Walden University
A higher degree. A higher purpose.

Walden University
ScholarWorks

Walden Dissertations and Doctoral Studies

Walden Dissertations and Doctoral Studies
Collection

2022

The Experiences of Male Veteran Victims Seeking Help for Military Sexual Trauma/Assault

Natasha Blue
Walden University

Follow this and additional works at: https://scholarworks.waldenu.edu/dissertations

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Natasha G. Blue

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Douglas McCoy, Committee Chairperson,
Human and Social Services Faculty

Dr. Tina Jaeckle, Committee Member,
Human and Social Services Faculty

Dr. Andrew Carpenter, University Reviewer,
Human and Social Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2022

Abstract

The Experiences of Male Veteran Victims Seeking Help for Military Sexual Trauma/Assault

by

Natasha G. Blue

MPhil, Walden University, 2021

MA, National University, 2015

BS, National University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services. Military Families and Culture

Walden University

November 2022

Abstract

Military sexual trauma/assault (MST/MSA) among male survivors is significantly underreported. Male survivors continue to deal with the societal and personal stigmas and barriers that impeded on their ability or desire to seek help for their trauma. The most prevalent barrier is the societal stigma that men cannot be raped or experience sexual trauma or assault. The primary goal of the current research was to illuminate the current barriers male MST/MSA veteran victims experience seeking help while on active duty. Qualitative analyses were used to examine the collected data from the semi structured interviews conducted with 12 male veterans who experienced MST/MSA while on active duty and have been revictimized by the institution while seeking help or stated seeking help or reporting was not an option. All the veterans discussed barriers that related to personal and societal stigmas to seeking help. Freyd's institutional betrayal trauma and betrayal blindness provided the study's theoretical framework. The theories revealed the betrayal they felt by the leaders in the institution created a lack trust. The themes that emerged from the analysis were obstacles related to seeking help, institutional betrayal and cultural influences, trauma, the art of coping and mechanisms used, and desire for significance/improve QOL. The study findings contribute to positive social change by helping DoD, Veteran Affairs, other military institutions, and policy makers develop male specific programs to provide needed services for victims, training tools and protocols to both healthcare providers and military command personnel necessary to help minimize the occurrence of MST/MSA.

The Experiences of Male Veteran Victims Seeking Help for Military Sexual Trauma/Assault

by

Natasha G. Blue

MPhil, Walden University, 2021

MA, National University, 2015

BS, National University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services. Military Families and Culture

Walden University

November 2022

Dedication

This dissertation is dedicated to my family. My husband Blue. He is my biggest supporter, motivational speaker, coach, and my rock. He has taught me how to believe in myself, to think outside the box, know my worth, and not to sweat the small stuff. The road we travelled was rough terrain, but here we are after 20 years. Thank you for your encouragement, sacrifice, patients, and motivation. To my children, thank you for being patient. I'm ready to beat each of you in monopoly with my eyes closed. To my grandmother, it was difficult growing up with someone who only spoke to me in parables. I now understand what those words and life lessons mean. I dedicate this doctoral degree to all of you with gratitude, grace, and thanksgiving.

Acknowledgments

“For I know the plans I have for you, “declares the Lord, “plans to prosper you and not to harm you, plans to give you hope and a future.”

Jeremiah 29:11

Thank you Lord for being my Shepherd. You have helped me through my fears, frustrations, self-doubt, and anxiety to come out victorious. You are the Rock on which I stand today. To the participants in this study, thank you for your selflessness and bravery to share your experiences with me. It is my hope that the experiences you shared will help develop better policies and tools to help other victims, and I am optimistic that it will help promote positive social change.

First, I want to thank Dr. Lela Llorens. You have been my mentor from undergrad to present. You were the first black woman who inspired me and provided me with the tools of how to be an efficient writer. Your passion for teaching and lifting others has truly made a significant impact in my life. To my classmates Marlana Glover and Alyse Gardner-Kennedy. Thank you for always being my voice of reason and never being afraid to tell me I’m wrong. Marlana, thank you for your mentorship. Thank you for sending articles my way to help expose me to the literature. To Dionne DeGrande, my previous director. This journey would not have been on my radar if not for your encouragement. Thank you! To Mrs. Mary Ellen Salzano. Thank you for helping me to think outside the box, to understand the why beneath the why so I could formulate ideas gorm different angles, so I understand the delicate nature of the experiences of these survivors. In addition, thank you for the exposure which helped me to learn about the

male pioneers who have lobbied and continue to lobby for training and awareness of MST/MSA.

I would like to thank Nicole Stallings my personal IT. You were always available to assist with any computer issue I had and will have in the future. Thank you for being gracious and available my friend Joe Sturdivant, you always given me the respect of Dr. Blue. It's official now. Thank you Joe! To the greatest supervisor or all times Ronald Anthony Williams. I am so grateful for you. You have helped me grow as an individual and a leader. I carry all your stories with me everywhere. My favorite "just give me the baby, I do not need to know how it happened!" I live by this. Give me the facts, everything else is not always necessary. Thank you for our talks on EQ/EI, encouragement, and guidance. Genevieve!!

Finally, Dr. Douglas McCoy, Dr. Tina Jaeckle, and Dr. Andrew Carpenter. Thank you all for your support. Patients, and dedication. Thank you Dr. McCoy for encouraging me to complete my annotated bibliography. It saved me a lot of time and energy. Thank you for your guidance and asking the "so what?" and "who cares?" questions which helped me find my answers and helped me to delve into the literature and grow through this journey.

Table of Contents

List of Tables viii

Chapter 1: Introduction to the Study 1

Introduction 1

Background 3

Military Culture and Sexual Trauma 3

Prevalence of Military Sexual Assault Among Men vs. Women 5

Psychological Impact 8

Male Military Sexual Trauma and Societal Stigma 9

Problem Statement 10

Purpose of the Study 12

Research Questions 13

Theoretical Framework 14

Nature of the Study 16

Definitions 18

Assumptions 20

Scope and Delimitations 21

Limitations 21

Significance of the Study 22

Significance to Social Change 23

Summary 24

Chapter 2: Literature Review 25

Introduction 25
Literature Search Strategy 27
Theoretical Framework 28
Institutional Betrayal Trauma Theory 28
Betrayal Blindness Theory 29
Culture in The United States Armed Forces 31
Military Culture 31
Dominance and Strength 32
Gender Differences 33
Literature Review Related to Key Variables and Concepts 34
Defining Military Sexual Assault and Trauma (MSA/T) 34
Military Sexual Assault and Trauma Among Active Duty 36
Active-Duty Females and Sexual Trauma 36
Active-Duty Males and Sexual Trauma 37
Military Sexual Assault and Trauma Survivors 38
Gender Ideology and Gender Bias 39
Gender Ideology 39
Gender Bias 40
Military Sexual Trauma, Male Masculinity, and Myths Among Men 41
Male Victims of Military Sexual Trauma 41
Male Masculinity 43
Male Sexuality 45

Myths of Rape Military Sexual Trauma Among Men 45
Military Sexual Trauma Among Women 47
Psychological and Physical Effects Related to Military Sexual Trauma....................48
Psychological Effects 48
Posttraumatic Stress Disorder 49
Self-Directed Violence... 50
Psychological Disorders... 50
Physical Effects 51
Negative Life Effects 52
Hostile Work Environment 52
Male Victims Negative Life Effects 52
Social Ostracism 54
Coping.. 55
Substance Abuse 56
Help-Seeking Barriers and Stigma Associated with Male Victims Seeking
Care 56
Help Seeking Barriers 58
Stigma of Males Seeking Health Care 59
Impact on Quality of Life 59
Summary 60
Chapter 3: Methodology 63
Introduction..63

Research Questions 64
Research Design and Rationale 64
Role of the Researcher 67
Research Methodology 69
Participant Selection Logic 69
Sampling Method and Rationale 70
Purposive Sampling Criteria 71
Instrumentation 72
Procedures for Recruitment, Participation, and Data Collection 73
Procedure 73
Recruitment 74
Gaining Consent 74
Data Collection 75
Data Analysis 77
Issues of Trustworthiness 78
Credibility 78
Transferability 80
Dependability 81
Confirmability 81
Ethical Procedures 82
Summary 84
Chapter 4: Result 86

Study Setting....87
Demographics / Sample....88
Data Collection....89
Ethical Considerations....93
Data Analysis....94
Evidence of Trustworthiness....95
Credibility....95
Transferability....96
Dependability....96
Confirmability....97
Results of Data Analysis....98
Primary Research Question 1: What Are The Help-Seeking Experiences Of Male Veteran Survivors Of Military Sexual Trauma Who Were Active Duty And Between The Ages Of 18-65 Years Old At The Time Of The Assault?....100
Theme 1: Obstacles Related to Seeking Help....102
Stigma/ Labeling....102
Personal Barriers/Lack of Trust....104
Theme 2: Institutional Betrayal and Cultural Influences....105
Lack of Trust Reporting Process/Sensitivity....106
Training and Male Specific Programs....108

Sub Research Question 1: What Are The barriers that Impede on Male Veteran Military Sexual Trauma Survivors Decision to Not Report or Seek Help for the Effects of the Experience? 109
Theme 3: Trauma 110
Disbelief of Victim Assault/ Lack of Trusted Outlet/ Support 110
PTSD/Mental Health/ Emotional Detachment 111
Sub Question 2: What Avoidant Coping Mechanisms Do Male Veteran Military Sexual Assault Victims Use to Cope with The Effects of The Assault and The Impact It Has on Their Quality of Life (QOL)? 113
Theme 4: The Art of Coping and the Mechanisms Used 114
Drugs and Alcohol 114
Risky Behavior/ Homelessness/ No Established Coping Mechanism 115
Sub Question 3: How do Male Veterans Who Have Experienced Military Sexual Trauma Describe their Military Experience and Their Current Quality of Life? 117
Theme 5: Desire for Significance/Improve Quality of Life (QOL) 117
Personal Journey 118
Improvement of Quality of Life (QOL) 119
Male Victim Perception 120
Summary 121
Chapter 5: Discussion, Conclusion, and Recommendations 123

Interpretation of the Findings....................125
Primary Research Question 1.................... 125
Theme 1: Obstacles Related to Seeking Help.................... 126
Theme 2: Institutional Betrayal and Cultural Influences.................... 127
Sub Research Question 1.................... 130
Theme 3: Trauma.................... 130
Sub Research Question 2.................... 133
Theme 4: The Art of Coping and the Mechanism Used.................... 133
Sub Research Question 3.................... 134
Theme 5: Desire for Significance/Improve Quality of Life (QOL).................... 134
Alignment With Theoretical Framework.................... 135
Limitations of the Study....................137
Recommendations....................139
Implications for Social Change....................139
Conclusion....................141
References....................143
Appendix A: Interview Questions....................168
Appendix B: Recurring Codes....................170

List of Tables

Table 1. Participants' Demographics and Coding 89

Table 2. Themes and Subthemes 99

Table 3. Themes Related to Research Question 1 101

Table 4. Themes Related to Sub Question 1.. 109

Table 5. Themes Related to Sub Question 2.. 114

Table 6. Themes Related to Sub Question 3.. 117

Chapter 1: Introduction to the Study

Introduction

Sexual assault among male and female active-duty service members is significantly underreported, with a possible vast majority of underreporting occurring among male victims (Sadler et al., 2021). In the last 20 years the United States Armed Forces and the Department of Veteran Affairs (DVA) have diligently worked to address this issue by devoting resources, formulating policies, and conducting research to identify the issues surrounding egregious sexual misconduct occurring in the military (Sadler et al., 2018). While the policies in place are designed to protect all victims who have experienced sexual violence, there is a consensus among many researchers that there is a straggle in acknowledging the male victims experience while on active duty (Sadler et al., 2018).

Military sexual trauma (MST) is a psychological traumatic response to physical assault or battery of an unconsented sexually occurrence that consists of unwanted or forced sexual behavior experienced by an individual while they are active duty in the military (Monteith et al., 2016; Veterans' Benefits: Counseling and Treatment for sexual Trauma, 2014, p. 285). In fact, the Department of Veterans Affairs refers to MST as defined in 38 U.S. code section 1720D, 2011 as physical assault or battery of a sexual nature which is also threatening in nature (Barth et al., 2016). Military sexual trauma also refers to unwelcomed and inappropriate advancements of a sexual nature to also include sexual harassment (Forkus et al., 2020). Inappropriate behavior of this nature may also be described along a continuum to include rape, forcible sodomy, oral or anal sex,

aggravated unwanted sexual contact, unwanted verbal comments, inappropriate attention, messages, and cornering (Stander & Thomsen, 2016).

Individual experiences of military sexual trauma share some similarities to civilian victim experiences except for working and living in the same environment for long periods of time. Work and living spaces can be confined spaces on ships, submarines, and military bases where victims and their attacker may also both be working and living in close quarters which may make it difficult for most victims to potentially avoid their assailant (Stander & Thomsen, 2016). Moreover, sexual trauma occurs at a greater exponential rate in the military than that of sexual assault and harassment in civilian communities (Gurung et al., 2018; Turchik & Wilson, 2010). A victim's inability to escape may foster or contribute to the display of a victim's MST symptoms to include Post Traumatic Stress Disorder (PTSD), depression, and suicide ideation (SI) (Monteith et al., 2019).

Historically, the focus of military sexual trauma has been on female victims and their experiences. However, over the past 30 years, researchers have provided evidence revealing the prevalence of men reporting their experiences of military sexual trauma (MST) at a rate of 12.4% which may be potentially higher if it were not for the process of reporting incidents that tends to trigger the stigmas associated with male victims who report MST during their active-duty career (Gurung et al. 2018). Although the awareness of military sexual trauma has increased, and the Veteran Administration (VA) has sharpened their lens to focus on both male and female veterans there is still limited research that focuses primarily on military sexual trauma among men (Obrien et al.,

2015). The current rate of research conducted on military sexual trauma among females is still significantly higher than male experiences.

The Veterans Health Administration (VHA) (2016) conducted a screening of 4.83 million veterans to collect data on their experiences related to military sexual assault. The number of male participants were 4,460,767 and 368,234 were female participants. It was estimated that 26% of the women and 1.4% of the men screened positive for military sexual trauma (MST) while on active duty (Monteith et al., 2020). The percentages of male and female MST victims revealed in most surveys and research primarily display higher percentages favoring female victims. However, since approximately 85% of active duty servicemembers are male and approximately 15% are female the number of assaults can be relatively close (Eckerlin et al., 2016). In fact, it was found that the rate of MST continues to increase as more anonymous surveys are submitted and as self-reports and interviews continue to be conducted (Monteith et al, 2020; Katz, et al, 2012; Wilson, 2016).

This next chapter will consist of the background of the study, problem statement, purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study. Finally, a summary will conclude the chapter.

Background

Military Culture and Sexual Trauma

The military is a microcosm of different cultures within a society compiled of different people of different ethnicities and creeds. It can also be considered as a melting

pot of distinctive cultural values, norms, and beliefs, that functions differently from the general society. Moreover, it is densely supported by the belief that military service is the "rite of passage" for men to be inducted into adulthood, establishing their masculine bravado, and eliminating any residual effeminate characteristics (Do & Samuels, 2021). Albeit the current military environment cultural objective is to depict an egalitarian institution (Do & Samuels, 2021) where both male and female servicemembers have equal opportunities. However, the separation and socialization of genders is seemingly more conducive to those considered to be alpha males. Alpha males are the men who exude dominance and are separated from other males who do not exhibit such definitive qualities and women (Do & Samuels, 2021). In addition, there is the "queen bee syndrome" which refers to selected higher-ranking women who use their authority to degrade other low-ranking women to deter them from joining the ranks (Do & Samuel, 2021; Kanter 1977).

The separation of rank, seniority, and the masculine dominance can be attributed to the psychological resocialization of individuals (Do & Samuel, 2021; Dunivin, 1994) which can also promote the culture surrounding sexual assault and trauma in the military. Overall, the most under-reported offenses in the military are sexual assault and trauma, particularly when it involves male victims (Voller et al, 2015). As a result, post-traumatic stress disorder (PTSD) is seemingly the most common severe injury victims develop due to the trauma as well as the adverse effects associated with self-blame (Kline et al., 2021).

Sadler et al., (2018) presented his findings which suggested that research related to any type of sexual trauma or assault occurring within the military is often likely to primarily focus on female victims, dismissing the notion that men also fall prey to such attacks. Nevertheless, the current policies, resources, and research implemented by the United States Military and the Department of Veteran Affairs Administration (DVA) was created to preserve the rights and safety of all sexually violated victims, along with the provision of equal available resources for all. Yet, there is still some delay in recognizing male subjection and victimization of military sexual assault (Sadler et al., 2018). O'Brien, Keith, and Shoemaker (2015) emphasized that the occurrence of military sexual assault (MSA) against men is not a new phenomenon. However, the research related to the violence of military sexual assault (MSA) against men conducted prior to the year 2000 offers the impression of a taboo like outlook bringing attention to the fact that studies were not being conducted on men who experienced MSA.

Prevalence of Military Sexual Assault Among Men vs. Women

Although significant research related to military sexual assault (MSA) and the victim experiences have been primarily female driven, there is a misconception that more women experience MSA than men when the number of men in the military is significantly greater than the number of women. In fact, Hoyt et al., 2012 and Sadler et al., 2018, suggested that because there are an approximate four males to one female ratio in the military, there is some possibility that the prevalence rate among both men and women are very similar. O'Brien et al., 2015 discovered that out of 74 published peer-reviewed articles that focused on military sexual trauma (MST) up to December 2009,

only two of those articles focused on men or had an emphasis on the adverse effects endured by male victims.

In addition, Eckerlin et al., (2016) provided statistics revealing the number of women who are more prevalent to experience MSA coincides with the outright number of male victims who experience MSA at the same rate of approximately 85% of service members being men and 15% women. The fiscal year of 2014 also revealed that servicemembers who used the Veteran Affairs Health System (VAHS) and participated in screenings for military sexual trauma/military sexual assault (MST/MSA), resulted in 25% (N = 85,033) of women and 1.3% (N = 60,599) of men testing positive for MST (Military Sexual Trauma Support Team, 2015; Schry et al., 2015).

Monteith et al., (2020) emphasized that the effects of military sexual trauma had similar symptoms among men and women, and the violation of the assault has no prejudice to race, ethnicity, status, or gender. Nevertheless, women are found to be at the forefront of most of the studies conducted at an exceptionally higher rate compared to studies on men. The symptoms known to be associated with MST are PTSD, substance use, depression, and other mental health disorders that have long lasting adverse effects on victims. In fact, men tend to report a higher prevalence of their symptoms compared to female victims (Sadler et al., 2018). Both male and female victims of military sexual trauma face barriers like shame and embarrassment when seeking help (Sadler et al., 2018; Morris et al., 2017) which may play a role in their decision to not report the incident.

Most military sexual trauma incidents are underreported due to the victim and attacker working relations and the environment in which they both must coexist and function. A recent study conducted by RAND found that rates in sexual assault were found to be lower in Reservist servicemembers on Active Duty which confirmed that assaults primarily occur in an active military setting (Sadler et al., 2018; Morral, Gore Schell, 2016). This may make the prevalence of assaults occurring among reservist to less likely occur than assaults among enlisted active-duty service members.

Nevertheless, sexual assault acts against men have been overshadowed by the stigma that men can only be perpetrators, when in fact, sexual assault against males is not limited to the military, but it also occurs in prisons, and used as a weapon of war against men and boys (Duchesne et al., 2018). The stigma is so heavily weighted against men who experience this form of assault or trauma. Therefore, they may sometimes choose to internalize the pain as discussing the incident may cause them to sometimes question their sexuality or have a negative perception that other individuals are also questioning their sexuality (Duchesnen et al., 2018). This can lead to the onset of consequential psychological trauma.

The prevalence of military sexual assault being carried out can be attributed to the macho and misogynistic behavior displayed by most men in the military. The unprofessional behavior displayed by these men may stem from calling other servicemembers “bitches or pussy” (DiRosa & Goodwin, 2014). While this may be a common trait among most males, it is particularly heightened and found to be accepted after the completion of bootcamp. Military drill instructors are tasked to make new

recruits fit for duty, and the use of profane language, insults, maltreatment, abuse, along with levels of hazing are tactics supposedly useful in stripping them of their civilian traits and dignity (DiRosa & Goodwin, 2014). Therefore, new recruits enter the fold with the perception that degradation and disrespect is commonplace among women and weaker males (O'Brien et al., 2015). In fact, the act of sexual assault is not truly about sex, it is about violence, dominance, intimidation, and power, and victims are selected based on their level of vulnerability (Ellison 2011).

Psychological Impact

Sexual assault is a traumatic event that affects every victim differently. Post-Traumatic Stress Disorder (PTSD) and depression are two of the main psychological disorders associated with sexual assault victims (Schry et al., 2015). Male victims who suffer with PTSD because of the sexual assault are more likely to engage in harmful behavior that may include suicidal self-directed violence (SDV) which is a deliberate attack on themselves due to being a sexual assault victim (Monteith et al., 2019). Subsequently, institutional response or a lack thereof to victim reports, diminishes trust in the system and the process due to fear of retaliation, breach of confidentiality, or mishandled cases (Rabelo et al., 2019). As a result, a male victim may experience internal battles which fosters the decision to remain silent and not report incidents which may also contribute to psychological trauma.

Military personnel who have been victims of sexual assault and display symptoms of depression are likely to be less productive in the workplace, and experience lower institutional morale (Rabelo et al., 2019). Oftentimes, the survivor must continue to work

in proximity to the assailant which makes reliving the incident quite debilitating. The psychological effect may also be intensified by the belief that victims can sometimes be overreacting and need to “suck it up” and fight through the pain associated with a traumatic incident. In addition, most victims are less likely to report incidents of such magnitude as they may sometimes become more victimized and stigmatized for being a victim (Rabelo et al., 2019). As such, distrust in the system is inevitable.

Male Military Sexual Trauma and Societal Stigma

There is a general pseudo perception that men who are sexually assaulted are supposedly gay, which leads to the marginalization of this group of men who have been negatively impacted by another or others indiscretion (Sadler et al., 2018). It is imperative that military institutions and society collectively comprehend that those male victims do encounter unique barriers related to reporting sexual assault or trauma (Sadler et al., 2018). The innate societal belief that may contribute to the low numbers of MST reports made by men may be a result of the societal and institutional norms that men are to be strong and independent and not defenseless and acquiescent, creating a disturbance in their overall self-image (Romaniuk & Loue, 2017; Hopper, 2006). Subsequently, there is the fear of stigmatization, character judgement, and the thought of being referred to or viewed as weak. Essentially, the common belief that the act of sexual assault can only be associated with men as the perpetrators creates a form of stereotype that harnesses barriers created by male victims which may cause them to internalize their experience (Sadler et al., 2018). Internalization of these attacks can lead to diagnoses such as PTSD, depression, or suicide ideation.

Most male victims seem to bear the burden of a more rigid form of stigmatization and marginalization than female victims which may also support their reasoning for not reporting incidents in addition to the mismanagement of reports within the Department of Defense (DOD) and the Department of Veteran Affairs (DVA) institutions (Sadler et al., 2018; Bastick et al., 2007). There is a general concordance among many researchers that more research needs to be done on male military sexual trauma. Acquiring an understanding of the male victim experience of military sexual assault will lead to the awareness underreporting, stoicism, fear of ostracism, humiliation, self-violence, help seeking, and other gender-specific barriers and biases associated with the assault, along with their concerns of institutional discretion and confidentiality with reporting an incident (Sadler et al., 2018). Moreover, gaining a better understanding of the experiences of male military sexual assault victims may help promote greater institutional awareness and aid in educating helping professionals to develop new tools and tailored specific treatment approaches that can contribute to lessening barriers men encounter when attempting to access needed assistance to promote a better quality of life.

Problem Statement

Military sexual assault and trauma (MST) among males have been underreported. The United States Armed Forces is comprised of approximately 85% males and 15% females enlisted (Eckerlin et al., 2016), which epitomizes the need for more inquiry related to males and MSA/T. However, most research is lacking in exploration of males who have experienced military sexual assault/trauma. Currently, researchers who study military sexual assault or trauma (MSA/T) primarily focus on the prevalence it has

among female active duty servicemembers (Wilson, 2018). This approach to the phenomenon marginalizes the impact the assault also has on male victims. The lack of research among male MSA/T victims can be attributed to the underreporting of assaults by male victims due to shame and self-blame (Morris et al., 2014; Kakhnovets &Holohan, 2007; Scarce, 1997; Tewksbury, 2007).

Furthermore, underreporting is also accredited to the fear of social and professional retaliation, shame and embarrassment, social isolation from peers, and the ostracism victims experience which can contribute to divisional dysfunction in the unit (Kintzle et al., 2015). The societal stigma of the disbelief that men can be victims of military sexual trauma is also exhibited by the healthcare providers they look to for help to cope with their experience, leaving them utterly deflated, lacking the confidence and optimism about seeking help. (Sadler et al., 2018). The effects of military sexual trauma can also be contributing factors to a servicemember's decision to retire from the military, then later file for disability compensation due to PTSD, depression, suicide ideation, or some other debilitating injury they incurred because of the assault (Eckerlin et al., 2015). Similarly, the institutional betrayal a victim may experience after filing a report may also contribute to the psychological, emotional, and physical implications on their self-perception (Andresen et al., 2019), which may also result in separation or retirement. Given such, little research has been conducted specifically focused on the prevalence of MST among male servicemembers and overlooked their experiences after the trauma.

According to Elder et al., 2017, an additional issue related to military sexual assault and trauma (MSA/T) among males that lacks in research, are the unique reactions

military sexual assault male victims display that require unique treatment approaches compared to the treatment approaches formulated for women. The lack in focus on the negative implications MSA/T has on men is of concern. According to Sadler et al., (2018), the formal policy in place related to MSA/T is to protect all victims of the assault, but reports made by males continue to be unfairly delayed in the recognition of the incident. Men who experience sexual assault do endure lasting sequel just as their female counterparts (Sadler, et al., 2018).

Nevertheless, military sexual trauma has been heavily based on female victims and their experiences, leaving a gap in the research on male victims underreporting and their experiences. For this reason, further research is necessary to gain a deeper perspective and understanding into the experiences of male military sexual trauma victims to learn of their experiences, to establish treatment approaches to ensure that male victims obtain the same or equal access to treatment and care as their female peers, and to help promote a better quality of life. In addition, an understanding of the victim's beliefs about their masculinity and sexuality and the relation they have on their reluctance to reporting (Monteith et al., 2019) is of equal importance.

Purpose of the Study

The purpose of this qualitative research study is to investigate the experiences of male veterans seeking help for military sexual trauma/assault and were active duty between the ages of 18-65 post 9/11 at the time of the assault. Examining the experiences of male sexual assault victims who were on active-duty post 9/11 and between the ages of 18-65 may result in significant findings on the experiences male MST survivors, the

avoidant coping mechanisms they use to aid with the effects of the trauma, and possible barriers that deter them from reporting the assault. Coping occurs due to the internal stress developed due to the victim's environment and the mechanism of choice used to promote internal homeostasis (Avcıoğlu et al., 2019; Weiss et al, 2019). Countless research studies have been conducted on military sexual assault. However, the bulk of the research primarily focuses on the experiences of female victims.

Research conducted on men have found that more aggressive and violent assaults are experienced by men which seem to trigger a greater traumatic experience (Monteith et al., 2019). This study aims to address the significant gap in knowledge that remains about the help-seeking experiences of male MST/MSA survivors and how they cope with the psychological, emotional, social, personal effects of the trauma, and whether their experiences pose lifelong effects on their self-perception, self-efficacy, and overall quality of life (Tiet et al., 2015). The findings from this research study may also offer insight to helping professionals, Department of Defense (DoD), and Veteran Health Administration (VHA) to educate and establish a program specifically catered to the unique experiences of male MST survivors and bring about social change by supplying a meticulous outlook of how MST affect males servicemembers.

Research Questions

The primary and sub research questions are being used to guide this study consist of the experiences of male veterans seeking help for military sexual trauma/assault, a question about the barriers associated with male sexual assault and underreporting, and the avoidant coping mechanism used by male sexual assault victims.

Primary Research Question: What are the help-seeking experiences of male veteran survivors of military sexual trauma who were active duty and between the ages of 18-65 years at the time of the assault.

Sub Research Question 1: What are the barriers that impede on male veteran military sexual trauma survivors' decision to not report or seek help for the effects of the experience?

Sub Research Question 2: What avoidant coping mechanisms do male military sexual assault victims use to cope with the effects of the assault and the impact it has on their quality of life?

Sub Research Question 3: How do male veterans who have experienced military sexual trauma describe their military experience and their current quality of life?

Theoretical Framework

The theoretical framework for this study will be based on institutional betrayal theory (IBT), developed by Jennifer Freyd to highlight the violation of trust by individuals' dependent on an institution or organization's protection (Freyd, 1996). Smith and Freyd (2014) later defined the specific tenets associated with IBT as the failure to prevent abuse, normalizing abusive contexts, creating difficult processes for reporting, failure to adequately respond to instances of harm, supporting cover-ups and misinformation, and punishing victims and whistleblowers. Institutional betrayal theory will speak to the betrayal and lack of support male victims make experience due to lack of institutional support.

Another concept that evolved from IBT is betrayal blindness (BBT) (Freyd,1996; Freyd Birrell, 2013; Smith Freyd, 2014). Betrayal blindness is the thought that a victim may cope with their trauma by deliberately avoiding thoughts of the assault or harm they experienced to maintain congruity within the institution or the individual who inflicted the offense because of their dependence on the said institution or individual (Freyd,1996; Freyd Birrell, 2013). Implementing the betrayal blindness approach to men who experience MST will provide a framework to offer reasoning behind why men may be less likely than female MST victims to report assaults. In addition, Melville-Weismann (2016), added that Fryed described the phenomena of IBT and the effects it may have on the victims based on the significant possibility that the assailant maybe someone familiar to the victim and the institution's response or lack thereof to the allegations.

In a search to determine the appropriate approach to illuminate the study of military sexual trauma among men and the reason for underreporting, IBT and BBT were found to be appropriate for this study to gain a deeper understanding of why male victims seldom report assaults. For example, men are seemingly more subjected to the guilt and shame that are interlaced with the socialized ideology of male traits and behavioral expectations (Rice et al., 2018). In addition, to the institutional and cultural beliefs that men cannot be sexually assaulted, and the stigma of questioning their sexuality or the assault not being held in confidence, displays a distrust in the military institution (Rabelo et al., 2019).

Nature of the Study

This will be a qualitative case study design. Case study design approaches are used by researchers to inquire and evaluate data for in-debt analysis (Creswell & Creswell, 2018). The case study design will be used to understand the experiences of male military sexual trauma survivors post 9/11, to determine their proclivity to refrain from reporting the assault, the avoidant coping mechanism used to alleviate the traumatizing memories of the assault, their experiences, and their current quality of life. According to Percy et al., (2015), a qualitative research approach provides the flexibility to explore options when selecting a specific methodology and number of participants to interview for a study. This approach will offer a meaningful outlook and seek to adopt deeper understanding of the experiences of the male MST survivors.

In addition, a qualitative case study approach will allow participants to openly share and describe their experiences, allowing the researcher the opportunity to collect data, extract meaning and analyze the victims' experiences (Hennink, Hutter & Bailey, 2011). Data will be collected by conducting interviews with participants via telephone. Other qualitative methods that may be used are phenomenology and grounded theory to understand their social and cultural constructs, experiences seeking help and their quality of life before and after the assault.

The Snowball sampling method will be used to help recruit participants who may be difficult to locate for studies of this nature (Waters, 2015). An alternate method will be purposeful sampling used to select individuals and their cases offering the opportunity to compare the factors associated with their coping behavior similarities and differences

(Ravitch & Carl, 2016). The participants must be between the age of 22-65, be a veteran who had served in the United States Armed Forces post 9/11. The sample size will consist of 6 to 10 participants. The use of a smaller sample size may also elicit the opportunity for the researcher to obtain rich data from the structured phone interviews and questionnaires. All data will be collected via unstructured open-ended interviewing which will be recorded, coded, and translated to identify similarities in participant experiences. The unstructured interviewing approach allows the researcher the opportunity to use questions that will elicit participants opinions and views surrounding the research (Creswell & Creswell, 2018).

The selection of participants would be based on the responses collected from a pre-screening questionnaire that includes 5-10 questions. This questionnaire will determine their eligibility to participate in the study. The questions would contain demographics that include the branch of service, rank, years of service at separation, age at separation, current employment status, marital status, and gender. The questionnaire will also consist of closed questions related to military sexual trauma, command and comrade support, discrimination, team division. After selecting the participants who have met the criteria, collecting the data for the study will be done using semi-structured interviews conducted via the telephone and zoom calls. All interviews and sessions will be recorded for language to identify verbal and non-verbal cues. After data collection, data analysis, and coding, the collected data will be converted into themes so the information may be easily assessed (Creswell & Creswell, 2018).

Definitions

Avoidant Coping: In this study, coping is a purposeful effort to manage internal and external stressors that apprises as taxing or exceeds one's resources (Lazarus & Folkman1984; Weiss et al., 2019). Additional avoidant coping is a measure of possible use of negative indicators of impulsiveness, irritability, or anger outburst (Block, Block & Keyes, 1988; Wills, Sandy, & Shinar, 1999; Wills, Windle, & Cleary, 1998; Wills et al, 2002 that are external responses displayed to deflect inner thoughts of the experience.

Barriers: Obstacles such as social norms and social construction of masculinity that can deter and make a victim feel marginalized (Bastick, Grimm & Kunz, 207). The barriers may include the stigmas surrounding sexual assault of male victims such as it being impossible for men to be raped by either gender (Turchik & Edwards, 2012; Sadler et al., 2018) and the disbelief in a man's ability to defend himself from being assaulted (Chapleau, Oswald, & Russell, 2008; Groth & Burgess,1980; StruckmanJohnson & Struckman-Johnson, 1992; Sadler et al., 2018)

Gender-Bias: Is the perception that a male's point of view is weighted greater over the female's experience, along with assuming that a male's experience is more objective and mainly associated with one gender group (Gray, 2018). In this case, I believe gender-bias to be the thought that only one gender is weaker and potentially more subjected to the occurrences of sexual assault or sexual trauma.

Institutional Betrayal Theory (IBT): The theory describes the betrayal an individual feels toward the institution they are dependent on for protection. The feeling of betrayal occurs when the institution fails to prevent, offer support, or provide aid based

on the wrongdoings of function within the guidelines of the institution Freyd &Birrell, 2013; Smith & Freyd, 2014; Cromer et al., 2018).

Institutional Betrayal Blindness (IBB): The idea that coping with trauma can be accomplished by avoiding one's consciousness awareness of the wrongdoing or harm experience to maintain dependence or harmonious relationship with the individual (s) or institution that was the source of the trauma (Freyd, 1996; Freyd& Birrell, 2013; Cromer, et al., 2018).

Military Sexual Assault: According to the Uniform Code of Military Justice (UCMJ), military sexual assault occurs when any person or persons performs an unwanted sexual act against someone by using threats, causing harm, committing the act when the person is unaware, or unable to consent due to impairment or mental or physical disability (Woodward, 2014).

Military Sexual Trauma: A psychological response a victim exhibits after the occurrence of a sexual assault (Monteith, 2016) that occurs while on active duty in the military. MST also a traumatic event related to mental health outcomes including post-traumatic stress disorder and depression (Blais & Geiser, 2018).

Ostracism: The imminent exclusion and dismissal by individuals or affiliations that causes internal and external discomfort for the individual (Brown, 2019). This act includes being excluded from conversations, being disregarded, or even labeled as unwelcomed.

Post-Traumatic Stress: This is a psychiatric disorder that may occur in people who may have experienced or witnesses a traumatic event such as rape, combat, or a serious accident (American Psychiatric Association, 2020)

Self-Efficacy: Bandura, 1982 defines self-efficacy as the reflections of an individual's belief about their ability to exert control over their environment and possessing the ability to master challenging situations. Individuals who have a higher self-efficacy are said to have lower stress levels (Voller et al., 2015).

Stigmatization: The perception of being a defect based on the effects of a negative occurrence associated with the stereotypical and belief system of social norms (Morris et al., 2014). Stigmatization is also related to the disidentification of the subjects who are marginalized based on societies perceived prerequisite of what is considered the norm and acceptable (Powell & Lever, 2017).

Suicide Ideation: This is the thought of or the consideration or the plan to commit suicide (Monteith et al., 2019). Suicide ideation is also experienced by individuals who suffer with psychological symptoms such as major depression or any type of trauma.

Underreporting: Occurs when victims refrain from reporting assaults due to the fear of the negative affect that may result in them making a report Sadler et al., 2018). The fear of retaliation for reporting plays a significant role in a victim's decision to not report. Especially, if the perpetrator is a higher-ranking individual.

Assumptions

There was a myriad of assumptions made in this study. The initial assumption was that all participants will be forthright in their response to the interview questions. Next, I

assumed that the selected participants would be a source to locating other male military sexual trauma victims (MST) to aid the research being conducted. I also assumed that all participants would be inclined to discuss in depth their decision to report or not report the incident. I assumed that participants would refrain from feeling guarded when speaking with me and would have a sense of trust and safety while discussing the event and their experiences after the event. Last, I assumed that participants would refrain from self-blame for what occurred, and they would not feel degraded or experience a reduction in self-worth, self-esteem, or manliness. There is an increased perception of which gender is most subjective to sexual assault, and that men are more likely to experience challenges with their masculinity after military sexual trauma (MST).

Scope and Delimitations

My primary focus is on the experiences of male veteran service-members who were on active-duty post 9/11, between the ages of 22-65 years old, and have experienced sexual assault or trauma while on active duty in the United States Military. The delimitations that may restrict this study are the experiences of servicemembers who currently active duty in any of the United States Armed Force branches as their responses may be influenced by their status. All participants must be retired veteran status and have served post 9/11. Participants who served in wars prior to 9/11 will be excluded. Last, all participants must be male to be included in the study.

Limitations

Possible limitations of the study may be my inability to locate male participants who are willing to participate and be transparent. My skills as a new researcher in

effectively recruiting participants, efficiently interviewing, and processing data. Moreover, due to the sensitivity of the research topic, male participants may be reluctant to wholeheartedly delve into the assault they experienced for the fear of reliving the incident. In addition, my fear of triggering an emotional response that may cause distress to the participant. Asking the right questions to identify the choices of the type of coping mechanisms victims chose to use and how it impacts their quality of life. Accurately transcribing and processing the data or not collecting enough data, as well as researcher bias. The possibility that participants would leave the between the recruiting process and interviewing because of cold feet.

Significance of the Study

Military sexual trauma among males has created a grave disadvantage for men seeking help for their traumatic experience. Underreporting of military sexual trauma or refraining from seeking assistance to aid in negative effects like avoidant coping behaviors used to manage stress and anxiety. This behavior sometimes promotes adverse implications that may also create concern for society and military affiliated institutions. The findings from this study will be deemed significant as it will explore the gap in the research related to underreporting and the experiences of military sexual assault among male veterans who were between the ages of 22-65 while on active-duty post 9/11 and the barriers that deter them from reporting these incidents.

The findings will also illuminate the avoidance path victims may use in efforts to suppress the effects of the assault by implementing specific coping behaviors to deal with the ramifications of the internal distress (Ullman et al., 2013). Although there is

significant research surrounding underreporting of military sexual trauma, most if it is primarily conducted on female victims. Albeit data shows that the individuals who self-disclose and frequently test positive at the Veteran Health Administration for these attacks are more likely to be men (Gross et al., 2020), the bulk of the research is based on women. Gross et al., also found that the experience of MSA is conducive to the prevalence of multiple psychological and physical consequences for men and women related to the risk for self-directed violence (SDV).

Significance to Social Change

The element of social change is related to the impact due to the action taken by others to change the behavior and social outlook of others that may generate a more conducive outcome or environment for the greater good of community and society (O'Cass & Griffin, 2015). The knowledge obtained from this research will also be paramount in the quest to promote positive social change as it relates to males who have experienced sexual trauma. Positive social change will occur as the provision of pertinent and useful data and recommendations may provoke The Department of Defense and the Department of Veteran Affairs Change Agents to advocate and develop new policies to help alleviate the barriers and stigmatization surrounding men who have experienced sexual assault while on active duty, so they may feel safe to report and seek services and to lobby for more training for healthcare professionals who work with this population.

In addition, it would also promote change within the ranks both upper and lower which can also play a major role in eliminating the bystander effect and cause other to speak up on behalf of victims. Moreover, it will help uncover the issues surrounding the

phenomenon MST and the implications associated with it like PTSD, to require a more in-depth PTSD type case management through healthcare facilities like the VA. Social change may also occur if the participants feel linked to bigger cause that can help bring awareness of this issue and possibly help others to become more inclined to seek help. Once the policies are put into effect, there should be an element of confidentiality that should also be implemented, and protection for those who have a desire to speak out against this form of assault.

Summary

Military sexual trauma (MST) has been occurring in the United States Armed Forces for decades with a focus primarily highlighted on the experiences of female servicemembers. However, with the increased number of reports being made by male victims, which in fact does not appear to be close to what should be reported, is promoting awareness, and bringing the prevalence of these assaults to the surface. It will also highlight the fact that men too, experience sexual assault, but because of the societal beliefs of who, what, and how a man is perceived to be does not delineate from the fact that they can also be victims to this horrific occurrence.

The goal in this qualitative case study, is to explore the and learn of the reasons related to underreporting and experiences of men who have experienced MST. The findings from his study will also provide the Department of Defense (DoD), Veteran Affairs Administration (VA), and other military or governmental institutions a greater understanding of the treatment approaches required to treat male MST victims. In Chapter 1, military sexual trauma and military sexual assault was described,

underreporting among males, and the increased need for health care providers to be more aware and sensitive to the experiences of males who have experienced military sexual trauma.

The theoretical framework was also discussed to gain insight on the participants. The assumptions, scope, and delimitations, and limitations of the study were also reviewed. The significance of the study was formed to identify why there is so little research on men who experience MST. Chapter 2 will highlight the literature that supports the experiences of military sexual assault and trauma among males, their experiences, and their reluctance to reporting the incident while on active duty and decision to not seek help. The literature review will also display the key concepts related specifically to the experiences of men who were active-duty post 9/11 who have experienced MST that may alter their quality of life and their beliefs about their masculinity and sexuality.

Chapter 2: Literature Review

Introduction

There is a common misconception that military sexual assault and trauma primarily occur only among female servicemembers (Sadler et al., 2018). The fallacy of this belief has caused a gap in the research related to military sexual assault and trauma among male servicemembers. In fact, it was found that men are more likely to willingly report the assault after being discharged from active duty because they are no longer conflicted or petrified about the consequences they may face for reporting (Romaniuk & Loue, 2017). For this specific reason, there is a critical need to identify the reason for the

significant disparity in reports made by men who have experienced sexual assault while on active duty, the psychological impact it has on their experiences (Morris et al., 2014) along with the barriers and stigmas that deter them from reporting or seeking help for sexual assault.

In addition, there is great concern regarding the training of healthcare professionals receive who provide direct care to male MSA/T victims due to the sensitivity of their traumatic experience (Bryan et al., 2015; Sadler et al., 2018). It is imperative that healthcare professionals understand that caring for MSA/T victims requires a special kind of subject matter expertise and sensitivity (Hickey et al., 2017). My primary focus of this study is to understand the experiences of males who have experienced military sexual assault or trauma (MSA/T) while in the military and how it has impacted their lives after transitioning to veteran status.

The demographic of men selected are between the ages of 22 to 65 years, have retired or been discharged from active duty, with heavy concentration on veterans. As such, a gap in the research will be evident as this demographic of men is largely understudied in the understanding of military sexual trauma or military sexual assault among men post 9/11 and who were active duty at the time of the assault.

This chapter begins with a discussion of the search strategy, theoretical framework and the literature review on institutional betrayal theory and institutional blindness theory, military sexual trauma and military sexual assault among men who were active duty in the United States Military post 9/11. A brief background on the culture of the United States Armed Forces and the gender differences within the

institution. I will then discuss the issues faced by males who have experienced MST or MSA while on active duty. Finally, I will focus on the factors that significantly influence a victim’s decision to deter form reporting.

Literature Search Strategy

In attempt to collect current data and literature articles that focused and highlight military sexual trauma and assault among male victims, the Walden University Library, Google Scholar, Veteran Affairs Sexual Assault Reports, and other credible online databases related to sexual assault and trauma. The academic and topic databases searched to locate articles were Thoreau Multi-Database Search, EBSCOhost Academic Search Complete, APA PsycArticles, APA PsycInfo, Military and Government Collection, Political Science Complete, Social Work Abstracts, ProQuest Central, SocINDEX with full text, Sage Journals, Dissertation and Theses Library. The keywords and terms I used to gather relevant articles include *military sexual trauma, military sexual assault, military sexual abuse, military sexual violence sexual assault, sexual trauma, male veterans, military sexual trauma & male victims, male military sexual trauma, coping, and coping behavior, underreporting, lived experiences, gender bias, post-traumatic stress, depression, mental illness, reporting barriers, avoidant coping, institutional betrayal, healthcare, health-seeking, underreporting sexual assault, sexual harassment, sexual assault and reporting, stigma and military sexual assault.*

My search for resources was limited to peer-reviewed journals and periodicals and reports published dating between 1980 - 2020. Google Scholar and Walden Library were used to search keywords *gender bias /discrimination, institutional betrayal theory,*

institutional betrayal, coping strategies, rape, quality of life, military culture, male specific sexual assault, psychological stigmas. Walden dissertation search tool was also used to broaden my search on obtaining relevant literature related to men who have been victims of military sexual assault and has also affected their quality of life using keywords *unseen battle, collateral damage, quality of life, healing the shame, military culture, and male rape.*

Theoretical Framework

The theoretical framework of this study involved the understating of victim perception of institutional betrayal, underreporting, and leaderships inability to navigate these complaints through the appropriate channels. The theoretical frame was based on two theories: Institutional betrayal trauma theory and betrayal blindness. My use of both Freyd's institutional betrayal trauma theory and Freyd, Birrell, and Smith's betrayal blindness is appropriate for this study as it provides insight into the institutional dynamics of victim's distrust the institution, the violation they experience while on active duty after the assault and the lack of empathy and understanding displayed by commanding entities based on the cultural nature of the institution. In addition, the barriers they face to reporting for fear of being reprimanded and targeted (Monteith et al., 2016).

Institutional Betrayal Trauma Theory

Freyd's (1996) Institutional Betrayal Trauma Theory (IBTT) was a theory used to describe the violation of trust victims experience when their affiliated institution or organization fail to provide adequate support during times of personal crisis or trauma. Institutional betrayal trauma is also specifically related to Smith and Freyd's (2013)

theory that military sexual assault survivors experience a sense of betrayal when they must continue to work in proximity with their attacker within an institution that is based on trust, safety, unit cohesion and mission readiness (Monteith et al., 2016). As a result of this felt violation, IBTT will be used to gain insight on what male victims experienced due to the betrayal and lack of support they receive from the military as an institution as discussed in Chapter 1.

Smith and Freyd (2014) continued to work IBTT to capture specific possible tenets. The tenets refer to an institution's inability to set or enforce protocols to prevent abuse, the normalization of abusive contexts, making the process of reporting very challenging and intimidating for victims, inflicting penalties on victims and whistleblowers as a form of punishment for speaking up, and promoting cover-ups for higher ranking officials who are perpetrators. Although institutional betrayal may not harness the same negative implications on women as it would men, the theory apt to provide an understanding of the experiences of men who were victims of military sexual assault. The IBTT also allows the exploration to understand the psychological effect on male victims, the characteristics of the male victims, and the fears they wrestle with daily when in the same space as their assailant and the failure of institutions to provide support or respond to indiscretions. (Monteith et al., 2016). Given such, once the psychological dependence is initiated, betrayal blindness is to be expected next (Zurbriggen, 2005).

Betrayal Blindness Theory

Betrayal blindness (BB) is theory that emerged from Freyd's institutional betrayal trauma theory (IBTT). It is said to be a natural basic response among humans and based

on Empirical research, BB is both customary and psychologically significant for the victim (Freyd & Freyd, 2013). Betrayal blindness explores the reasoning behind a victim's deliberate choice to suppress circulating thoughts related to the assault used as a form of coping, especially, if there is still some affiliation to the institution or perpetrator (Freyd,1996; Freyd Birrell, 2013; Smith Freyd, 2014) rather than acknowledge and ignore the trauma. The constructs of institutional betrayal trauma and betrayal blindness describe the disassociation, forgetfulness, amnesia, and possible suppression of an event which may be used to possibly function and adapt to the new conditions within their altered environment (Zurbriggen, 2005). Men who have had traumatic experiences such as sexual trauma or assault may experience a decline in their self-esteem as they are faced with a possible identity crisis and may question themselves about their masculinity, as masculinity is synonymous with power and strength amid any circumstance (Romaniuk & Loue, 2017).

Betrayal blindness may not be a reaction that performed flawlessly by many victims as it requires significant focus to pretend to display certain attributes and qualities when in the presence of the person who is the perpetrator (Freyd & Freyd, 2013). In these said instances, victims may have difficulty showing genuine concern and external non-verbal gestures like smiling or attention which can be a risk factor for the victim (Freyd & Freyd, 2013). In exploration of specific understand of the theory, it was found that to combat against betrayal blindness may include increased transparency and protection of victims who report incidents and increased victim awareness to safeguard against further assaults (Tang, 2015). Finally, military sexual trauma poses different types of challenges

experienced among men than they do among female victims. Understanding the cultural belief that sexual assault against men only happen to gay men or that men specifically cannot be forced into sexual acts and should be able to ward off any unwanted encounters (Sadler et al., 2018) can be used to identify effective training tools to protect potential victims. The jaded belief men cannot be victims of sexual assault is a main contributor to the reality of why men are seldom likely to report these acts of aggression and receive adequate healthcare services from professionals (Sadler et al., 2018). Additionally, the gender-related stigma encompassing military sexual trauma is another primary reason for multiple mental health disorders being exhibited in male victims, with depression and Post-Traumatic Stress Disorder (PTSD) being the most significant diagnoses (Schry et al., 2015). Historically, military sexual trauma was believed to be a form of assault that was only targeted at women and men being the aggressors. However, while much research had not been conducted, the current data is providing a deeper understanding of why more has not been done.

Culture in The United States Armed Forces

Military Culture

The United States Armed Forces (USAF) consists of four entities which includes The Airforce, Army, Marines, And Navy. Although they all may fall under the umbrella of the USAF there are significant cultural diversities that exist within each group (Hall, 2010). Within these set cultural norms, there are a specific dress codes, languages, belief systems, norms, and rituals exhibited by individuals of the different branches (Reger et al, 2008; Hall, 2010). These set norms, values, and belief systems along with family

tradition, benefits or form of escape may contribute to choosing the branch an individual may decide to enlist (Hall, 2010) from daily life stressors or negative environment. Moreover, it is a male dominant institution that is influential in shaping the behaviors and altering the personalities of the men and women who join (Bennett, 2018).

Being part of a military branch promotes cohesiveness among one's unit, the emphasis of mission comes first above everything and unit commitment (Martin & McClure, 2000). Cacace (2020), also proposes that individual self-esteem increases with military affiliation, but at the cost of a self-identity reduction because of the promotion of cohesiveness and unity. The USAF plays a vital role in the lives of the young men and women who are new to the military lifestyle and territory and following the status quo may innate desire many may have longed for, while others may struggle with authority because of egotistical traits (Bennett, 2018).

Dominance and Strength

A primary function of the USAF is training the best for the worse, with the assurance that mission and unit duties come before personal needs, while the display of any form of weakness is deemed unacceptable (Fennel, 2008). This may contribute to the display of showing little to no emotion during adversity which translates as showing stability (Hall, 2010) and strength. The USAF also functions on a merit system where individual capabilities, ego, drive, potential, talent, skills, and performance are frequently evaluated and under a microscope to determine their rank in the hierarchy which may foster internal challenges for some resulting in outburst to restore their injured ego and weak self-esteem (Bennett, 2018; Baumeister, Smart & Boden, 1996).

The types of outbursts may consist of males being more liable to commit a sexual offense (Bennett, 2018). In addition, there is a separation of class among officers and enlisted (Hall, 2010). The separation of class distinguishes the rank, authority, and seniority one has over the other, along with available liberties and flexibilities which may deter junior enlisted members from reporting sexual assaults (Cacace, 2020). Consequently, this may sometimes promote the fear of reporting to a higher chain of command or other unit members. For this reason, victims of military sexual assault are more likely to disclose the details of the assault to informal support sources, which may be critical to their mental health (Holland & Cipriano, 2019).

Gender Differences

Military enlistment and service use to be duty designed to attract men to service, and later resulted in drafting men for service. The process of allowing women access to join active military service aside from being a translator or clerk in World War II was slow (McGregor, Dye & Dougherty, 2020). Changes in certain policies allowing women to serve in combat made it possible for women to function in specific roles (McGregor, Dye & Dougherty, 2020). The opening of these roles also unlocked doors for women to be deployed in combat zones. With that, several national studies were conducted on the high rate of sexual assault among women in the military with reports between 22% to 84% and a rate of 1% to 12% males

Although Eckerlin et al., (2016) have indicated that there are approximately 85% males and 15% females enlisted in the United States Armed Forces. Yet, there seems to

be differences when support is provided for men that when it is being provided for women, with a greater del of support is provided for women (Khan et al., 2020).

There are also the differences in which men and women react differently to traumatic experiences while serving in the military. Men who have experienced military sexual trauma are more likely to exhibit great deal of shame, stigma, and anger (Khan et al., 2020). While women are likely to be depressed, have eating disorders, or substance abuse (Burns et al., 2014). In relation to seeking healthcare, the feelings of guilt, shame, embarrassment, fear of confidentiality, and fear of not being believed identified were both experienced by men and women. Nonetheless, experiences specific to men carried more negative psychological effects than women displayed while they are on active duty (Turchik, 2013).

Literature Review Related to Key Variables and Concepts

Defining Military Sexual Assault and Trauma (MSA/T)

Military sexual assault and trauma may be used interchangeably, however, the actions associated with both terms are the same. Military sexual assault and trauma refers to the nonconsensual sexual act or rape, forced or coerced physical body contact of sexual body parts, sexual intercourse against an individual's will to participate or any form of forcible penetration that violates someone while they are active duty in the military (Yalch et al., 2018), to also include sexual harassment.

According to Title 38 U.S. Code 1720D, military sexual trauma is defined by several negative experiences to include unwanted and inappropriate verbal or physical contact of a sexual nature, or sexual acts that occur without a consensual agreement,

force, intimidation, or coercion (Forkus et al., 2020). Sexual harassment otherwise described as continuous unsolicited physical or verbal advancements or contact that is threatening can also be described as military sexual trauma (Barth et al., 2016). The phenomenon of military sexual violence can be attributed to myths and conquests of ancient Roman soldiers who displayed violence which included rape when they won (Kuhl et al., 2018). Moreover, sexual misconduct of this magnitude continues to impact U.S. Military servicemembers with 9-13 % women and 1-2% of men annually (Holland et al. 2014; Kuhl et al., 2018). Most studies conducted on the sequela of military sexual trauma on victims have found that MST affects 1 in 4 women in the military and 1 in 100 men (Wilson, 2018), while gender equity between men and women exist in the military (Sadler et al., 2018) and is notable.

Consequently, as continuous efforts are being made to increase preventive measures to address MST, prevalence and underreporting continues (Burns et al., 2014). Albeit most research conducted on MST, essentially focuses on the impact the trauma has on women, even though men are also subjected to these types of assaults (Tiet et al., 2015). The increases in the disparity of the traumatic effect it has on men and the differences in which they respond to the traumatic experience Tiet et al., 2015). And while it may seem that women are more likely to suffer these attacks, there is a greater male population (Tiet et al., 2014), who may not report due to the stigma associated with reporting this type of assault. In other words, the prevalence of male sexual assault is greatly underreported, and altogether sexual assault being considered as one of the most

underreported crimes with male sexual assaults being at a particularly higher rate (Kimerling et al. 2002).

Military Sexual Assault and Trauma Among Active Duty

Military sexual assault is a ubiquitous issue that continues to permeate throughout the United States Armed Forces (Kameg & Fradkin, 2020). Moreover, Kameg and Fradkin, 2020 deduced that military sexual assault is still significantly underreported at about 31% among victims. The low reporting rate can be attributed to the lack of trusts victims may have in the system related to reporting. According to McNeely, 2015, more focus must be placed on both victims and offenders to decipher how this type of assault continues to occur within their confined spaces, so a viable plan can be established to reduce occurrences. According to Wilson et al., 2020, a recent meta-analysis of 43 studies found that there is a 13.9% higher prevalence of military sexual assault occurring among women with a rate of 1.9% being men and 23.6% women. The increase in the prevalence of MSA also harbors the increase of PTSD, depression, and self-directed violence among the victims.

Active-Duty Females and Sexual Trauma

The enlistment of women in the military has made the endemic of MST appear to be a more common occurrence among service members (Department of Defense DOD, 2010; Groves, 2013). Although MST sexual assaults have always been an issue for active-duty service members (Groves, 2013), the amendment of the 1992 Veteran Health Care Act in 1994 included men and opened the discussion and the acknowledgement of MST against men (Romaniuk & Lou, 2017). Hazing, which is described any form of

unacceptable acts conducted, performed, or imposed on other servicemembers that is deemed painful and/or humiliating, inflicts physical or psychological pain on the victim (Keller et al., 2015; Manzanedo, 2013; Groves, 2013) is another form of MST. Schuyler et al., (2017), stated that the rates of military sexual assault in women ranges between 3 - 54% and 3% in men. There is a possibility that these percentages may be inaccurate due to the inefficient methods and the characteristics of population sampling (Schuler et al., 2017).

Active-Duty Males and Sexual Trauma

Military sexual trauma among males is an understudied phenomenon. As such, men who screen positive for experiencing assault at a greater risk for self-directed violence (SDV) (Monteith et al., 2019). In addition to SDV, male victims are frequently diagnosed with post-traumatic stress disorder (PTSD), depression, potential substance abuse (Monteith et al., 2019). The military is an environment that fosters the ideology that men cannot be raped or be victims of sexual assault or trauma. As a result, they experience greater marginalization and stigmatization than women creating a barrier to reporting the incident (Sadler et al., 2018). Due to underreporting, and reluctance in seeking help, men experience a unique emotional response which may intensify their emotions of guilt and shame that may become a detriment to their mental health (Rice et al., 2018).

The fear of being ostracized by their colleagues, labeled and assault being exposed also contributes to male victim’s underreporting. Rabelo et al., 2019 conducted a study related to military sexual assault victim’s trust and confidence in the military

system as it relates to privacy and found that victims who report are further victimized for reporting their assault by facing blame and doubt. Moreover, males in the military are bred to be tough. They face stigmas such as men who are assaulted must be gay, it is impossible for a man to be raped, male victims should be strong enough to fight off their attacker, it is a man's fault if he is raped. Along with the belief that only gay men commit sexual assault (Sadler et al., 2018).

Military Sexual Assault and Trauma Survivors

Survivors of MST or MSA face challenges of being ostracized if they report incidents, based on the military values or code of honor engrained at their indoctrination to the specific branch (Schuyler et al., 2017). Some MST survivors endure the challenges with reporting and remaining silent about the incident as they may still have to work in close quarters with their assailant (Schuyler et al., 2017). Military sexual trauma also negatively effects on the victim's psyche which may also impact their overall health and behavior, which is expressed differently between men and women (Schuyler et al., 2017). Oftentimes, male MST victims are assaulted by more than one perpetrator and the assault commonly occurs during some form of hazing which may pose as a threat to their masculine identity (Schuyler et al., 2017), which may also contribute to their decision to not report the incident. A victim's decision to conceal an assault and not report may be attributed to their fear of retaliation or their fear of being believed. Wolff and Mills (2016) indicated that MST may be difficult to prove due to the unreliability of self-reporting victims. This may also be linked to a victim's belief of the perpetrator not being reprimanded for their indiscretions (Wolff & Mills, 2016). A point that is often

overlooked is that the continuous occurrence of MST is contradictory to the values and beliefs of the military such as: honor, integrity, and respect (Schmid, 2010). Thus, addressing MST within the military is paramount for the safety and well-being of all who are called, volunteered, and have a desire to serve.

Gender Ideology and Gender Bias

Gender Ideology

Gender is the scope used by society to determine and assess the roles of men and women. Bell et al., (2014) found that that gender is used as a lens by men and women to determine their worth and each gender places great emphasis on what they are man enough or women enough to endure as it relates to internal and external pressures. It is sometimes difficult for some to fathom those men are subjected to military sexual assault because their gender seems to organically exempt them from these said forms of assault because of their genetic makeup. However, media coverage of the Tailhook Scandal that occurred in 1991 when 83 women and 7 men reported being sexually assaulted by high-ranking officers, which also led to the resignation of the Secretary of the Navy (O'Malley, 2015) brought immediate attention and highlighted the fact that men too are victims of sexual trauma. Albeit the awareness of men being sexually assault was made, most of the research conducted since then has still primarily focused on women.

The divide created by gender based on experiences has created an even bigger gap in the efforts to highlight the experiences of men compared to women, or even merely acknowledge that men are also victims, has left men to remain as an understudied population regarding military sexual trauma (Bell, et al., 2014). Another divide that

created a bias in the treatment of male and female MST victims is that MST was only associate with the ratings for women and not for men, which also provider and patient communication along with coordinating healthcare (Kimmerlin et al., 2011; Monteith et al., 2020). Nevertheless, the honor code associated with each branch that includes some form of commitment and value to service involves being loyal, respectful, courageous, commitment to the Corp before self, excellence, and integrity (Bell et al., 2014), may sometimes contribute to the gender differences in reporting MST or determining which gender is more at risk of being victims.

Gender Bias

Historically, sexual assault was only associated as an offense only experienced by women (Turchik et al., 2013; Robertson, 2010) and it is apparent that women have been and still appears to be the most studied gender related to MST. A study conducted on the eligibility for care between both male and female MST victims found that men are less likely to receive out-patient services in the 12 months after they have been screened and identified as eligible to receive care compared to women (Turchik et al., 2013). While there is no clear distinction to why there is a difference in one gender receiving care compared to the other, there may be gender specific sexual trauma barriers that surrounds the reason for some not receiving optimal care (Turchik et al., 2013). What must also be understood is that MST is a stressor and not a diagnosis and that the barriers to receiving care may be closely related to the effect of PTSD (Turchik et al., 2013). A few barriers that are gender specific to women are the belief that they were responsible for what occurred by shifting to self-blame for the attack, saying that they provoked it, men cannot

be trusted, or it was not a big deal which in turn disrupts the homeostatic personal internal functioning (Turchik et al., 2013; Hollon & Garber, 1988; Resick & Schnicke, 1993). Nevertheless, data collected form the Department of Defense in (2014) found that service members who have experienced sexual assault do encounter barriers when reporting, such as fear of appearing weak to their peers, their inability to move on from the incident and the possibility of the similar barriers following service (Blais et al., 2018).

A Government Accountability Office study conducted in 2014 found that post-traumatic stress disorder ranked as the highest disability claim processed for those who were victims of military sexual trauma (Parnell et al., 2018). It was also found that 32% of the female veterans' who participated in the survey experienced some form of MST during their active-duty career (Parnell, et al., 2018). Furthermore, another study conducted with a sample of 408 men and 62 women who were deployed in Iraq and Afghanistan wars reported that 51 (12.5%) men and 26 (42%) women experienced MST which also created readjustment issues (Katz et al., 2012). Individuals who were diagnosed with PTSD due to MST revealed more symptoms of undesirable health symptoms which resulted in smoking and substance abuse (Katz et al., 2012; Koss & Heslet, 1992; Koss et al., 1991; Skinner et al., 2000).

Military Sexual Trauma, Male Masculinity, and Myths Among Men

Male Victims of Military Sexual Trauma

Men who experience military sexual trauma (MST) is still an understudied phenomenon. Military sexual trauma is understudied in the male military population

based on underreporting (Monteith et al., 2019). For instance, men who refrain from reporting MST may be related to the stigma, shame, myths associated with rape, and the examples they have witnessed of past rape reports, along with the perception of others who may question their masculinity and sexuality (Holland et al., 2016; O'Brien et al., 2015 Turchik et al., 2013; Monteith et al., 2019). A Workplace and Gender Relations Survey conducted by the United States Department of Defense conducted in 2012 among male and female active-duty members who decided not to report sexual assaults were asked to reveal their reasons for not reporting and the men selected fear of being punished for other violations, decreased chances for promotions and fear of not being believed and women having a fear of discomfort and confidentiality of the assault (Obrien et al., 2015; United States Department 2012).

The challenges of guilt, shame, and stigmatization have created barriers for male victims who may want to report, which in turn fosters a higher risk of these male victims developing psychological and physical conditions (Monteith et al., 2019). These psychological and physical conditions may also play a role in the deterioration of their quality of life. Under those circumstances, the highly impactful and personal violent nature of MST has found it to be the highest type of assault one may experience that is also indicative to developing post-traumatic stress disorder (PTSD) among other forms of traumatic experiences (Kang et al., 2005; Kessler et al., 1995; Elder et al., 2017). Wilson (2016) also indicated that there may be a higher percentage rating than 3.9% of men reporting to have experienced MST based on self-reporting measures and interviewing the victims in comparison to the reports found in Veteran Affairs (VA) medical reports.

Another study revealed that the limited research on MST among men, specifically highlighted the prevalence of men being at a higher risk of experiencing some form of sexual assault while in the military (O'Brien et al., 2015). Moreover, the said study also indicated that the annual occurrence of military sexual trauma among men differ from .02% to 6% and has an overall lifetime incident possibility of .03% to 12.4% of offenses experienced by men (O'Brien et al., 2015; Hoyt, et al., 2011). Previous literature revealed that men who have experienced MST are at a significantly greater risk of displaying decreased work productivity, homelessness, eating disorders, and suicide ideation compared to women (Monteith et al., 2019).

Male Masculinity

Male masculinity is synonymous with strength, ambition, seeing violence as the first line of defense, and a certain type of bravado majority of men develop based on the social theories that define masculinity (Carlsson 2013; Kuhl et al. 2018). As such, this persona is threatened or can be compromised in lieu of the display of such vulnerability and weakness. For this said reason, it may be difficult for men to lower the bar on the traits of strength, power, and dominance. The effects of MST force the male victim to challenge his identity and to occupy a space of perceived vulnerability and submission, rather than one of strength and self-reliance (Hoyt et al., 2011).

A survey conducted by the United States Department of Justice (2013) found that 81% of men and 67% of women do not report their military sexual assault (MSA). The survey captured the number of men who decide not to report their MSA and can be attributed to fear and stigma associated with the assault, but little is still known about the

root reason of their fear of reporting these incidents. Moreover, there is very little research that places significant emphasis on the effect of MST among male victims and their experiences compared to the studies conducted on the impact MST has on women.

Researchers have also attributed underreported MST and the lack of research due to underreporting occurrences to male servicemember’s understanding of the institutional norms that surround the military environment as well as the societal cultural norms associated with evident beliefs of masculinity and male sexuality (O’Brien et al. 2015). Furthermore, studies conducted on sexual assault in the military and among civilian males suggests that males are more prone to suffer from exponential rates of psychiatric hospitalizations reported distress, display other psychiatric symptoms (Kimerling et al., 2002; O’Brien et al., 2015), substance abuse and self-harming traits (O’Brien et al., 2015).

Male servicemembers were conditioned to exhibit strength, to suppress or refrain from displaying emotions that exhibit any form of weakness in the presence of others (Romaniuk & Loue, 2017). When in fact, men appear to experience the same type of emotional struggles as women, like anger, betrayal, guilt, helplessness, humiliation, and shame (Romaniuk & Loue, 2017), and maybe more so because of the societal norm and expectation of their gender to exhibit that masculine strength. Men are more likely to spiral and participate in reckless behavior, resort to substance abuse, and have a severely increased risk of suicide (Romaniuk & Loue, 2017; Blosnich et al., 2014).

Male Sexuality

Heterosexual male victims begin to question their sexual orientation and appearance on whether the appear gay or bisexual, while gay/homosexual men believe they were targeted because of how they identify (Romaniuk & Loue, 2017). In many instances, most men seem to join the military to develop their masculinity and looks to the military as they would a family, for a sense of belonging, which makes MST occurring seem like incest (Hopper, 2006; Hunter, 2007; Kimerling et al., 2007; O'Neill, 1998; Street & Stafford, 2009). The feeling of betrayal when attacked by an individual or individuals they look to for support and consider family and comrades is expected. Gay/homosexual men experience the same questions and shame as heterosexual males. In fact, Gay/homosexual men are attracted to men, and after sexual trauma, their ability to find intimacy becomes a difficult feat as they develop an inability to trust men (Penn, 2014).

Myths of Rape Military Sexual Trauma Among Men

The myths related to men who experience military sexual trauma offers the perception that men do not get raped or sexually assaulted, or at least not real men or strong men (O'Brien et al., 2015). Another myth is that real men cannot be forced to participate in sexual acts against their will and they ae less affected by the implications of sexual assault than women (Chapleau et al., 2008; Turchik & Edwards, 2012: Depraetere et al., 2020). The myths present the connotation that men have the strength to fight off their assailant not allowing himself to be assaulted or incur any serious injury as a result because the perception of the male servicemember is one who is able to control a hostile

situation and usually the aggressor who initiates sexually activities because of their size (O'Brien eat al., 2015). This also challenges the concept and belief that "all men are created equal."

Furthermore, there is also the myth that males who are raped or sexually assaulted are homosexuals and therefore, they are the only ones who are more subjected to these types of assaults as well as males who are raped by other males would perceive and labeled a homosexual (O'Brien et al., 2015). Uniquely, there is another myth that state that men who experience MST are not too concerned with the assault assuming that men are men are emotionally stoic and are able to brush it off and cope with the experience offering little or no empathy or sympathy to male victims minimizing the severity of the assault (Struckman-Johnson & Struckman -Johnson 1992; Burczyk & Standing, 1989; Obrien et al., 2015). Another misconception about MST among men is that men cannot be assaulted by women or a man who has been assaulted by a woman should not be taken seriously and will not be identified as a strong military male (O'Brien et al. 2015). According to Eckerlin et al., (2016), women possess the capability committing sexual assault.

This too may be overlooked as research conducted by Smith et al., (1987) uncovered that 47% of men who are sexually assaulted by the other sex find some sense of sexual pleasure from the encounter which may make it difficult to believe their claim. In essence, because of the military culture and the lack of concern for the severity of MST, male service members suppress their emotional distress and develop a stoic appearance or attitude for the greater good of the unit which is believed to enhance unit

cohesion, and which is associated with the overall success of the unit (O'Brien et al 2015; Greene et al., 2010). This leaves the open window of opportunity for perpetrators to target males because they are less likely to report incidents, making them a vulnerable population (Sadler et al., 2018).

Military Sexual Trauma Among Women

Women are more commonly identified as victims of military sexual trauma (MST) and therefore, studies are more directed to the effects in has on them as victims. The commonality may occur as women are more likely to report incidents compared to male victims. For instance, a study conducted by the Department of Veteran Affairs (2017), found that one in four women equating to 26.9% women compared to 1 in 100 men 1.4% screen positive for MST (Brownstone et al., 2018). Sexual harassment and assault rates for women were roughly about 52.5 % and 23.6% respectively (Wilson 2016; Brownstone et al., 2018). Another study conducted by Morrall et al., (2015) found that out of the 52.5% of women who reported their assault, 7.29% of those women ranked (E1 – E4) faced some form of retaliation for reporting. The retaliation female victims experience fosters a deterrence to reporting assaults for other victims.

Women who experience MST are also at a higher risk of being diagnosed with a myriad of mental health symptoms, including post-traumatic stress disorder (PTSD) depressive, eating, anxiety, alcohol related, dissociative, bipolar, and psychotic disorders (Brownstone et al., 2018; Blais et al., 2017; Kimerling et al., 2007; Maguen et al., 2012; Surís et al., 2007). Female victims usually have a higher usage of health care facilities to manage the effects of the assault (Katz et al., 2017). Many of the female victims were

already predisposed to interpersonal violence (Katz et al., 2017). The study conducted by Katz et al., (2017), on 21 women who experienced MST, it was found that 67% of these victims had unwanted pregnancies because of the assault. Based on Lathrop (1998) Coitus theory, it is possible that during these inappropriate encounters, fear, anger, and stress may activate hormones in the body and trigger premature ovulation resulting in an unwanted pregnancy (Katz et al., 2017).

Psychological and Physical Effects Related to Military Sexual Trauma

Psychological Effects

There is a myriad of psychological responses emitted by MST victims which is related to the severity of the assault and the gender of the victim (Street & Stafford, 2004). In addition, the psychological response of military sexual trauma may not primarily stem from the actual assault, but from the lack of responses associated with seeking help, retaliation, stigma, and the inability to obtain retribution for the assailant. Furthermore, the gender-specific bias surrounding psychological responses like post-traumatic stress disorder (PTSD) social assigns the effects of PTSD to be associated with female rape and male combat exposure, which may also contribute to lack of reporting among male victims (O'Brien & Sher, 2013).

Reporting incidents may be difficult at times, especially if the perpetrator is a higher-ranking officer. The subordinate victim must file reports through the chain of command as established by the military equal opportunity policies (MEO) in which commanding officers are informed of the allegations filed and a formal investigation must be done (Daniel et al.2019). Due the process and the policy in place where victims

must report using specific steps through their chain of command, they may be reluctant to report leaving the assault unreported. The decision to not report can also be attributed to the lack of trust they have in the process and the institution to protect them as victims (Rabelo et al., 2019).

Some of the psychological implication associated with MST are PTSD, major depression, substance abuse, suicide ideation (SI), anger outbursts, guilt, and self-blame (Street & Stafford, 2004). While the psychological and physical very similar for men and women, studies have found that the implications may be more significant in male victims (Street & Stafford, 2004). Male victims are more likely to question their sexuality and masculinity and at a much greater risk of succeeding with suicide (Monteith et al., 2019). In fact, male MST victims are at a higher risk of committing suicide (Monteith et al., 2019).

Posttraumatic Stress Disorder

Post-traumatic stress disorder (PTSD) is triggered by a traumatic event such as sexual trauma and can have debilitating effects on the person diagnosed. PTSD is made up of four clusters that consist of the victim reexperiencing the traumatic event, avoidance of things of this that remind them of the event, dysphoria, hyperactivity, and reactivity (Goodman-Williams & Ullman, 2020). The effects of PTSD among MST victims seem to be longer lasting to include months and years which is higher than individuals diagnosed with PTSD due to other traumatic events (Chapman et al., 2012; Müller et al., 2018; Najdowski & Ullman, 2009; Goodman-Williams & Ullman, 2020). Moreover, there are other psychological disorders individuals diagnosed with PTSD tend

to display. The disorders include self-directed violence, suicide ideation, depression, anxiety, eating disorders, intrusive memories, avoidance, changes in physical and emotional reactions, hypervigilance, insomnia, self-destructive behavior, overwhelming guilt, and shame among other debilitative effects.

Self-Directed Violence

In 2014 the Department of Veteran Affairs collected data on the rate of suicide among veterans and found that the rates were 22% higher than civilian rates in the United States (Wiblin et al., 2021). Victims who have experienced military sexual assault are more likely to have a higher rate of behaviors that cause them to self-inflict pain. This consequence of sexual assault causes feelings helplessness, unlovability, and an inability to bear the psychological pain associated with the trauma (Wiblin et al., 2021). Their inability to deal with the ramifications of the assault sometimes result in the victims displaying deliberate behavior referred to as self-directed violence (SDV). Self-directed violence is commonly found in victims who have experience military sexual assault or trauma and the intent to die is sometimes imminent (Wilson et al., 2020). However, MSA/T victims who display self-directed violence do not result in fatalities.

Psychological Disorders

Military sexual assault and trauma can become very debilitating on the mental make-up of victims who are still active duty. As such, mental and physical barriers can be created as a form of protection and defense mechanism. Male MSA/T victims display a greater association to symptoms related to dissociative and personality disorders (Kimmerlin et al., 2007; Morris et al., 2014). According to Morris et al., (2014),

psychosis, bipolar disorder and schizophrenia are more prevalent in male MST victims that they are in women. A point mainly overlooked is that most victims fear disclosing their ordeal, because of the negative feedback they are likely to receive from comrades and due to the closed space environment in which they work. As such, researchers have discovered that male veterans who bond by the set norms of emotional toughness in place are more likely to have a positive screening for PTSD and depression (Jacupak et al., 2014; Voller et al., 2015) Nevertheless, underreporting, or underreported incidents, victims maintaining their silence, will likely have and an adverse effect resulting in one or more of the psychological responses.

Physical Effects

Military sexual assault (MSA) is heinous act that can create debilitation effects among victims. Researchers have suggested that MSA among men is likely to be more violent than the attacks among women (Tewksbury, 2007). Sexual attacks on male victims are likely to be more physically violent accompanied by excessive force and use of weapons (Tewksbury, 2007). The physical trauma sustained by the victims are bodily injuries like broken bones and black eyes due to being beaten, subdued, and restrained (Struckman-Johnson et al., 1996). Other injuries include anal tears due to forced penetration, abrasions, bleeding, and friability. The severity of the physical violence male MST victims experience compared to females is more likely to occur because male victims are usually assaulted by two or more assailants and it is considered gang rape (Kaufmann et al., 1980). In addition, to the physical attack male MST victims experience, they are more susceptible to certain sexually transmitted diseases like HIV/Aids, herpes,

syphilis, and disorders such as sexual desire and sexual arousal disorders (Turchik et al., 2012; Morris et al., 2014).

Negative Life Effects

Hostile Work Environment

Military sexual assault victims who are required to effectively function in a hostile work environment can have a debilitating and detrimental effect within the unit. Sexually assaulted victims such as those in the military required to work in close possible proximity to their attacker may have significant negative adverse effects. The implications of sexual assault can be more detrimental to males as they are particularly confronted by the emotional and behavioral challenges that goes against the values and beliefs of how men behave in the military (Daniels, 2013). More importantly, a hostile work environment may be evident for men who decide to report as it may either impede on their advancement opportunities and the stigma that men who are sexually assault are potentially gay. Establishing pathways in which males can feel secure in reporting MST should be viewed and an institutional responsibility and that everyone regardless of gender feels safe in those spaces.

Male Victims Negative Life Effects

Fear of sexual assault never appears to apply constraints on the lives of men as it seems to posit on women (Weitz, 2015). This is because sexual trauma is thought to be a type of assault that only occurred where women, are the victims. While the military exudes masculine dominance and a cultural attitude that men are superior to women (Weitz, 2015), the phenomenon shows that both genders are subjected to this type of

assault. Nevertheless, military sexual trauma and assault research has revealed that male victims are at a higher risk of being doubted because of the stigma associated with the belief that men cannot be raped or they were raped because they wanted to be and available health services are more specific toward female victims (Stermac et al., 2004). Moreover, the constant aggression and required obedience the military is known for, makes men 10 times more likely to be assaulted than their female peers (Penn, 2014).

A male victim reporting sexual assault may be a calculated risk as the social and cultural expectation that men are supposed to be strong and sexually dominant, and reporting may either cause them to blame themselves for the assault, be stigmatized by their peers, or question their sexuality (Duchense et al., 2018). Other research has also found that between male and female genders, men are more likely to be victims of repeated physical and violent assaults committed by multiple perpetrators (Morral et al., 2016; Filo et al., 2018). Ironically, this is not known, as the nature, consequences, and effects of MST against men in the military is significantly underreported (Filo et al., 2018).

It would be considered quite important if a bit more exploration can be done within the institution among active-duty members to determine why men are more likely to be violently assaulted than women (Morral et al., 2016). Some researchers have stated that most sexual assaults against men and women are primarily committed by men, and yet, there is a possibility of there being differences in the motives of the assailant(s) when committing this egregious act (Filo et al., 2018). The military is a vastly male dominated environment, and sexual assault among women can be viewed as an assertion of power

and dominance, while violence against men is geared toward humiliation and abuse (Morral et al., 2016). An understanding of the significant differences in the type and the purpose of the attack may aid in identifying possible preventative outcomes to minimize risk of victimization and creation a lasting positive social change within the military.

If this approach is considered and implemented, there is possibility that male victims may tear down the barriers they have built because of the guilt and shame they feel to seek help (Monteith et al., 2019). The only way for more to be accomplished on the side of prevention and holing perpetrations accountable, would be a result of more victims reporting their assault and stepping out of the shadows which may also be of a benefit to help other potential victims to be cognizant of the warning signs of possible danger.

Social Ostracism

The military is an institution that promotes unity and camaraderie and when one member of the unit experiences a sexual assault while on active duty is cause a disruption in the togetherness of the unit. Military sexual trauma has the potential to severely impact the victim physical, psychologically, and social during and after being discharged (Gonzalez-Prats, 2017). The psychological effects are associated with the anxiety, depression, and post-traumatic stress (PTS) which impacts the victims social and occupational function in an adverse way (Suris et al., 2004; Gonzalez-Prat 2017) that trickles over to unit performance breakdown. Social ostracism can also stem from the victim and the perpetrator being in the same unit which may create a possible divide on the team.

In turn, things that the ostracized member may have been a part of before may result in them being rejected, shunned, or excluded from based on the allegations they made, especially, if they are not believed. From the male perspective the ubiquitous social phenomenon carries a great deal of weight for victims especially if they must work in proximity for the duration of their tour of duty. No victim wants to endure the negative outcome that occur being a victim of sexual assault while on active duty and social ostracism may contribute to the difficulty in their ability to effectively function resulting in greater psychological distress.

Coping

Military sexual trauma (MST), like PTSD can be likened as a “silent killer” of the mind and spirit of the victims. MST victims experience conflict emotions related to reporting incidents due to the fear of retaliation, the shame and guilt they feel, stigma and fear of social judgment, not being believed, the impact on their professional record, and facing questions related to sexuality for male victims (Romaniuk & Loue, 2017). It can be extremely challenging to cope with the effects of MST for most victims, especially if they are unable to fully process the traumatic event and psychological symptoms impede on their daily functions (Gaher et al., 2016). Coping with the trauma may be expressed differently by individual victims and genders. Some victims resort to alcohol use which can be associated with coping behavior MST victims exhibit as a form of avoidant coping (Creech & Borsari, 2014). Male MST victims specifically are more likely to abuse alcohol and other substance to help aid in numbing the attack, so they distort the replay images of the event in their minds as well as excessively exercising to promote tiredness

(Monteith et al., 2019). Victims are also likely to display signs of Alexithemia which is the difficulty in identifying their own emotional responses, which may also be like PTSD and depression (Gaher et al., 2016).

Substance Abuse

Other forms of coping military sexual assault and trauma victims use is alcohol and any type of substance that would possibly mask or alter their feelings to temporarily erase the assault. Alcohol and other substances are distractions used to desensitize their emotions as MST victims sometimes have difficulty with emotional regulation (Forkus et al., 2020). However, Military sexual trauma victims tend to have difficulty associating and accepting positive emotions as good and self-sabotage as a form of punishment for the guilt and shame that they feel because of the assault (Forkus et al., 2018). However, Turchik and Wilson (2010) suggested that the victims and perpetrators are usually under the influence of a substance before assaults. A study conducted by the Department of Defense (DoD) in 2005 found that 50% of reported incidents resulted in a servicemember's alcohol use (Turchik & Wilson, 2010).

Help-Seeking Barriers and Stigma Associated with Male Victims Seeking Care

Military sexual trauma victims (MSTV) can be very hesitant when deciding to seek care related to their ordeal. This stems from the perceptions of the care them may receive form the Veteran Affairs Administration (VA) (Monteith et al., 2020). A recent study showed that women display grave disappointment and a sense of betrayal with government organizations that trust to provide care which ultimately result in their discontinuation of the service (Monteith et al., 2010). The same occurrences also

appeared in the treatment of male MST victims with greater intensity (Monteith et al., 2020).

Men are also less likely to utilize VA outpatient MST care, and even more so, delay any attempts to seek care at VA facilities (O'Brien et al., 2015). The prevalence and the impact military sexual trauma (MST) and assault has on the military community has forced a paradigm shift in the Department of Veterans Affairs focus on detection, treatment of MST (McManus et al., 2018). However, based on the current unassigned diagnosis or syndrome of MST, and no specific treatment plan, it fosters an enormous feat in recognizing and understanding of how to treat victims (McManus et al., 2018).

The Department of Defense (DoD) has made strides in creating reforms related to sexual assault and providing victims with resources available to receive care and assistance (Holland et al., 2016). The resources include the Sexual Assault and Prevention Response Office (SAPRO) which is the primary office that provide resources for victims (DoD Directive 6495.01, 2012; Holland et al., 2016). There is also the Sexual Assault Response Coordinator (SARC) who would be the point of contact for care coordination for MST victims. There is also the Victim Advocates who aid with victim crisis intervention (DoD Directive 6495.01, 2012; Holland et al., 2016). Yet, with all these resources, researchers still found that victims are not forthright in reporting the history of their assault, which delays treatment, or they refrain from ever disclosing the attack resulting in no treatment at all ((Burns et al., 2014; Campbell & Raja, 2005; Surís et al., 2004; Turchik et al., 2013; Holland, Rabelo, & Cortina, 2016).

Help Seeking Barriers

Previous studies conducted have found that men and women display similar barriers in seeking help or making a formal report for MST (Bell et al., 2014). However, seeking help for the effects of MST among men may be a difficult feat due to the barriers and stigmas associated with the way men who have been sexually assaulted while on active duty in the military are perceived. Barriers that they face when seeking help are related to the shame, guilt, other thoughts and opinions of them, and the weakness they feel due to the attack and their inability to protect themselves and ward off their attacker or attackers (Holland et al., 2016).

The feeling of guilt and shame tend to impede on the victim's decision to seek help for the effects of the assault and the distress they experience may contribute to additional barrier created to deter them from seeking help (Holland et al., 2016). Given such, self-created barriers, strategies, and creative methods must be created to reassure victims that they will receive the help they seek with the utmost discretion, privacy, professionalism, and provider sensitivity, which will also foster and environment of comfort and safety making it more conducive to disclose their ordeal.

Another barrier that may impede on male MST victim's decision to refrain from seeking help is the perception of them causing trouble, the fear of retaliation, ostracism, the ramifications it may impose on their career and opportunity for advancement, and the belief that nothing will come about the report made (Steiger et al., 2010; Turchik & Wilson, 2010; Bell, Turchik & Karpenko, 2014). The fear of being prematurely discharge for service is also another barrier which stems from the "Don't ask, Don't Tell"

policies in place for male same sex relation and the possibility for being ousted it discovered (bell et al., 32014). To understand these barriers and how they impact the decision-making process of males who have been impacted, researchers and investigators and researchers alike must understand their "why" in their decision not to disclose their ordeal.

Stigma of Males Seeking Health Care

Stigmas associated with males seeking healthcare for MST tends to be questioned by some providers. Questions related to their masculinity and sexuality and the belief that only women are susceptible to sexual assault play a role in the underutilization of MST-related care available to men (Turchik et al., 2013; Monteith et al., 2020). Some male victims of MST struggle with gender identity and masculinity after being assaulted and an internal conflict which result in a stigma, they impose on themselves is that they are less of a man for allowing themselves to be assaulted (Bell et al., 2014). In seeking help, men may tend to minimize the assault to avoid the negative connotations of beliefs related to their sexuality because they were victims of assault and the labels may receive to diffuse other beliefs and to sway others perception of their ordeal (Bell, et al., 2014).

Impact on Quality of Life

The quality of life for any individual who has experienced sexual assault or trauma becomes negatively altered after the ordeal. In the case of male military sexual trauma victims, the self-efficacy they once possessed which aided in their ability to control their environment and circumstance that occur has become a challenge (Bandura, 1982; Voller et al., 2015) which may negatively impact their quality of life. Expressing

and being in tuned with emotions is not a trait that is typically taught with to males. They are taught to conceal their feelings and exhibit strength which is consistent with the military norms, values, and environments (Berkowitz et al., 1994; Funk, 1993; Katz, 2006; Voller et al., 2015). Males are not taught to display their emotions, hence, the disconnect they with confronting or disclosing the effects an assault may have on their quality of life may be extremely difficult (Voller et al., 2015).

Males who have experienced MST due to the shame and the fear they feel with thoughts of now being thought of as homosexual which impacts their quality of life (Morris et al., 2015). The effects of Post-Traumatic Stress Disorder (PTSD), depression, hypervigilance and other psychological implications do take a toll on the victim and can impact their personality in an adverse way. This may also impact their relationships with spouses causing intimacy issues, friends and family relations, and their relationship with their children.

Summary

The social dilemma of military sexual trauma is nothing new, nor is male sexual victimization a new phenomenon within the United States Armed Forces. Yet, the occurrences of military sexual assaults against males are a regrettably understudied one. Men have been victims of military sexual trauma for many years, but the prevalence of women being assaulted has always been highlighted. There are social and cultural myths generated about men which indicate that men cannot be raped, and they are to blame for their own demise if they are. The social anomaly of the differences in the acknowledgement and treatment of male and female victims is astounding. Nevertheless,

women are considered the weaker sex/gender which make them appear more susceptible to experience military sexual assault, especially in confined spaces and because their work environment which primarily consist of men. Because of the social norms which suggest that women are more likely than men to be raped, they have received much attention regarding the issue.

However, the social norm of men being the stronger sex of the two and the shame, guilt, and disbelief that they can be subjected to rape, has formed an interpersonal barrier that creates an impediment for disclosure and seeking help. Males in the military are taught to display their masculinity by exhibiting strength and power, refrain from showing emotion, aggression, the belief that pain is weakness leaving the body, and ultimate authority. These norms and values have created a negative barrier for men who have experienced sexual trauma.

The shame and the guilt they feel, along with the questioning of their sexuality force many of them to refrain from reporting the assault and suffer in silence. Despite the efforts the Department of Defense (DoD), Veteran Affairs Administration (VA) and the military branches to raise awareness of MST, there are still significant contributing factors that cause men to be reluctant to report the incident. Therefore, examining the experiences of males who experience sexual assault who do not report the assault will help to raise awareness of these occurrences and strategies to create an environment and system where they feel safe to step forward.

In chapter 3, I will discuss the methods and methodology used to examine the experiences of veterans who have experienced military sexual assault, along with the data

analysis, findings, and recommendations. I also explained how research methods with the use of semi-structured interviews fill the research gaps of this phenomenon. Issues related to study validity and trustworthiness will also be discussed.

Chapter 3: Methodology

Introduction

Underreporting of military sexual trauma among male victims and understanding their experiences is of paramount importance, but limited research has been devoted to the understanding of this topic among male victims (Kimmerlin et al., 2002; O'Brien et al., 2015). Most of the research on military sexual trauma has been primarily focused on female survivors and the negative effects it has on their quality of life, increased possibility of being diagnosed with Post-Traumatic Stress Disorder (PTSD), along with physical health issues, chronic pain, suicide ideation, difficulty readjusting to civilian life and a myriad of psychological diagnoses (Himmelfarb et al., 2006; Haskell et al., 2000; Katz et al, 2007; Kimerling et al., 2007; Valente & Wight, 2007; Kimerling et al., 2007; O'Brien et al., 2015).

In this qualitative case study, I explored the experiences of 14 male veteran victims affected by military sexual trauma/assault while on active duty and seeking help for their experiences. My goal was to answer the questions about their experiences of seeking help while on active duty, and whether they reported and sought help for the incident. This chapter will provide my description of the qualitative case study approach I used to gain insight on the participants' experiences and their decision-making process in deciding to report the trauma or not. I also describe the participant recruitment process, data collection, and the process in which it was analyzed. Last, all ethical procedures are discussed as they relate to my role as the qualitative researcher and the anonymity, confidentiality, and protection of all participants' rights.

Research Questions

The following questions were used to guide this study:

RQ: What are the help-seeking experiences of male veteran survivors of military sexual trauma who were active duty and between the ages 18-65 years old at the time of the assault?

Sub Q 1: What are the barriers that impede on male veteran military sexual trauma survivor's decision to not report or seek help for the effects of the trauma?

Sub Q2: What avoidant coping mechanisms do male veteran military sexual assault male victims use to cope with the effects of the assault and the impact it has on their quality of life?

Sub Q3: How do male veterans who have experienced military sexual trauma describe their military experience and their current quality of life?

Research Design and Rationale

I conducted a qualitative case study with 12 male veteran participants who shared their experiences of military sexual trauma/ assault (MST/MSA) and seeking help. The interviews allowed the participants to give an account of how the event has altered their quality of life, the barriers they faced and continue to face, the effects of their decision to report or not reporting and how it impacted them, and the coping mechanisms they used to combat the effects of the trauma. A qualitative research approach was ideal for understanding and exploring the male veteran's experience of seeking help for

MST/MSA and how it allowed them to speak their truth. According to Creswell and Creswell (2018), a qualitative approach allows the focus of the study to be on individual meaning and the intricate details surrounding the situation or issued being studied. Moreover, the qualitative approach allows the researcher to openly discover the context of issues raised surrounding raised in the data (Hennink et al., 2011).

The case study methodology offers the researcher with the opportunity to collect pertinent and detailed data utilizing a variety of procedures (Creswell & Creswell, 2018) to gain a holistic view of the participants experiences. According to Hennick et al., (2011) a case study offers a broader perspective where key events, actions and choices can be highlighted to develop different themes and a specific narrative of specific participants.

I also considered using a narrative and phenomenological design for this study. A narrative research design is typically used when the researcher combines the stories or views, he or she collects from one or more of the participants and combines them with the stories of his or her life and retells the story with a collaborative approach (Creswell & Creswell, 2018). This approach did not apply to this study as the focus was not on the stories of the participants lives, but rather on their experiences after separating from active-duty military and living or existing with the effects of being a victim of military sexual assault. Phenomenology, initially seemed to be the best design approach for the study, as it aims to describe the experiences of individuals about a phenomenon described by participants (Creswell & Creswell, 2018).

Nevertheless, the study focused on the male veteran participants individual experiences, instead of how they experience or understand the phenomenon of military sexual trauma. Neither a narrative or phenomenological approach was used because I wanted to have to have the ability to listen to the individuals share their experiences and speak to the effects of seeking help for their ordeal so I may capture truth and the authenticity of their reflections, not necessarily about the phenomenon. I conducted a case study as it seemed to be the more appropriate approach to answer the research questions and offered more opportunity for me to intently listen to participants as they discussed their experiences authentically in their own words. In addition, a case study approach fits appropriately as it is used to aid in in depth understanding of the real-life phenomenon along with ability to interview the individuals related to the phenomenon (Yin, 2009).

I also considered conducting a quantitative research study to obtain a larger consensus on the experiences of male MST victims and the factors and their reasons surrounding underreporting. However, quantitative research can be stoic, in that the data may present a barrier to truly understanding the experiences of the victims without having a direct conversation. According to Creswell and Creswell (2018), quantitative research is more of an objective approach, in that, the researcher is seeking to find a relationship among variables while testing the objective theories. In the case of this study, this research method would not be conducive to capture the rich data to analyze to learn and understand the experiences of the participants.

Case study designs can be used to aid the researcher in providing detailed analysis and description of a case or subject's life. Moreover, it allows the researcher to seek patterns in the participants behaviors and the ability to also study participants experiences (Creswell & Creswell, 2018). In addition, Yin (2009) also described the case study design method as unique, with the capability to work with a variety of evidence which may include documents, artifacts, interviews, and observations which may not be available in conventional approaches. As such, I decided to use a case study approach to investigate the cases of the experience of male veterans seeking help for the effects of military sexual trauma/assault. My goal is to obtain an account of the help-seeking experiences for the traumatic event from the participants perspective, and to identify if their experiences should be further explored.

Role of the Researcher

As the researcher, it was imperative that I illuminated my connection and relationship to the topic being studied to identify possible biases. While conducting this study, I currently volunteer as a Veteran Caregiver Provider Coordinator for female caregivers. Although I work primarily with the women who care for male veterans with PTSD, it may potentially highlight possible indications of male military sexual trauma/assault. Although my experience with this phenomenon is limited, it does not negate the fact of the effects it has on the individuals and their quality of life. Researchers have found that men who have been diagnosed with PTSD may have also experienced military sexual trauma (MST) and may have not reported the incident and have displayed PSTD symptomology and diagnosed. My goal as the researcher is to be open minded and

not be prematurely influenced by the interviews conducted. Furthermore, be forthright with the data collected, emotionally intelligent, and conscious of my own non-verbal responses while interviewing.

I have not experienced any type of sexual assault or trauma myself, but I am passionate about discovering pathways to create programs specific for male victims. In addition, I would like to participate in developing policies to help males find ways to move beyond the negative experience so they can enhance their quality of life and use the trauma to help create positive social change within the Armed Forces, VA facilities, and DoD to display how bringing this issue to the forefront can help make the military environment safer. I was also aware of my reflexive thinking where incorporating my own personal experiences did not influence my interpretation of the results by limiting my personal experiences, so the importance of the study content could not be overridden (Creswell & Creswell, 2011).

Reflexivity in this case allowed me to be upfront and honest with my biases related to my personal and past experiences and understand how those experiences could have influenced my approach to coding as emerging themes (Creswell & Creswell, 2018). Hennik et al (2011) refers to reflexivity as a process in which conscious self-reflection as a researcher is necessary to extract potential influences during the research process. As the researcher, I was consciously aware and sensitive to my cultural, gender, and values to ensure that my personal biases did not impact or influence the data being transcribed. To help with self-awareness, I reviewed the data for several days and hours eliminating my thoughts each time and allowed the data to speak. I also had my chair

review the data to ensure that my biases did not impact the analysis process. The use of member checking, also referred to as participant or respondent validation technique that can be used to aid in exploring the credibility of results (Birt et al., 2016) was not used as most of the participants did not want to be recorded, and those who were did not want to reread the information as it would cause them to relive the ordeal again. However, those who were not recorded, I was sure to reiterate questions and responses to ensured what I heard and understood aligned.

Research Methodology

Participant Selection Logic

The demographic for this study were male veterans 18-65 who were active-duty post 9/11 and have a history of military sexual trauma or assault. This specific age group of veteran males were selected because they met the criteria of eligibility to have served in the Afghanistan Operation Iraq Freedom (OIF) Operation Enduring Freedom (OEF) post 9/11 wars (Schry et al., 2015) and currently have a veteran status. The recruitment process for the participants included posting the flyer on Facebook and Instagram. I also joined several veteran groups and gained permission to also the flyer on their pages. The flyer included information about the study, criteria eligibility, a number where I could be reached, monetary incentive, and my email address. Once the participants reached out and agreed to move forward with the study, I obtained their telephone information, scheduled a date and time to conduct the interviews that were convenient for them and the timeframe of 30-60 minutes which indicated the duration of the session. Only male

veterans who served post 9/11 and have experienced MST/MSA were included in the study.

Sampling Method and Rationale

The population for this study were male veterans seeking help for the effects of military sexual/assault. The participants for this study were snowball sampling of 14 men 18-65-years old who had experienced military sexual trauma/assault while on active duty. A secondary method using purposeful/purposive sampling was also used. A purposeful selection of participants for this study helped learn and understand the problems surrounding the issue and the research question (Creswell & Creswell, 2018). Moreover, purposeful sampling allows for specific participants to be selected for the study based on the specific criteria that are related to the core constructs and contexts of the research questions (Ravitch & Carl, 2016). Ravitch and Carl (2016), also went on to describe the benefits of purposeful sampling involves the deliberate selection of participants for a study that will help with obtaining the information and data needed to answer the research question. Snowball sampling, or otherwise known as chain sampling, is a form of recruitment used to locate participants who fall into specific categories, have rare experiences, or associated with hidden population groups that may be difficult to identify and recruit (Hennick et al., 2011).

This form of sampling requires the researcher to ask the study participant if he or she are aware of anyone else who they believe may meet the criteria to be part of the study and request a referral be made to the researcher. Then the process continues as the researcher asks the current referred participant to refer someone they may know and

maybe interested and willing to participate (Hennick et al., 2011). While the snowball sampling technique can be beneficial as it is grounded in the use of social networking, shared knowledge of individuals, and the link to a trusted person who may be able to touch on interview processes that may reduce any concerns that may take time to recruit eligible participants (Hennick et al., 2011). As a result, purposeful sampling may also be used to combat the drawbacks associated with the snowball sampling method. Purposive sampling includes strategically selecting participants who are relevant to the research study question being asked (Bryman, 2016).

After receiving approval from the institutional review board (IRB), the approved flyer to seek participants for the study was advertised on my Facebook, Instagram pages, along with Facebook pages for veterans, and individuals who experienced military sexual trauma. The flyer was specific displaying the population I was seeking, the number of participants, the timeframe in which I was looking to interview the participants, the age range, and criterion. All interested participants were instructed to email me showing interest in the study. Some participants reached out via my Walden email, some reached out via messenger on Facebook, and others texted their interest in the study. Following their interest in volunteering for the study, interview times were set up and the consent form was sent via email for them to review. A $15 e-gift card was offered to thank participants participation in the study.

Purposive Sampling Criteria

The research participant criteria inclusion consisted of a sample of 12 male veterans ages 18-65, and their experiences with seeking help for their effects for military

sexual trauma/assault. They must have also been on active-duty post 9/11. The participants must be U.S. Citizens and English speaking. This minimized the scope by excluding legal residents and Green Card holders. The interviews were conducted via phone adding another layer to the curtain of participants security and anonymity, and the comfort to speak freely without the concern of being identified or feeling ashamed of their experience.

Instrumentation

The purpose of this qualitative case study was to explore the help-seeking experiences of male veterans who had experienced military sexual trauma/assault (MST/MSA) while on active duty. As such, the questions used in the interview are categorized related to these interests: coping mechanisms used to alleviate the effects of MST, seeking help, changes in quality of life, and psychological responses. The full list of interview questions is in Appendix A. The interviewing process began with demographic questions of age, race/ethnicity, branch of service a description of why they joined the military, did they report the assault, has the assault impact their quality of life. The approach allowed the participant to be initially relaxed so they had the freedom to tell their story in their own voice and describe their experiences as opposed to asking closed questions that may affect their responses.

The next set of questions included how they cope with the effects of the assault, the type of coping mechanisms used, if they developed them on their own and how it helped, did they seek help, or were there in issues seeking help. Follow up questions such as changes how their lifestyle changed, what do they think about their quality of life now,

or do they experience psychological effects. The initial questions allowed me to gain insight on the impact the military had on the participant and to gain insight on their decision to join the specific

The questionnaire will be designed for participants to respond to questions related to their specific help-seeking experiences for after MST/MSA. The questionnaire/instrument consisted of 30 items that describes “the participants broad range of help seeking for the effects of MST/MSA coping with the experience and their quality of life.

Procedures for Recruitment, Participation, and Data Collection

Procedure

After I received Institutional Review Board (IRB) approval, the flyers were posted on Facebook and Instagram. The study included participant eligibility criteria, my contact information, and incentive. Participants were able to call, text or email me regarding their interest in participating in the study. For those who expressed interest in the study, a date and time was set for us to connect via phone or in person prior to the interview. A e-gift card was sent via email to those who interviewed on the phone and a Visa gift card were presented to those who I interviewed in person. The consent form was sent via email for phone interviews and present at in person interviews. Interviews were scheduled via phone and email. This is because some participants were given my number by others who participated. The other participants received my information from Facebook platforms. During the phone calls and emails there was dialogue to determine

participant eligibility. When the participants were deemed eligible an interview date and time was scheduled. All interviews were scheduled based on the participant's availability.

Recruitment

In response to the flyer, emails were sent to those who expressed an interest. The email contained information about me and the purpose of the study. Participants who contacted me because they were referred by another participant, were informed about who I am and the purpose of the study via telephone. Consent forms were sent via email to some and presented to those I met in person. However, prior to meeting participants in person, the consent form was discussed via phone to which they initially agreed and agreed again when presented in person. After they consented and agreed to participate, meeting times were scheduled via Google Calendar and email with them sending their availability. Several interviews were conducted via telephone and recorded with the use of a voice recorder to maintain anonymity. The in-person interviews were also recorded. No names were used to maintain confidentiality. The participants used their personal numbers and emails to communicate.

Gaining Consent

During the phone interviews, initial consent was received via email for some and verbally for others. For the in-person interviews, the consent was verbal. In additions to obtaining consent, participants demographic information like their age range, race/ethnicity, marital status, and branch of service were collected. Participants were also reminded of their right and freedom to withdraw their consent and terminate their participation in the interview at any time. I also informed participants that I had a legally

obligation and had a duty to report if they were considering harming themselves or others if indicated. They also made aware of the VA health hotline if needed.

Gaining participants consent were acquired orally, written (Hennink et al., 2011) and electronically. The consent form provided the participants with a general overview of the study while explaining their participation as voluntary and the right to withdraw at any given time (Ravitch & Carl, 2016). For instance, the description of the purpose of the study presented upfront allowed the participants to make a conscious educated decision on whether they want to participate or not. This promoted transparency of the study without any indication of being manipulated or tricked. The decision was solely theirs. More importantly, the assurance of anonymity and the process in which confidentiality and data will be managed and stored were also explained (Hennink et al., 2011). The consent form consisted of the title of the research, my name, email address, and phone number, the purpose of the study, declaration of consent, a description of the risks and benefits of participating in the study, time and commitment asked of the participant, and the phone number and email address to Walden University's IRB Office for any questions or concerns regarding their rights as a participant in the research study (see Appendix A).

Data Collection

The data collected for this study was done using semi structured face-to-face and phone interview formats using an interview protocol. I conducted individual interviews with participants who met the criteria for participation. The questions were open-ended. I collected data using a recording device and handwritten notes. The interview questions

were formulated based on the literature review for this study. I tested the questions on Sexual Assault Recovery Caseworkers experts in the field to determine if the questions were triggering and invasive for validity, clarity, and to verify if participants would clearly understand the questions being asked. This pathway allowed me to collect rich data for the study.

The first few minutes of the interview process is paramount. Building a rapport with the participants to help calm their nerves and feel comfortable to discuss their experiences. This also aids informing trust. At the beginning of the interview, I collected data on their branch of service, why they chose that specific branch, and had them discuss what their initial experience of joining the specific branch was like for them. In doing so, it helped me to better transition into discussing their experiences of seeking help. This provided me with a rough idea of who the men were prior to joining the military, what they were like as they began their service, and who they became after their experiences of seeking help. All the question were geared toward their military experience and seeking help for military sexual trauma or assault while on active duty. I asked follow-up questions based on the participants responses to the questions. Some participants felt comfortable enough to go into grave details about their experience. I completed the transcription of the recordings by hand, using Microsoft word to document the data. No personal identifiers were used in this process. However, all participants were given a numeric identifier to protect their identity.

Data Analysis

Data analysis is a process used to determine the number of possibilities available to convert the data into plausible findings of the study (Creswell & Creswell, 2018). Also, data analysis in qualitative research is a perspective that challenges a researcher's perception and beliefs during the process (Ravitch & Carl, 2016). Creswell and Creswell (2018) discussed Rossman and Rallis (2012) description of coding as the process of organizing the data by bracketing chunks (or text or image segments) so a word that reflects the meaning of the category is established and can be written in the margins. For this process, I used thematic content analysis to analyze the interview the data, and I coded using the program Quirkos and manually. Codes can be formulated into three categories: the codes expected to surface, include surprising codes, the codes of unusual or of conceptual interests (Creswell & Creswell, 2018). I began the coding process by printing each transcript with a wide margin so I could make notes. I then assigned codes and labels.

I read the transcripts multiple times to help me familiarize myself with the data which in all allowed me to connect with the participants experiences and the choices they made or did not during their ordeal. I established an initial list of codes to help harmonize with the study's theoretical framework to assist with the analysis process in answering the research questions (Saldana, 2009). As I establish more codes, I then categorized them into themes by. I coded using Quirkos coding program and manually coded to ensure that I was extracting all the possible codes. By doing this I was able to be more organized and to obtain a broad visual of the codes that were being developed. Roman

Numerals were used to categorize the patterns that emerged from the data and to examine the similarities. The groups were personal barriers (I), institutional culture (II), trauma (III), fear (IV), coping (V), significance (VI), and personal journey (VII). The themes were generated using these seven groups. A few of the themes were merged to ensure that they did not overlap in meaning.

The data analysis process allowed me to identify key themes, patterns, and codes from the collected data which I used to formulate a relationship between the data and the research question to provide a description of an unanswered question (Ravitch & Carl, 2016). Creswell and Creswell (2018) states that data analysis consist of a five-step process: organize and prepare data for analysis (compiling), read, or look at all the data (disassembling), begin coding all the data (reassembling), generate themes and descriptions (interpreting/transcribing) and representing the description and themes (concluding).

Coding is the primary procedure for identifying the issue, idea, and opinions that are evident in the data (Hennink et al., 2011). Thematic content analysis was used to analyze the interview data, and coding process was done with the use of Quirkos and manual coding.

Issues of Trustworthiness

Credibility

The issue of credibility is one of four topics of great concerns for scholar practitioners when they are conducting research. Creswell and Creswell (2018) stated that credibility is a researcher’s ability to consider and address all the complexities presented

in the study and to also focus on the patterns not easily explained. It was also found that in qualitative research that credibility or internal validity is directly to the research design and the researchers instrument and data (Creswell & Creswell, 2018).

In this study, credibility was established with the use of member-checking and triangulation. The participants were encouraged to be candid as they shared their experiences and responses to the interview questions. This approach helped promote the credibility of the data collected. While the interview was in progress, I would frequently pause to reiterate what was stated, summarizing the responses, and clarifying with the participant that everything was correct. This helped both the participant and I ensure that what was being relayed was being accurately recorded. The member-checking process was conducted during the interview rather than the end, as I was aware of the sensitivity of the experiences and wanted to refrain from repeating the responses and questions again. By doing it this way, the participants had the option to withdrawn, correct, or add to their response before moving on to the next question. Therefore, when the interview questions were completed, the interview ended unless they had additional information they wanted to add. I understood what was being said. This approach gave the participants the peace of mind that the research was being conducted on the principles of good practices (Bryman, 2016).

I chose to have frequent pauses for clarifications instead of all at the end to deter from revisiting the question all at one time.

Transferability

I established transferability by providing a detailed description of the data in addition to the context which is otherwise referred to as “thick description (Guba, 1981; Ravitch & Carl, 2016). Qualitative research is unique in nature (Eamonn & David, 1999) and can be generalized to identify similarities in new cases (Creswell & Creswell, 2018). The in-depth description of the rich data was used to enhance the transferability of the data, as well as the management of the documents (Creswell & Creswell, 2018). In addition, the context from the collected field notes were used as examples to promote in-depth descriptions of participant responses. The notes and recorded responses were used to promote further research.

I used open-ended questions to extract detailed and honest responses from the participants. Transferability is how qualitative research studies are presented as applicable or transferable, to broader contexts while still maintaining is specific rich context (Ravitch & Paul, 2016). The transferability in this study was promoted by several participants who also displayed a different perspective, providing other researchers, participants, or readers with the clues that the findings in this study can be applied to other studies and they can draw their own comparisons and conclusions based on the research presented (Guba, 1981; Ravitch & Carl, 2016). However, there is no guarantee that even with a thick description, snowball, or purposeful sampling method or, data triangulation transferability of the study can be repeated as it there is a limitation to the sample of the study.

I provided a detailed copy of the questions used for data collect to help reflect the transferability and the context of the study. An audio recorder was used along with taking detailed notes to ensure the reliability of the data content. This was done to show that transferability is based on the research but can be generalized. As a result, an audio recorder and manual notes were taken to ensure reliability and that the collected data can be applied to other settings and contexts (Guba, 1981; Ravitch & Carl, 2016).00

Dependability

Dependability is required for research to maintain the stability of the data. Dependability includes the researcher's assurance that the way in which the data is collected is consistent with the research argument and it is providing applicable responses to the research question (Ravitch & Carl, 2016). Dependability of the study findings was ensured by an audit trial used to analyze, warrant the accuracy of the completed data collection process, and the reporting of each phase of the study (Bryman, 2016). Three of my peers were also present to verify the accuracy of data credibility and trustworthiness (Bryman, 2016). This process additional process alleviates any thought of inaccuracy, personal biases, errors, or other flaws that may occur. Dependability and reliability are used to minimize researcher biases and errors (Miles et al., 2014). Dependability also includes using the appropriate methodology use to collect data and the research questions used.

Confirmability

Confirmability is the final issue related to trustworthiness. Confirmability or otherwise referred to as objectivity is the understanding that complete objectivity is

impossible, but as the researcher, I was forthright and acted in good faith not allowing my personal beliefs, values, and judgments manipulate or alter the findings (Bryman, 2016). In qualitative research, the researchers are more subjected to confirmability. This is because qualitative researchers attempt to obtain confirmable data and "relative neutrality and a reasonable amount of freedom from unacknowledged researcher biases at minimum, and the existence of explicit biases (Miles et al, 2014; Ravitch & Carl, 2018). To achieve confirmability, I used a recording device to ensure that the data collected was accurate. In addition, the same procedures were used to collect participant data.

Qualitative researchers must be aware that the world from their perspective is subjective and not objective and to accomplish and obtain confirmability in their research, they must be able to fully confirm their personal biases and prejudices onto their interpretations with no reservation possible through structured reflexivity (Ravitch & Carl, 2016). To combat this potential hindrance to the study, I used member checking and recording devices for accuracy of data collection and accountability of data reporting and analysis. I was able to take notes during all interviews and compare the responses. Therefore, I was able to reflect on the participant responses which solidified the elements of trustworthiness to include credibility, transferability, dependability, and confirmability to be met consecutively for a successful study.

Ethical Procedures

Ethical procedures for this study included confidentiality, anonymity, informed and written consent, privacy, access to free counseling via the assigned Veteran Affairs Outpatient Clinic, the freedom to withdraw from the study at any appointed time, along

with the opportunity to refuse to respond to any interview questions that may cause discomfort. This procedure was used as the study involved a traumatic event of military sexual trauma and the decision-making process men use to seek help fir the effects of the traumatic experience. The ethical considerations I pondered upon regarding this research study were, who are the entities or individuals that will benefit from the findings? How will the research promote social change within the community? What programs can be introduced or established to legislature and policy? How can the research improve communication among DoD, Veteran Affairs and other institutions that provide aid or benefit guidance for veterans? How will I present myself as a female asking these sensitive questions to male military sexual trauma victims (Hennik et al., 2011)?

Ethical standards must be specifically adhered to related to research. Albeit ethical principles were originally developed for research conducted in the medical science field and the use of the principles have indicted in all type of research (Hennink et al., 2011). The ethical code of ethics standards will follow the guidelines of The American Psychological Association Ethical Principles of Psychologists and Code of Conduct including the 2010 Amendments (Creswell & Creswell, 2018). In addition, the guidelines issued by Walden’s IRB department process will also be followed before the initial data collection phase. An E-gift certificate/card was given as a thank you to participants time for being part of the study. While monetary gifts may seem like a form of participation coercion, it was only presented to participants after the interview was completed. The participants who participated in the study provided their information to receive the gift card.

The participants were informed of their voluntary participation in the study, their right to withdraw or cease from the interview or study without ramifications, and the possible outcomes that may occur for taking part in the study. It was also reiterated that the data would be anonymous, with the assurance that their identifiers would not be added to the transcript. I also informed the participants that a list of referral provider names will be available and provided upon request. I also notified the participants that my intention was not to cause harm by conjuring their memories which may trigger unwanted emotions. All collected data including notes, files, audio, transcripts will be kept on a laptop with a required passcode and hard copies will be stored in a lock box where only I have access. Pseudonyms will be used to protect participant information which is an additional form of security.

Summary

This generic qualitative research method was the chosen approach for this study since the focus was to explore the help-seeking experiences of male veteran military sexual assault victims. The use of a qualitative case study was useful in gathering data from the participants to gain a greater understanding of the phenomenon. All attributes of the research method were presented to include research design, methodology, role of the researcher, participant selection logic, instrumentation, procedures for recruitment and participation, data analysis, data collection, data analysis plan, and issues of trustworthiness, along with ethical procedures to aid in the decisions and selection made in the study. The participants for this research consisted of 13 male participants who were screened and assessed for emerging themes. The criteria to be qualified to participate in

the study included being a heterosexual male, veteran status, between the ages of 18-65 years old, served post 9/11 and experienced some form of sexual trauma or sexual assault while on active duty. The study consisted of a 45 - 60-minute phone or in-person interviews with the male veterans. Phone interviews were conducted as some wanted to maintain their anonymity. In-person interviews were also conducted, and pseudonyms were used for these participants to maintain confidentiality.

My overall goal in conducting this case study was to provide information that was uncovered in the research on the help-seeking experiences of male veterans affected by military sexual trauma/assault. In Chapter 3, I discussed the data collection method and process used to accomplish this goal. In Chapter 4 I present my findings from the data collected.

Chapter 4: Result

This chapter contains data from this qualitative study focused on the help-seeking experiences of male veteran victims of military sexual trauma/assault. The data gathered was based on the lived experiences, thoughts, perceptions, and beliefs of male veteran victims from three military branches. A primary research questions was used to explore and understand the experiences of the participants, along with three sub questions. The questions were as follows:

> RQ: What are the help-seeking experiences of male veteran survivors of military sexual trauma who were active duty and between the ages 18-65 years old at the time of the assault?
>
> > Sub Q 1: What are the barriers that impede on male veteran military sexual trauma survivor’s decision to not report or seek help for the effects of the trauma?
> >
> > Sub Q2: What avoidant coping mechanisms do male veteran military sexual assault male victims use to cope with the effects of the assault and the impact it has on their quality of life?
> >
> > Sub Q3: How do male veterans who have experienced military sexual trauma describe their military experience and their current quality of life?

The process I used to analyze the transcripts from the 12 individual interviews conducted to discover and uncover codes and themes is discussed in this chapter. Three levels were used in this study: (i) open coding, (ii) selective coding, and (iii) theoretical coding. At each stage of the analysis process, I compared all the data so I would be able

to extract and breakdown the established codes until themes emerged from the data. This chapter also includes tables and graphs used to display the codes and themes, as well as vignettes from individual interviews used to highlight key themes and results.

This study was conducted with 12 males meeting the criteria of being a post 9/11 OIF/OEF/Afghanistan veteran and had experienced MST/MSA while on active duty. Each of the participants were asked about their experiences prior to joining the military and to discuss their motivations to join the service and the specific branch they joined. Everyone was also to discuss in detail what was their initial experience like when they first became active and if they felt a sense of belonging and camaraderie. Most of the participants were very descriptive about their initial experiences. Others were very brief and abrupt. There were no changes in the initial research design, and I was able to obtain the projected number of participants for this case study.

Study Setting

The data I collected for this study was done via phone interviews and face-to-face interviews from a sample of 12 male veterans experiences with seeking help for military sexual trauma/assault. I posted flyers on my personal Facebook and Instagram pages. I also requested permission on other Facebook veteran platforms in which I received permission to join three and was able to post the flyer on their pages. The participation criteria for the volunteers were that they had to be male, between the ages of 18-65 years of age, have a veteran status, served post 9/11 OIF/OEF/Afghanistan period, and experienced some form of sexual trauma/assault while on active duty. Eight of the interviews were conducted via telephone at a time of the participants choosing. The other

four interviews were conducted face-to-face in a private library room setting which was convenient for the participant in terms of privacy and confidentiality.

Demographics / Sample

The sample consisted of 13 males. However, one participant did not meet the criteria and hence, was disqualified. Twelve participants were interviewed for this study. All participants were male and had a veteran status. A more in dept summary of the participant demographics and coding is located below in Table 1. The participants ages ranged from 28 – 51 years old. Six participants self-identified as Black/African American, five identified as White/Caucasian, and one self-identified as Hispanic/Latino. Three of the six branches of service were reflected in the study sample, with six (50%) former U.S. Marines, four (33%) U.S. Navy, and two (17%) U.S. Army. One participant had a Ph.D. (8.33%)., two had a master’s degree (17%), one had a bachelor’s degree (8.33%), two had an associate degree (17%), five had some college credits (42%), and one had a high school diploma (11.33%). Eight of the participants were married (67%), one separated (8.33%), one divorce (8.33%), and two were single never married (17%). Eleven of the 12 participants are currently seeking some form of mental health treatment through the VA and private health systems. Two of the veterans have been homeless post service. Overall, the initial goals all the participants had when they joined their specific branches was to excel, to be the best, develop structure, and travel.

Table 1

Participants' Demographics and Coding (N = 12)

Participants	Data Collection	Coded as	Age (years)	Branch of Service	Ethnicity	Marital Status
Participant 1	Face to Face Int	P1FF	50	U.S. Marines	Black/AA	Married
Participant 2	Face to Face Int	P2FF	28	U.S. Marines	Black/AA	Separated
Participant 3	Phone Interview	P3Ph	30 – 35	U.S. Marines	Caucasian	Single
Participant 4	Face to Face Int	P4FF	42	U.S. Navy	Black/AA	Married
Participant 5	Phone Interview	P5PH	35 – 45	U.S. Marines	Caucasian	Married
Participant 6	Phone Interview	P6PH	35 – 45	U.S. Navy	Black/AA	Married
Participant 7	Phone Interview	P7PH	38	U.S. Navy	Caucasian	Married
Participant 8	Phone Interview	P8PH	35 – 45	U.S. Army	Black	Married
Participant 10	Phone Interview	P10PH	38	U.S. Army	Caucasian	Divorced
Participant 11	Phone Interview	P11PH	35 – 45	U.S. Marines	Latino/Hispanic	Married
Participant 12	Face to Face Int	P12FF	45 – 55	U.S. Navy	Black/AA	Married
Participant 13	Phone Interview	P13PH	40	U.S. Marines	Caucasian	Single

Note. P = participants; FF = face to face interview; PH = phone interview; S = single; AA = African American

Data Collection

The recruitment process began by posting my flyer on my Facebook (FB) and Instagram pages. I also changed the private settings to public to ensure that the flyer was seen by as many people as possible. I received responses from two interested participants and scheduled interviews. After those two interviews a month went by without any traction. I then sought out veteran groups specific to MST/MSA. After locating the groups, I had to provide a brief statement of my intention for joining, along with presenting a copy of my flyer. This process took a week before I was granted access. All participants had to be male 18 – 65 years of age, have a veteran status, served post 9/11, U.S. citizen, and experienced MST/MSA while on active duty. Six of the 12 participants

responded to the flyer by emailing me via the email on the flyer or FB messages. The other six were recruited via snowball sampling, and then reached out to me via email. Upon receiving their emails that displayed interest in the study I arranged for the participants to be interviewed. In my email communication, I sent a calendar link so they would be able to select dates and times they were available to be interview. After the dates, times, and preferred form of interviews were arranged, I provided my contact number. The consent forms were email to each participant individually. Some participants submitted their signed consent via email. The face-to-face participants verbally consented. Prior to beginning all interviews, I took an additional step to re-read the letter of consent to have additional assurance of their consent to participate. In addition, they were also reminded that they could cease to participate at any time with no restrictions. Interviews were conducted at a time that was agreed upon by both the participants and me.

The interviewing process had a unique setting where I met with some participants in person and others over the phone. None of the participants wanted to meet via Zoom even though they were assured that the camera feature would not be used. Each participant was interviewed individually in a private setting. The phone interviews provided an additional blanket anonymity. Prior to the phone interviews, I found and prepared a quiet location to eliminate interruptions. The face-to-face interviews were conducted in a quiet setting of the participants choice. Some were in libraries or the comfort of their office. Participants were interviewed in the months of March and April.

All interviews were digitally and manually recorded and stemmed from 25 -45 minutes. Participants were informed that they have the option to receive a copy if the transcripts, which they all declined. Before I began transcribing, I went over my notes and listened to each recording to ensure that the data was captured organically. The data was then transcribed using Quirkos.com. I then reviewed the data received from Quirkos, edited for errors, and transferred the transcript to a Microsoft Word document. In addition, I compared the transcripts with the recordings again and made updates to the transcripts with minor edits.

Each interview began with a brief personal introduction and the purpose for conducting the study as well as reconfirming that they can vacate the interview at any time. I also asked if they were comfortable and still open to answering the questions about their experiences. This approach helped to lighten the mood and the atmosphere in preparation for the research questions to be asked. Last, I reassured them that their names would not be used, reminded them that the session would be recorded so I would no longer be referring to them by name at that point. I collected demographic information on age, years at veteran status, marital status, highest level of education, race/ethnicity, branch served, and employment status. I began every interview with general open-ended questions of why they joined the specific branch of service, what was their initial experience like in the military, and if they felt of camaraderie and belonging when they were initially on active duty. This help be to gather background information of who they were prior to seeking help for their negative experience. Many of the participants went into grave details of who they were and the plans they had when they joined, how excited

they were to excel and be great, learn new trades, and the brotherhood they were seeking. They were provided the liberty to speak freely. As they spoke, I gained additional information about their goals and aspirations as an enlisted service member and the changes that occurred after their negative experience.

During the interview process, I took manual notes of the participants verbal responses, their nonverbal cues such as sighing, facial expressions, folded fists, elevate tone of voice, and signs of frustration. I also used active listening to gain an understanding to what was being relayed by the participants. Active listening is essential to understanding what the participants point of view is rather than wanting to rush to the next question and discussing a point that may be unrelated (Ravitch & Carl, 2016). Displaying active listening assured the participants that I was engaged in the conversation and what was being said. It also helped me to condense what was being said when I asked for clarifications so the data can be correctly documented. The interviews were semi structured using the same interview questions, but not always asked in the same order. However, based on participant responses, they were asked to elaborate further with some oof their responses.

While conducting the face-to-face interviews, I was cognizant of my facial expressions, non-verbal gestures, and movement. This was not much of concern on the phone. However, I was conscious of my breathing and verbal gestures like sighing. Most of the participants appeared to be tense and guarded about the interview, but as we progressed, they were open about their experiences and eager to contribute to the bringing the issue of seeking help for MST/MSA to the forefront. As they began to share,

I assessed their level of comfort by listening to their responses before I asked them to elaborate deeper. This allowed me to collect rich and in-dept data. At the beginning of the interview process, participants were informed that we would not discuss the actual MST/MSA incident, we will only focus on the help-seeking aspect, all but four participants voluntarily shared the actual experience with me and confirmed it was ok to document.

Ethical Considerations

The ethical protocol guidelines were followed as discussed in Chapter 3. Verbal and written consent were received before interviews began. Prior to beginning interviews, all participants were advised that their participation was voluntary, and they had a right to discontinue the interview session without any reprisal. Prior to start of the recording, they were all asked if they were ready to begin in the event, they had clarifying questions. At the end of each interview, participants were presented with a gift card to show my appreciation to them for sharing their experiences. They were also asked if there was anything they would like to add, or if there are questions, they thought I should have asked just to be certain that I have collected all the rich data I could. I stored all the interview data in a safe and transcriptions in word files and audio are stored on a password protected file. The interview data will be kept for a minimum of 5 years. At the five-year mark, all hardcopies will be shredded, and all recordings and transcripts will be deleted.

Data Analysis

I used thematic analysis for this study. As noted by Ravitch and Carl (2016), thematic analysis consists of identifying relationships, similarities, and differences in the data. I analyzed the data by using Creswell and Creswell (2018) eight step guidelines to thematic coding analysis: (1) Prepare the data for coding and analysis by importing images into applications, and printing with wide margins; (2) Coding the images by tagging/color coding and assigning labels; (3) Compile all codes on separate sheet; (4) Review the codes to eliminate redundancy and overlap; This helps to minimize the codes to potential themes; (5) Grouping of codes to form themes that are common; (6)Assign the codes/themes to three groups; expected, surprising, and unusual code/themes. This creates diversity in the findings; (7) Arrange the codes/themes by mapping which displays the flow of ideas; (8) The write up for each theme that will go into "findings" section of the study or for a general summary that will go into "discussion section as part of overall findings. This process allowed me to display transparency of my process (Creswell & Creswell, 2018) and helped me to gradually identify the frequency in which codes emerged in the data. I formulated a list of codes created from the dataset and then regrouped until finally eight codes emerged. The eight codes were: barriers, trust institutional issues, trauma, fear, coping, personal journey, and significance which aid in the development of themes and subthemes.

The developed codes were further analyzed and condensed into operational model codes that exhibited an array of attributes of the participants' experiences. Operational model coding is a process in which large sums of data can be formulated into diagrams to

disentangle the threads of the analysis to aid in the presentation of results in a more intelligible form that also aids in arrive at conclusions (Saldana, 2012) For instance, institutional challenges influenced revictimization, therefore, it was categorized under revictimization. As a result, there were multiple codes illustrated within the themes that emerged. I carefully reviewed and dissected the data while also reviewing my approaches and demeanor throughout the interview process to determine if my actions had any influence on the development of themes. A table of codes and statements that led to emergent themes is in Appendix B.

Evidence of Trustworthiness

Credibility

Credibility of the data collected for this study was warranted with the use of member checking throughout the interview process and at the end of each interview. Member checking was a way for me to validate my findings and to verify my interpretations with the participants themselves (Saldana, 2009). In taking this approach it also helps with the accuracy of my interpretation of the data. Transcripts were transcribed verbatim. The same questionnaire was used to interview all participants with minor probing such as “can you elaborate” or “just so I am clear, could you provide an example?” I was objective while conducting the interviews as I wanted to ensure that I captured the facts and not influenced by my feelings or opinions.

While interviewing the participants, I took notes and informed the participant that I was also taking notes to be certain that I capture all the data accurately. As the participants discussed their experiences seeking help, I manually took notes and asked

clarifying questions so that I would comprehend and capture what they experienced. All participants were reassured at the beginning, and at the end of the interviews that their identities would be remain confidential. After each interview, I privately reviewed the data and reflected on my thoughts and feelings in a separate journal to decompress. As I journaled about my thoughts and feeling related to each interview, I was able to be transparent with my thoughts, insights, emotions, and opinions acknowledging the this to be part of the research process reflecting on it as part of the research write-up. After each interview, I also reflected on what I could have done better or did better with the other interviews.

Transferability

Due to the nature of the experiences of the participants, transferability was done by displaying a detailed description of the research process that may help provide more information for other methods of studies with different groups or genders who may have similar experiences. This was done using purposive and snowball sampling. This was an effective approach to locate the participants needed to obtain rich data for this research. Detailed description of the population was provided, and in-depth description of the participants was used to promote transferability.

Dependability

Creswell and Creswell (2018), describes member checking as an ongoing dialogue regarding my interpretations of the informant's reality and meanings to true value of the data. To ensure member checking I used a journal to record my own biases and emotions I felt while interviewing each participant. This help me to separate my

feelings and thoughts so that I would be able to truly focus on the raw data. This was done because none of the participants were open to receiving a copy of the transcripts to review their responses to the questions. Therefore, I had to be mindful and record my feelings in my journal and not allow it to transfer to the data. This helped me promote dependability which aids in reduction of biases, errors, and ambiguities. Throughout every interview session I verbally summarized participants responses to ensure I was capturing the exact meaning of what was being described to promote clarity and accuracy. The participants were encouraged to add to their responses, confirm, or omit any of their responses before the interview sessions concluded. This entire process was documented in detail and shared in my findings.

Confirmability

Confirmability was maintained by following the interview protocol of asking the same questions on every interview and to be sure that I accurately document the participants responses regarding tier experiences with no personal influences or biases. The participants' direct quotes were used to inform this chapter's source of data. My identity was disclosed as a researcher on the consent form, and I had no prior knowledge of any of the participants before this study Member checking was also used as a tool to ensure confidentiality. The credibility, transferability, and dependability were relevant to the trustworthiness of this study. The interpretation of the data was discussed with my chair.

Results of Data Analysis

All the participants in this study discussed and shared their experiences seeking help for military sexual trauma/ military sexual assault, and how they cope with the experience and how it has impacted their quality of life. After I coded the transcripts, themes emerged and were extracted to discuss the findings. The following section is divided by the main research question and its respective theme, along with the three sub questions and the respective themes. The five themes were established which reflected the key factors the participants mentioned as barriers to seeking help. Each theme had at least three related subthemes, displayed in Table 2. Each question and theme are discussed following Table 2.

Table 2

Themes and Subthemes

Theme	Subtheme
Obstacles related to seeking help	Questioned masculinity and sexuality Fear of homophobic labelling, stigma, viewed as weak, judging Personal barriers: anger/shame/guilt/ embarrassment/others perception/fear of negative outcomes/ isolation/hypervigilance Self-reliance/confidentiality/lack of trust
Institutional betrayal and cultural influences	Sensitivity/disconnect of the male experience/Revictimization/outcasted/ Disbelief/ institutional reprisal Institutional betrayal Lack of faith in the reporting process Lack of training among healthcare/mental health/Providers and programs specific to male victims
Trauma	Disbelief surrounding assault, relationship issues/No trusted outlet/support system, PTSD, depression/ nightmares Masking the pain, sleep disruption, Emotional detachment/ hypervigilance, sexual dysfunction
The art of coping and the mechanisms used depression,	Self prescribed coping mechanisms: Illicit drugs/prescription drugs/ risky Behavior/ abstinence Promiscuity /binge watching / Isolation /homelessness/psychological effects
Desire for significance/improve QOL	Personal journey to overcome the trauma Desire to heal to inspire other victims Advocate for new policy and programs

Note: Quality of life = QOL

Primary Research Question 1: What Are The Help-Seeking Experiences Of Male Veteran Survivors Of Military Sexual Trauma Who Were Active Duty And Between The Ages Of 18-65 Years Old At The Time Of The Assault?

Two themes and three subthemes emerged in response to the main research question 1: (a) Obstacles seeking help (b) personal barriers (guilt, shame, embarrassment) (c) Fear of homophobic labelling (stigma, judging) (d) Institutional betrayal (reprisal, revictimization, lack of trust) (e) lack of male specific programs (sensitivity to the male experience). The occurrence of these themes is summarized in Table 3.

Table 3

Themes Related to Research Question 1

Theme in the	*n* of participants contributing to the theme ($N = 12$)	*n* of references to theme and sub them in the data
Theme 1: Obstacles seeking help	4	18
Sub Theme 1: Fear of homophobic labeling stigma and judging	12	14
Sub Theme 2: The personal barriers associated with guilt, shame and embarrassment to seeking help	12	22
Theme 2: Institutional betrayal. Reprisal revictimization lack of trust	12	14
Sub Theme 3: Lack of male specific program resources. lack of sensitivity to the male experience	6	10

Theme 1: Obstacles Related to Seeking Help

There were over 17 codes associated with barriers that deterred participants from seeking help while on active duty. The codes that appeared the most were, lack of trust in the institution systems related to confidentiality and anonymity to reporting, overall fear of homophobic labeling, stigma personal barriers associated with anger, shame, guilt, and being weak. Most participants adamantly discussed the circumstances surrounding the multiple barriers with seeking help for their trauma. The participants all expressed that while female victims of military sexual trauma/assault did experience some barriers to seeking help, it was exceedingly arduous specifically for male victims because of the societal and cultural stigma surrounding the disbelief that men cannot succumb to these types of experiences. In addition, some of the other barriers associated with seeking help were individual barriers implemented by the victims themselves. Barriers related to seeking help was formulated as a theme because all the participants declared that seeking help was frowned upon especially if the victims were male, and the imminent backlash of being labeled as weak, or considered to be homosexual, or the fear of being emasculated deterred them from seeking help. Some participants also disclosed that they have seen other victims experienced the backlash of reporting and saw what it did to their careers and the hostile environment that ensued. Moreso, how the victims were ostracized forced them to suffer in silence.

Stigma/ Labeling

Several instances of stigma and labeling were identified including questioned masculinity and sexuality, fear of being referred to as gay or weak, and being judge for

what they experienced. Many participants expressed that they did not know how to communicate what transpired, and those who did were revictimized by their superiors and their comrades, “because again…. males cannot be assaulted or raped. Ahh, you’re a male, as big as you are why are you complaining” (P 6). Participant 7 stated that a barrier to not reporting was that it happened so often, and people are unlikely to report incidents. Participant 7 also expressed that “It happened while I was at sea, what happens in Vegas stays in Vegas type, when in Rome. I was thought to sweep things under the rug.” While interviewing, most participants said that they did not seek help by using terms like “there were no MST/MSA programs for men, “I am a man, I am supposed to be strong not perceived as weak” and “reporting was not an option.” Participant 6 stated that ‘the military was incompetent at my duty station related to the male sexual assault/trauma victim experience. Another participant disclosed, “I did not seek help until two years after I got out. I was afraid of what may have happened if I reported.” Participant 3 said “I did not report because I did not want to be ostracized or thought of as weak.” Participant 5 said “Reporting was never an option. There were no women in my command and there was much blow back from chain of command. It was difficult navigating through the culture.

Participant 8 said”

> I had mixed feelings about reporting because it was done by a female. You know the stigma around the military is that if they do something and you like it or whatever. Females cannot really rape guys or whatever the case may be and back then you would not have told anyone a fmale raped or sexually assaulted you.”

” One participant who immediately reported his assault stated

> I reported my incident and after I returned from medical and went back to work my superior called me a “disease” in the presence of my peers and advised the company that if he caught anyone talking to me, they would be in trouble. I was fucked by another due and labeled “just another fagot.” It was then I felt ostracized, I was called names, hazed, and basically revictimized. I went from machine gunner to a piece of shit. As a result of that, I isolated myself and became homeless. (P 13).

To summarize, most of the participants did not seek help for their assault or traumatic experience while on active duty, and the ones who did were labeled and revictimized. Moreover, the participants associated their obstacles to seeking help with the lack of trust and support they had within the institution of the military and the inept leadership in their command setting.

Personal Barriers/Lack of Trust

The type of personal barriers most study participants discussed included the heaviness of the anger, shame, and guilt they carried on their shoulders, in addition to blaming themselves for being victimized, the embarrassment and the fear of the negative outcomes. These personal barriers were identified as being related to the cultural, societal, and self-imposed beliefs that male victims seeking help does cause men to be somewhat disenfranchised because of the beliefs of what can or cannot happen to men and why if it does it was supposedly their fault, or the belief that they wanted it to occur. One participant described his personal barrier as self-doubt and embarrassment because

his attacker was a female. “At one point it made me feel bad that somebody would not take my word and believe me because of the circumstance of female on male is really bad. I had a lot of resentment toward females who were more tomboyish.” (P 8).

The lack of available specific programs for men also caused them to develop personal barriers because most believe that no one understands their circumstance. Most participants reported that they waited until they were discharged or became a veteran to seek help.

Theme 2: Institutional Betrayal and Cultural Influences

The military is viewed as an institution that embodies camaraderie and a brotherhood that cannot be broken. The affiliation supports the development of an attitude and a construct that signifies a sense of belonging which makes the military bond different from the bonds civilian societal bonds formed. The key institutional betrayal and cultural code that frequently occurred included disconnect of the male experience, sensitivity to information reported, revictimization, institutional reprisal and betrayal, lack of healthcare training, and programs specific for male victims.

There were at least seven participants who provided indebt details of their feelings of betrayal and abandonment. One detailed description of betrayal and abandonment stated

> I was a top performer in my unit. I exceeded expectations. I was the top 10 in my class. But after the incident, I went from being a high functioning achiever to being homeless and a manager at Chipotle. My 20-year career path was destroyed

> by the incident and PTSD. Female victims in general receive more attention, while male victims are swept under the rug. (P 13).

Another participant expressed that the cultural disbelief that men can experience sexual assault or trauma is prevalent during active duty. He stated that

> A man is supposed to be strong, right? This makes it harder for a man to open up. Not saying it's not very hard for a woman, but it's hard for a man because of the society thoughts and outcomes. I respect a woman who can open up about it. (P 10).

Several participants reported that it was a difficult reality to adjust to being a man who experienced MST/MSA while in the military. Some also stated that the already existing stigmas of men cannot be sexually assaulted, and if they were, they were weak and probably wanted it anyway weighed heavily on their decision to seek help within a system that shows little to no empathy for what they experienced within an alpha dominant environment.

Lack of Trust Reporting Process/Sensitivity

The participants also elaborated on the fact that seeking help while on active duty was risky because there is no sense of privacy or confidentiality reporting any type of incident. There is a great chance that their personal or private report could be leaked causing a great deal of shame and embarrassment which can also lead to a form of revictimization. Most participants went on to report that the lack of trust in the ability of leadership or healthcare professionals to maintain confidential information or display professionalism is not skill that many possess. One participant mentioned that he wanted

to report initially so he tested reporting the incident to his comrade and was blown off and told it was not a “big deal” of what happened to him. His comrade responded to him in that way because he was assaulted by a female. With that the participant decided not to report and decided to internalize the situation and move on. One participant described his lack of faith in the reporting process by stating that

> There is a type of brotherhood that has the power to influence rank, awards, liberty, job assignments, and workspaces. Reporting incidents that negatively affect individuals who are part of that brotherhood causes more problems for the victim. Therefore, the decision to not report while on active duty is a tough decision, “but what can you do when you must work and live in a space with people for a set period before you are eligible to leave? (P 12).

There was a certain complexity among many participants when they discussed the lack of trust in reporting on active duty and to veteran organizations as males. Most participants stated that it was more difficult for males to seek help and trust the institutions and organizations because they were not taken seriously. As such, the systems and leaders were not equipped to deal with male MST/MSA type victims, and the process of reporting was much easier for women to report. Most participants believed that, in essence, it was expected that women would be victims of sexual trauma or assault while on active duty because they worked in a male dominant environment. Additional, one participant remarked “If I had to go back, I still would not report it, because I don’t know which way it would go. Would it be better that I report it, or would it be better if I fucked up his career?” (P 7)

All participants indicated that they had inadequate leadership which fostered a lot of mistrust. It was difficult for them to approach leaders who were supposed to protect them especially in this unforeseen circumstance. Another participant referred to his military command leadership “as a gang that feels that they can do whatever to you and they don’t have to be accountable whatsoever, but legally in a sense.”

Training and Male Specific Programs

Many participants reported that the difficulty of reporting MST/MSA was associated on the lack of programs specific for men such as Sexual Assault Advocacy Programs (SAAP) and Sexual Assault Rape Counseling (SARC) that consisted of male counselors who are trained to work specifically with male victims. One participant said,

> there were no real programs I or other male victims could have gone to talk about or experience or ask about treatment that would be restricted meaning confidential. Those things weren’t in place and if they were, they were not put out for guys to be informed. When it comes to sexual assault, it was always geared towards females (P 8).

One participant described his experience with healthcare providers as unprofessional and demeaning.

> I had to go to the hospital to complete a rape kit and the way in which the three white female nurses conducted the procedure was humiliating and demoralizing the way they took pubic hairs and pictures of penal area, and I was the victim. In addition, my command did not even support me through this ordeal and even gave me a bad evaluation which was illegal. In my case I was guilty before proven

innocent. If I had not fought for that eval to be removed, I could have been dishonorably discharged. This was a form of institutional reprisal (P 1).

Overall, all participants discussed their like of trust and sense of security in seeking help from military and veteran institutions and organizations. They discussed how ineffective leadership as it relates to the sensitivity and confidentiality of reporting MST/MSA incidents as males. Without the umbrella of protection of their chosen branch, it became difficult for them to trust leaders and affiliated institutions and organizations alike.

Sub Research Question 1: What Are The barriers that Impede on Male Veteran Military Sexual Trauma Survivors Decision to Not Report or Seek Help for the Effects of the Experience?

One theme and two sub themes emerged in response to SQ 1: (a) trauma (b) disbelief of victim assault, lack of trusted outlet, support (c) PTSD, mental health, emotional detachment. These themes are preface in Table 4.

Table 4

Themes Related to Sub Research Question 1

Theme in the	*n* of participants contributing to the theme (*N* = 12)	*n* of references to theme and sub them in the data
Theme 3: Trauma	8	12
Sub Theme 1: Disbelief of Victim assault, lack of Trusted outlet, support	6	20
Sub Theme 2: PTSD Mental health, emotional Detachment	10	14

Theme 3: Trauma

The effects of trauma and the frequency of codes related to trauma consisted of participants personal and institutional disbelief surrounding the assault, no trusted outlet or support system, mental health, masking or burying the pain, emotionally detaching from family and society, hypervigilance, sleep disturbances, sexual dysfunction, and nightmares. Most participants disclosed that the effects of the traumatic experience were immediate after the assault. Others stated that they went through the motions of whether they were assaulted based on the feedback they received from peers and the perceived belief of what a man can or cannot experience and be considered assault. One participant stated his disbelief, masking his pain, one mentioned emotional detachment, while others referred their hypervigilance and the difficulty dealing with the trauma alone. One participant stated, "I did not immediately report the assault to chain of command. I based by decision to report on what my trusted peer stated. I also had mixed feelings about reporting because it was done by a female" (P 8). Moreover, the participant went on to discuss the perspectives surrounding the male traditional ideals of females cannot overpower and rape or sexually assault guys.

Disbelief of Victim Assault/ Lack of Trusted Outlet/ Support

One participant referred to his traumatic experience as "gaslighting" where the things he was ordered to do and the tasks he was instructed to perform were considered part of the initial process to transition into the brotherhood. Eight of the participants expressed that the lack of support heightened the effects of the trauma they experienced. They described it as having no sense of belonging and being outcasted and ostracized.

One participant indicated that even though he went through the proper chain of command to report his incident, how he was treated and patronized made it worse. He went on to state that “I was considered guilty before innocent. I had to prove my case, and I was arrested in front of everyone” (P 2). This event added to the participants trauma, as he reported feeling isolated, existing in a hostile environment without any form of support.

Another participant reported that he felt so ostracized and constantly revictimized that the only way he could be relieved of the situation was to get out of the military. That was a difficult feat because enlisted personnel must complete their tour of duty to be discharged. Therefore, the only option he felt he had after seeking help on several occasions and did not receive it, was as he stated,” I used pot to deliberately fail drug test to get out. I also failed another test for meth which I used for nightmares. I had no other option” (P 13). This negatively impacted the participant as the drugs were used to help him mask the pain and disