progress. "I was very frustrated. I was kind of angry," said Rachel of this process, "I felt like my time had been wasted, but I understand the military works; you have to sometimes talk to interns…I wasn't prepared for such a textbook interview process when I was reaching out."

Rachel's statements here highlighted another problem that participants described of their experiences seeking help through the VA, which was that the VA felt very clinical. For Alice, this meant that the VA did not feel like a comfortable place for her, which she attributed to being a woman. Alice explained,

> Thinking I was leaving, I didn't have access to healthcare or anything leaving, and when I got to Puerto Rico I got in touch with the VA there, and because I was a pregnant veteran, first of all, they didn't really…It wasn't a very warm, fuzzy place for female veterans…And at first, they would just, like, every single time I

> would try to check in and get an appointment, they were like, "Okay, and what's your spouse's name?"…I was frustrated and felt really marginalized. Like my military service wasn't appreciated because I was a female… [The process] was just pretty mechanical…I feel like it was more just putting the checks in the box.

Alice's experience was characterized by frustration with the VA, as were Rachel's and Martha's experiences. This was partly due to the clinical—as opposed to warm—experience Alice had. In addition, Alice felt marginalized because she was a woman, and the VA did not appear to treat her the same they would perhaps have treated a male veteran. Beth also felt like the providers at the VA were "just checking boxes," similar to Alice. Beth wanted more support but instead, described an approach that "[was not] very intentional of, like, 'how are you doing?'," Beth said.

Kara also described a very clinical, sterile help-seeking and disclosure process at the VA. "I felt like I was on display," Kara explained. She said she felt like the VA was there for her if she needed medication, but not when she needed someone to talk to. Kara said,

> [I felt like] what am I getting out of it? With the VA, it always felt like, "We'll throw all the drugs at you that you want." But when you tell them, "No, I'd actually like to just come talk to somebody," oh, well then that's more difficult.

Women also became disillusioned with VA when they were made to feel that their MST was not important. Jenna felt that her chain of command after transitioning to civilian life did not take her seriously, which made her feel like she was on her own to help herself. In some cases, this feeling of minimization came in relation to other veterans. Kara went to a support group for PTSD but found she was the lone person the

group experiencing PTSD related to MSA. “That was extremely awkward for me, because everyone else there was a combat veteran, male combat veteran,” Kara recalled. She appeared to internalize this belief that her MST was not as significant an event as PTSD from, for example, war and conflict. “I felt like, talking with these guys, that some of them had limbs missing, that I didn’t deserve to be there,” Kara said, even though she knew that her MST was no less traumatic and said, “It’s a different type of trauma.”

Martha also attended a PTSD support group, but specific to women veterans who had experienced MSA. Martha recalled how, in that group, “people don’t think you’re sick enough for this stuff,” and she wondered why she had to meet some kind of “checklist to get treatment in the VA.” Martha sought help from another vet center but was “compared to combat PTSD things, and I didn’t feel very validated,” which led her to feel minimized.

Kara got a similar feeling to Martha and Kara from her VA when she sought treatment. Kara explained:

> I think with the VA, and this is just my personal opinion, maybe the interns or the majority of folks that they see there are the elderly community, elderly population, and those with a lot of war-associated PTSD, not necessarily PTSD from MST or any type of trauma [from] being deployed. That’s usually the first questions that they ask. “Were you deployed? Do you have PTSD from that deployment?”

Participants felt that the VA, as an institution they should have been able to trust to take care of them after military discharge, was not there for them. Women felt uncomfortable because the setting felt too clinical. They felt that the VA and other

military-associated institutions that could and should have helped them post military discharge did not provide them with needed support. When participants sought help from the VA, they were made to feel that their trauma was not as serious as combat veterans' PTSD, and they internalized this feeling of minimization. Through this, participants became disillusioned with the VA.

Theme 5: Satisfaction with Provider in Disclosure Process

Participants described some negative experiencing in the help seeking and disclosure processes, particularly with the VA and other veteran-related services. However, as experiences are complex, the women also had positive help-seeking experiences, both with the VA and with other community clinicians and providers. Participants learned coping skills that helped them in their recovery, which led to overall satisfaction with the disclosure process. It appeared as though once participants found the right provider, they were satisfied with that provider, which is addressed in Theme 5. Four subthemes supported the creation of this theme, and each subtheme relates to a facet of women's disclosure and help-seeking processes that led them to feeling satisfied with their provider. The exception to this is the fourth subtheme, which presents a negative case. Subtheme 5d, the fourth subtheme, describes those instances when participants believed did not get what they needed from their provider in the disclosure process, leading to feelings of dissatisfaction. This provided a counterpoint to the other three subthemes.

Subtheme 1: Feeling Supported During Disclosure Process

Nearly all participants described situations with their providers when they felt supported. One way that participants felt supported was when they felt heard by their

providers, or that their providers were really listening to them. Brianne said her providers listened to her and did not force her to do something in her disclosure and help seeking that she was uncomfortable with. “They really listened or were open, and they still are,” Brianne said. Grace also appreciated that her provider listened. Grace shared:

> [H]er active listening and her gentle nodding and overall, just her demeanor was so gentle, and accepting and nurturing that I, at no point, ever felt uncomfortable or anything like that. So, I think all of that helped. Her response was, I guess, no response, but actively listening.

Marie, like Brianne and Grace, felt like she “was actually heard” by her provider. Marie said this made her feel that her trauma was recognized. Mary also said her provider was “very open, and warm, and caring, listened.” Mary said she never felt pressured to talk about anything she was uncomfortable with, which added to her sense of being supported.

There were discrepant cases regarding feeling heard, as some participants said they felt their providers lacked empathy. Bernadette said,

> To be honest, at that point, I had pretty much had some experience with counselors and psychologist, prior to this person, and felt that they weren’t really vested in my care. It seemed like she wanted to get through it, didn’t really go into it very much further about my assault. She just was like, “Okay, so how many times did it happen?” Or asking and kind of like ran through the questions and didn’t really show... I didn’t feel like she cared.

Latrice also felt that her provider lacked empathy. “They’re not empathetic,” Latrice said, “I would never recommend anybody to disclose to a psychiatrist because

that's kind of not their strong suit." Latrice felt the psychiatrist was better suited to medication prescription but not disclosure and psychotherapy.

Participants also felt supported through the validation they received from their providers. Brianne recalled her provider telling her "It's not your fault," in reference to her MSA. Brianne said this made her feel that she was "entitled to" her feelings, and she was not treated like her MSA was her fault. It took Martha three providers to finally find one who made her feel supported. Martha currently sees that same therapist, who made her "feel very validated," though she also noted that people who helped her through the disclosure on the civilian side were more receptive and understanding of her MST.

Other women were also told that their MSA was not their fault, which led them to feel validated by the providers. Sasha said her providers "pretty much told me not to blame myself," which provided her with comfort "in recognizing the fact that [the MSA] wasn't my fault." Mary's provider also told her that nothing related to her MSA was her fault.

Provider validation enhanced participants' sense of comfort with their providers and led to overall satisfaction with the experiences. Grace said she was "lucky to get a therapist that I felt very comfortable with right when I met her," which she said helped her a lot. This was similar to Marie's experience with her provider, whom she sees through the VA. Marie explained that her provider "goes out of her way to break down the barrier that she's a doctor and I'm not," which Marie connected to her sense of comfort with her provider. Sasha also described her sense of comfort with her provider. Sasha already worked with a community center in her job and used this as an opportunity to seek help. "This gave me an opportunity to actually go in and speak with someone…I

would be able to at least verbalize it and talk to someone about it…gave me more comfort in being able to do it," Sasha explained. Kara described the feeling that she was "a specimen instead of a person."

Subtheme 2: Feeling Empowered Through Disclosure Process

Participants were also satisfied with their providers because they felt empowered through the disclosure process. For several participants, this was because their providers made them feel like they were an active part of the process. Beth "got to make the decision who I disclosed to," which made her feel in control of the situation. Jenna said her disclosure experience was "empowering, healing, hopeful," and Kara said she felt "more in control now." Sasha also described feeling "empowered," because she felt valued and that she could go on in life.

Marie explained how her provider helped her feel empowered in the process. Marie's psychiatrist asked for her input on treatment with medication, and she "really appreciated having some kind of control in my treatment plan." Sarah also felt in control of her disclosure process because her provider did not push her during the process. Sasha described the first appointment she had with her provider:

> [W]when I first went to the very first appointment with her is, okay, now I have to tell the story again. And she is very good at if I just say, "Okay, that's it. I'm done." We go onto another topic. There's no pushing.

When participants were free to move through the disclosure process at their own pace, they appeared to feel empowered. This feeling also came from having providers who sought their input. Having a sense of control over the situation helped participants feel empowered.

Subtheme 3: Trusting the Disclosure Process and Provider

Part of feeling satisfied with the disclosure process came from trusting the disclosure process and the provider. When Brianne moved to a new state, where she knew there was a great VA system, she decided to go there and trust that the process would work. Brianne said,

> When I first went up to mental health, they were very great, the nurses that were up front too. They set me up with the intake nurse and I sat down with her and she was great too. Gave me a little bit of their background, what she could do for me. Anything that I said to them, they would not judge against me.

Grace also said that despite the "negative rep" of the VA, she decided to "wholly trust the VA" because she knew she needed help. Grace said she was glad she made the decision to trust the process, because she found a provider whom she was satisfied with through the help of the VA. For Sarah, the fact that her provider did not push her created "a lot of trust," according to Sarah.

Unfortunately, not everyone had this sense of trust, and Alice presented a discrepant case here. Alice said there was a "lack of trust" in the VA because of how she was initially treated by the providers at the VA. That initial experience turned Alice away from trusting the VA, which had a lasting impact on her.

Subtheme 4: Not Getting What She Needed from Disclosure Process

The final subtheme in Theme 5 is about a dissatisfaction with the disclosure process due to participants not getting what they believed they needed in the way of help. Kara had this experience with the first provider. She said, "Well, the first provider…exactly told me, 'Let go and let God, and pray,' and my feeling was 'Dude, I

need science here. Please don't tell me to pray this away'." Kara recognized that she needed more help by way of therapy and not prayer and did not receive this from the first provider she disclosed to.

Martha was made to feel that she was a burden. She said she could tell that the providers she saw were "overworked," and she said she "felt like I was more of a burden trying to seek care than anything else." This led Martha to stop seeking help because she did not want to be told that the providers were full.

For Marie, the experience of not getting out of the disclosure process what she needed was related to the provider neglecting to work on the MST with her. Marie described,

> With my therapist, we initially focused on the MST itself, but then it branched to other areas. I feel that my initial goal of going to the therapist to talk and deal with my MST has kind of been lost. She's never handled it in a poor way, but the focus was moved away from that. At first, I didn't mind it because I didn't have to talk about it. But then as I kept going back, I felt that I wasn't getting out of it what I wanted. I'm not sure if I will be going back with her…I guess there wasn't as much support as I was hoping for.

Sarah did not feel she was getting the help she needed from her provider either. Like Marie, Sarah said that her provider did not handle her poorly but did not provide what she needed. Sarah said,

> [M]y provider was brand new and didn't have a lot of experience. I didn't gather in certain areas. And so, that did not really help my confidence level on her ability to get me where I needed to be…She was with a local community counseling

> center, a young white female, very new. I think her newness came out, and not that she was doing anything wrong per se, but she just didn't give me a lot of confidence that she would be the right fit for me.

After this experience, Sarah found a new provider who turned out to be a better fit, and who Sarah said is a comfort.

Participants had many experiences with providers that they were satisfied with during the disclosure process. They were satisfied when they felt listened to and heard and were made to feel comfortable and supported through the process. Participants also appeared satisfied with their providers when they decided to trust the process. However, this was not the experience of everyone. There were participants who had negative experiences, which were often related to the perception that they were not getting what they needed from the disclosure process. Despite negative experiences, most participants either were still getting help for their MST or would continue to get help, which is the subject of Theme 6.

Theme 6: Ongoing Help-Seeking

Participants who had both negative and positive disclosure experiences, with providers at the VA or VA-adjacent and in the community, would continue seeking treatment. That is, although participants did describe disclosure processes that were not good, many would seek, with some qualification, ongoing help if needed. Three participants were still in ongoing therapy. Grace still saw a therapist through the VA. At the time of her interview, she was applying to nursing schools, and an important consideration for her when deciding where to go to school was how close she would be to a VA. Grace knew that she needed ongoing treatment, and this played a big part in her

major life decisions. Martha, whose therapist had left the practice, was looking for a new therapist when I interviewed her. She said she "decided to switch and try to go with someone that was veteran-specific" after her therapist left. Sarah also continued therapy after learning that telehealth was not the right option for her. Only one participant, Sasha, believed she was "not at a point where I think I want to continue seeking help." Sasha leaned heavily on her mother for support and felt that the therapy she received in the past, combined with the support from her mother, was sufficient for her.

Some participants were nervous to seek help after negative experiences but continued. Marie said of her therapist, "Our appointments kind of, as they're dragging on and as they kept going, I felt less inclined to want to go back, which makes me more nervous going to a different one." However, Marie said she would be "willing to try [a new therapist] but I don't think I would be as actively searching for one." Mary was also nervous but undeterred. Mary said,

> Yeah. I still did seek help. It did not 100% deter me. It made me hesitant. I guess that's probably a good way to say it. It made me think about should I continue to seek help, and I ultimately decided that I did need to continue to seek help.

After an initial bad impression of and treatment by providers at the VA, Alice continued seeking treatment. She said when she first visited the VA, "the conversation was just, like, immediately shut down," but a year later Alice went to a women's clinic that left her with "a much better impression." During that second visit, Alice felt that she was given the opportunity to build some trust with the provider and determined it was safe to continue with ongoing help.

Bernadette was also undeterred by her negative experience, which may have been because of her attitude toward therapy, which was that she was a consumer. Bernadette said,

> The VA rep that did the claim, I mean, she's just one person…if I needed help now locally through the VA, I would absolutely still go to the VA and try. I feel if you're not happy with the person you're seeing, you are a consumer still, you know what I mean? Like you can shop around, like if you don't like your therapist, your psychologist, you have to be honest and be like, "I need to see someone else." So, if I felt necessary to go seek help, I would still go to my local VA and go there first and try to meet with somebody if I felt I needed help, for sure.

Bernadette also advocates that friends and family go to therapy, even if it takes a couple of tries to find the right provider. As a consumer, Bernadette believed that she could shop around until she found the right therapist, which worked well for her.

Those women who had good disclosure experiences were also inclined to continue help seeking. Brianne said that because of her experience with the VA, she was more inclined to seek help with them again. Alice also said she would continue to seek help, though perhaps "not necessarily related to my MSA." Having a good experience with her second provider led Alice to want to continue therapy. In contrast, Martha, who had a bad experience with the VA, said she would "strictly stick with civilian side," and she would also encourage other veterans to do the same.

Participants sought help from different types of providers both in and out of the VA and other military institutions. They saw male and female providers of all ethnic

backgrounds and ages. They saw providers who were psychiatrists and psychologists, providers who were social workers and counselors, and providers who were members of the clergy. Participants described a mix of positive and negative experiences with those providers and although there were negative disclosure experiences that, for some participants, led to some hesitation about further help seeking, most participants were undeterred by those negative experiences. Those participants who were not still currently in therapy said that they would seek help in the future if necessary.

Summary

Findings from this study indicated that women had mixed experiences with their providers during the disclosure process. Some participants had positive experiences with their providers during the disclosure process. Some participants had positive experiences with all providers they visited, making them feel comfortable and satisfied with the process. Other participants reported feeling that their MSA was not taken seriously or that their experiences were not a big deal. Many participants reported negative experiences with providers at the VA, an organization they believed was meant to help and support them. Despite any negative experiences, participants were clear that they would not let these experiences impact help seeking in the future.

The next chapter will synopsize and offer conclusions about the results of this study. Chapter 5 will also discuss the six themes that emerged in this study, the connection of these themes to the literature and the limitations of this study as well as future recommendations for ongoing research on this topic.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this phenomenological study was to explore perceptions of the post service help-seeking experiences of female veteran MSA survivors, which addressed a gap in literature and provided insight that can inform treatment for this population. The female veteran participants provided rich details pertinent to their MSA-related help-seeking experiences while emphasizing the impact that MSA continues to have on their daily lives. Qualitative analyses revealed that the female veterans had complex and varied feelings associated with MSA incident itself, most of which were negative such as righteous indignation, trepidation, and self-doubt. The participants described these feelings as sometimes co-occurring and at times, emotions, and subsequent behaviors in some cases became unsettling to the point that their hospitalization was warranted. The participants also discussed consequential physical and mental health disorders as well as suicidal ideation and suicide attempts. The impact that these negative feelings, triggering events, and other traumatic experiences had on the participants' recovery eventually led them to disclose their MSA when seeking help.

The female veterans also had mixed experiences with their providers when disclosing their MSA. Though some female veterans had positive encounters with the providers they visited that left them at ease and content with the process, others indicated that they came away feeling as if their MSA disclosure was not taken seriously or that their providers behaved as if the female veterans' MSA disclosures were insignificant. Several participants expressed disappointment and even disdain with the VA as a result of their negative encounters with VA providers. However, regardless of any unpleasant experiences, some participants maintained that they would not let this deter them from

future help-seeking efforts. From these results, six themes were identified with the use of Braun and Clarke's (2006) approach to thematic analysis as a guide: Theme 1: Feelings surrounding MSA incident, Theme 2: Intuitively knew the right time to seek help, Theme 3: Finding the right provider, Theme 4: Disillusionment with VA in help-seeking process, Theme 5: Satisfaction with provider in disclosure process, and Theme 6: Ongoing help-seeking.

Interpretation of the Findings

Theme 1: Feelings Surrounding MSA Incident

Theme 1 highlighted the participants' mixed negative emotions about their respective traumatic experiences, some of which consisted of second guessing their feelings, fear of not being believed, self-blame, anger, shame, and embarrassment in addition to personal relationship difficulties. Reluctance on the part of some to report their assaults while serving in the military out of fear of reprisal such as victim blaming, and re-traumatization is a common sentiment among many MSA survivors (Lucero, 2015). Further, due to their own acceptance of rape myths, sexual assault survivors have reported feelings of awkwardness and guilt, which tended to deter further help-seeking efforts (Mitchell, 2015). Sexual assault survivors are motivated to disclose to informal social supports when they feel ready to talk and are supplied with a comfortable environment (Mitchell, 2015); however, both providers and survivors have felt that providers are unprepared to render adequate aid and that the support that was given during the disclosure might be insufficient. This is significant to address, as sexual assault survivors are more prone to suicidal ideation (Turchik & Wilson, 2010). This theme supports previous research that suggested that providers who were perceived as

caring and who communicated at the same level as the veterans likely facilitated MSA disclosure (Jeffreys et al., 2010).

Theme 2: Intuitively Knew the Right Time to Seek Help

The results of this study indicated that the participants recognized the residual impact of untreated MST on their post military lives, which signaled their need to seek help. Participants experienced events that triggered an upsurge in their MST-related symptomology such as debilitating anxiety and depression, which prompted their help-seeking. The conceptual framework of this study, the social constructivist theory as proposed by Leung (2017), supports the timing of the female veterans' help-seeking efforts based on their knowledge and interpretation of the social context as exemplified through their culture, interpersonal encounters, and availability of support. Thus, this theme supplied a platform for a deeper understanding of what prompted MSA disclosure during the participants' help-seeking encounters.

Theme 3: Finding the Right Provider

Theme 3 presented the perspectives of the participants on finding the right provider, which are supported by a cognitive theory in general research proposed by Liang et al. (2005) that called attention to help-seeking in stigmatizing situations. This cognitive theory served as the conceptual framework for the help-seeking processes of female veteran MSA survivors regarding (a) problem acknowledgement and definition, (b) deciding to seek help, and (c) choosing a help provider. Clinical settings that consistently provide supportive provider interactions while facilitating trauma disclosure allow patient privacy and ensured adequate treatment time (Jeffreys et al., 2010). Such a clinical setting is an essential component in the search for an ideal provider, and it is

significant that providers acknowledge gender-specific physical and psychological problems associated with MST in their treatment of survivors. Thus, provider responses to this population are significant in terms of their impact on the recovery of female MSA survivors.

Theme 4: Disillusionment with VA in Help-Seeking Process

Theme 4 revealed the participants' disillusionment with VA in help-seeking process. Some perceived barriers to MST-related care within the VA health care system encountered by female veterans are gender-related concerns such as awkwardness with a male provider and the absence of support from a male-dominated environment, which exacerbate feelings of fear, shame, and embarrassment that female veterans may already have as a result of their experiences with this traumatic phenomenon (Turchik et al., 2014).

Moreover, MSA survivors with PTSD acquired from sexual assault continue to be held to a more rigorous standard of proof when they apply for disability benefits through the VA (Rosenthal & Korb, 2013). But many MSA survivors lack the officially documented proof of their MSA that was required by the VA due to underreporting. However, the VA and Congress have had no plans to eliminate the paperwork requirement for servicemembers suffering from MSA-related PTSD, unlike those with combat-related PTSD for whom the documentation requirement was relaxed in 2010 (Rosenthal & Korb, 2013).

Another aspect related to the participants' disillusionment with the VA during the help-seeking process is the invisibility and inequitable treatment of female veterans in within the VA system. Despite attempts to reduce the healthcare services disparity

between women and men by increasing the number of available healthcare providers, creation of comprehensive primary care services, and emphasis on improving specialized mental health services for female veterans, the care female veterans receive in comparison to their male counterparts is often substandard (Military Officers Association of America, 2015). Further, the invisibility of female veterans within the VA system was characterized by them being mistaken for a spouse of a veteran or being overlooked by staff (Dolsen, 2015)

Theme 5: Satisfaction with Provider in Disclosure Process

Theme 5 detailed the participants' satisfaction with provider in disclosure process and consisted of the following four subthemes: feeling supported during the disclosure process; feeling empowered through the disclosure process; trusting the disclosure process and provider; and not getting what she needed from the disclosure process. The support, empowerment, and trust from a provider during the disclosure process are vital factors in the establishment of a positive patient-provider relationship. Subthemes 1 through 3 are affirmed by research indicated that healthcare settings where providers are forthright and have cultivated positive alliances are those in which sexual assault survivors are likely to demonstrate a willingness to disclose their trauma history (Berry & Rutledge, 2016). These subthemes are further substantiated by research suggesting that though the self-worth of sexual assault survivors can be reaffirmed with supportive responses by providers, feelings of shame and isolation can increase with negative provider responses (Jacques-Tiura et al., 2010).

Female MSA survivors not getting what they need during the disclosure process is confirmed in current research on health care satisfaction. Subtheme 4 is corroborated by

research demonstrating that women who used VA health care were more dissatisfied with the services provided than the men using VA health care services and women who received civilian health care because of the perception that the needs of male veterans were primarily emphasized in VA health care (Campbell & Raja, 2005; Kelly et al., 2008). Early MST/MSA assessment and referral to appropriate care when transitioning from the military with the coordination of treatment and care between both the military and veteran health care systems is one potential strategy to ensure that the needs of survivors are adequately addressed (Schuyler et al., 2017).

Theme 6: Ongoing Help-Seeking

Theme 6 shed light on the participants' ongoing help-seeking, which suggested both negative and positive disclosure experiences with both VA and community providers. Research has supported female MSA survivors' preference for non-VHA MST-related care due to the environment that health care institutions create (Monteith et al., 2021, p. 7). This greater preference for non-VHA MST-related care was thought to be possibly due to the survivors feeling more comfortable with health care that has no connection to the military (Monteith et al., 2021). Conversely, institutional betrayal was also affiliated with MSA survivors being more likely to have obtained VHA MST-related care possibly due to the greater need for health care that supplants previous institutional encounters that would have otherwise caused the survivors to be reticent in seeking help (Monteith et al., 2021). Hence, the results were mixed as it related to the likelihood of whether female MSA survivors who experienced both negative and positive disclosure encounters would seek ongoing help VHA and non-VHA providers.

Ongoing treatment was a major consideration for some of the participants when making significant life decisions. One of the participants valued ongoing help so much so that she was in the process of looking for a new 'veteran-specific' therapist to replace her former therapist who had left the practice when she was interviewed for this study. Another participant exercised her therapy options as it related to her preference for continuing therapy in person rather than telehealth. Only one participant in this study chose not to continue seeking help as she believed that drawing from the therapy she had in the past along with her mother's support, was the best option for her. Yet another participant who had an unpleasant experience with the VA, was adamant that she would continue to seek help in the civilian sector and would advocate for her fellow veterans to do the same. Lastly, there were some participants who, although they were not currently receiving any treatment, indicated that they would be willing to seek treatment in the future if they deemed it necessary.

Limitations of the Study

An innovative approach was utilized in the current study to unveil the resonant details associated with the help-seeking processes of female veterans in which they disclosed their MSA incidents and the impact on their perceptions surrounding these experiences. However, it is important to mention the limitations of this study that may contribute to opportunities for future research on this topic. An issue that could possibly influence the research process is the anticipated power differential that may crop up in research, particularly when studying military veterans who may assume that a de facto hierarchy is present in the research relationship. Accordingly, a participant may communicate only those facets of her experience that she deems to be more palatable, but

in doing so, may jeopardize the credibility of the study results (Goldblatt, Karnieli-Miller, & Neumann, 2011).

Similar concerns may arise during the member-checking process during which time participants are afforded the opportunity to verify their individual interview transcripts for accuracy, especially when the participant has shared unfavorable opinions about their experiences with a provider (Goldblatt et al., 2011). Additionally, a limitation encountered in this study was in the way of trepidation related to conducting research with this specific subgroup of trauma survivors, which is that of "institutional cautiousness" from fear of exploiting this vulnerable population (Burgess-Proctor, 2015, p. 128). Burgess-Proctor (2015) warned that:

> Not only does it appear to be unwarranted, excessive institutional cautiousness restricts the ability of abused women and other trauma survivors to have their experiences represented in "what we know" about violent victimization. That is, failure to conduct research involving abused women out of a desire to shield them from harm or exploitation deprives them of the opportunity to give voice to their experiences (Clark & Walker, 2011), while simultaneously limiting our understanding of violent victimization. Not only does this violate the justice principle of the Belmont Report, it potentially harms trauma survivors by hampering their ability to share their experiences (Cromer & Newman, 2011) (p. 128).

Hence, establishing unconditional positive regard (acceptance and caring) with the participants prior to interviewing and throughout the interviewing and member-checking process is a key consideration in the adequate acknowledgement of both issues.

Recommendations

The case for future research on the connection between the likelihood of secondary victimization upon disclosure and the first theme that emerged from this study, *Feelings Surrounding the MSA Incident*, coincide with the assertion by Campbell and Raja (2005) that:

> Over half (59%) of the military sexual assault incidents were reported to military legal officials, but most survivors (70%) indicated that they were actively discouraged from reporting the assault. In other words, when women came forward to report incidents of completed sexual penetration committed by the use of force or the threat of force, they were told they should not report the incident. In many cases military officials refused to take the report or directly told the victim that what had happened to her was not serious enough to pursue further. Not surprisingly, 83% of victims who tried to report their assaults to military officials stated that this experience made the reluctant to seek further help (p. 104).

This is a significant direction for future research that can help both military and civilian providers and stakeholders develop a clearer understanding of this connection in light of the fact that female veterans are more often than not discouraged from reporting MSA incidents while serving in the military. Schuyler et al. (2017) suggested that military personnel need "appropriate and timely assessment for MSA/MST…such as prior to leaving the military, in order to mitigate related negative health effects and risk behaviors and provide linkages to sensitive and appropriate sources of care" (p. 9). It stands to reason that there may be continued reluctance on the part of MSA survivors to

seek help even after military discharge due in large part to how the secondary victimization that they suffered in service contributed to the feelings that they have surrounding the MSA incident. Therefore, future research and protocol within the military and civilian communities should also examine transitional aspects and methods to alleviate the deleterious effects of MST/MSA during this time in an effort to avert persistent physical and psychological problems (Schuyler et al., 2017).

Research is also needed that investigates the disclosure and support dynamic in more detail through a longitudinal study of female MSA survivors and providers in which the providers' perceptions of the help-seeking encounter is also emphasized. It is believed that a wealth of knowledge can be gleaned by examining this phenomenon from more than just the perspective of the MSA survivors. Ahrens and Aldana (2012) posited that the limited research on the survivor-support provider relationship that does exist indicates that survivors and support providers often do not perceive the survivors' disclosures in the same way. Future research in this area may yield results that could have far-reaching implications for clinical practice and policy in both the military and civilian communities. Moreover, research highlighting the point of view of both the MSA survivors and support providers during help-seeking encounters in which disclosures take place can effect positive social change as it relates to the concerns of the MSA survivors that surfaced in Themes 2 through 5 of this study.

Despite the fact that the smaller sample size facilitated in-depth qualitative analysis and given the prevalent findings in previous research, this was believed to be a representative sample size for this study. However, a larger sample size in future research might also help to boost findings of the veterans' help-seeking perceptions about MSA

disclosures to formal providers and add to the robustness of the study as well. Furthermore, it should be noted that future qualitative studies using a larger sample size might be beneficial for the confirmation of the qualitative themes developed in this study.

Although previous research indicates that a majority of MSAs involve a female servicemember, future research should investigate the help-seeking experiences of male veterans as little is known about the help-seeking experiences of the male MSA survivor population. Research with male veterans is an important consideration that can add to the research knowledge base for this study topic because male and female MSA survivors may present in a healthcare setting with unique sets of clinical treatment needs. The military's masculinist nature is experienced differently by male and female servicemembers (Weitz, 2015). The "band of brothers mentality" that is considered to be a military institution, and which could potentially have a harmful effect among male servicemembers who experience MSA, given the fear and shame that is associated with the betrayal of a comrade by a self-report of the MSA incident (Schuyler et al., 2017, p. 8).

Implications

Positive Social Change

There are several policy and clinical implications that can be ascertained from this study as the scarcity of previous research accentuated the necessity of considering the experience of MSA survivors with the aim of developing interventions directed at more efficacious healthcare communications. For instance, as the Department of Defense and Veterans Affairs continue to implement a variety of support initiatives for MST survivors, a significant implication for practice to consider is the critical initial approach

of practitioners with this population in the interest of effectively facilitating disclosure and providing better informed trauma-focused treatment. Additionally, military health policies that target military servicemembers should focus on the significance of destigmatizing mental health and adopt a proactive approach in providing regular professional military education on sexual assault prevention for all ranks to include military health providers. Granted, much improvement has yet to take place in the way of effectively addressing MSA as a whole within the context of military culture as we know it because comprehensive treatment for MSA survivors is still lacking. Worth considering is the notion that if military servicemembers are provided with unfettered and discreet access to culturally competent mental health and primary care services and receive sexual assault prevention training throughout the course of their military careers, then stigmatization, concerns over shunning by one's peers and fear of reprisal from their chain of command for seeking help may potentially be abated.

Mitchell (2015) elucidated that the use of anonymous interventions is another clinical implication in which a web-based intervention that allows for the receipt of anonymous feedback in a comfortable environment regarding a sexual assault could be beneficial. Thus, the opportunity for servicemembers and veterans to privately access timely and effective clinical interventions could be the pathway to more positive, less challenging help-seeking experiences for female MSA survivors in particular. Another worthwhile intervention as proposed by Schuyler et al. (2017) might include early MST/MSA evaluation and referral to appropriate care at the time of transition from the military, with treatment coordination and care taking place simultaneously between the military and veteran health care systems.

Conclusion

The phenomenon of interest for this study were perceptions of help-seeking experiences among female veteran survivors of MSA. The aim of this study was to increase awareness and understanding of the help-seeking experiences of these female veterans and to address gaps in the literature regarding the MSA survivors' perceptions of their help-seeking experiences in which they disclosed their MSA. Specifically, the use of rich, poignant descriptions provided the participants of this study with a voice that could not otherwise be heard in existing quantitative research. Additionally, due to the scarcity of knowledge about what experiences female MSA survivors have when disclosing MSA, this study further aimed to contribute to the literature gap by giving a voice to and strengthening the prospect for outcomes that can be utilized to help this population.

Participants utilized the help of different types of VA and non-VA providers and other military institutions. They obtained treatment from male and female providers of various ethnic backgrounds and ages. They were treated by providers who were psychiatrists, psychologists, social workers and counselors, as well as providers who were members of the clergy. Despite some of the participants having previous negative disclosure processes that may have led to their apprehension about seeking ongoing help if needed, the findings of this study indicated that they were largely undeterred and continued seeking help.

Findings from this study provide solid examples of both positive and negative help-seeking experiences which can inform healthcare providers and stakeholders about what communication behaviors during MSA survivors' help-seeking encounters with

providers are beneficial for their recovery and those that are not, and which may need to be adjusted.

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Appendix: Interview Instrument and Protocol

Subject ID#: _____

Date of Consent and Interview: _____

INTERVIEW

I'd like to gratefully acknowledge your generosity for your time and presence here to share your experience with seeking help from healthcare providers to whom you've disclosed your MSA. Although discussing your help-seeking experiences may be difficult for you, please understand that you are in a safe environment and please feel free to take a break at any time during this interview. You may also decline to answer any question that you do not wish to answer, and you may also end the interview at any time, with no further questions asked. Should you feel the need to talk with a professional counselor, victim advocate or other qualified responder, one will be made available to meet with you. Are you ready to start?

We will begin with some personal background questions first:

PERSONAL BACKGROUND QUESTIONS

1. Are you a Veteran?

   Yes___
   No___

2. What is your age? _____

3. What is your marital status?

   Single/Never married___
   Married___
   Living with a partner___
   Separated____

Divorced____

4. What is the highest level of education you've completed?

   Some high school___
   GED___
   High school graduate___
   Trade or technical school___
   Associate degree___
   Bachelor's degree___
   Master's degree___
   Doctoral degree___

Next, I will ask you some background questions about what healthcare and/or community providers you disclosed your MSA to while seeking help after military discharge.

HEALTHCARE AND/OR COMMUNITY PROVIDERS FROM WHOM HELP WAS INITIATLLY SOUGHT AND TO WHOM MSA DISCLOSURE WAS MADE AFTER MILITARY DISCHARGE

1. What kind of establishment did you visit when seeking help?

   Local County Health Department___
   Local Community Hospital or Clinic___
   Women's Center/Rape Crisis Center___
   Veterans Affairs (VA) Clinic, Medical Center or Hospital___
   Other, specify___

2. What type of healthcare and/or community provider(s) did you seek help from?

   Psychologist/Counselor/Therapist
   Social Worker___
   Psychiatrist___
   Medical Doctor___
   Nurse___
   Clergy___
   Other, specify___

3. What was the gender of the provider from whom you sought help?

   Male___

Female___

4. What was the ethnicity of the provider from whom you sought help?

   African American___

   Asian/Pacific Islander___

   American Indian/Alaska Native___

   Caucasian___

   Hispanic___

   Other, specify___

   Unknown___

Now, I am going to ask you some additional background questions about decisions you made about seeking help, the reactions of those healthcare and/or community providers to whom you disclosed your MSA while seeking their help, and how you felt during and after your visit with the provider.

HELP-SEEKING DECISIONS, PROVIDER REACTIONS, AND SUBSEQUENT PARTICIPANT IMPRESSIONS OF THE HELP-SEEKING VISIT

1. After discharging from military service, when did you seek help from a healthcare and/or community provider? Follow-up question: why did you choose to seek help then?

2. Tell me about how you decided who you wanted to disclose to while seeking help. Follow-up questions: why did you choose this person? what factors went into this decision-making process? Did you know anything about this person already, and if so, what did you know?

3. Describe the way that your provider handled your disclosure. Follow-up questions: what was their response to your disclosure? How did this make you feel? What did the provider do or say to you?

4. Describe your overall impression of (how you felt about) your visit with this provider.

Lastly, I am going to ask you about how you believe your encounter with this provider will impact your recovery and based on this help-seeking experience, whether you will be inclined to continue seeking help in the future.

IMPACT OF THE HELP-SEEKING ENCOUNTER ON THE PARTICIPANT'S RECOVERY AND LIKLIHOOD OF SUSTAINED HELP-SEEKING EFFORTS IN THE FUTURE

1. Describe the effect you think your help-seeking visit with this provider will have on your recovery going forward? Follow-up question: would you continue seeking help based on this experience?

INTERVIEWER NOTES: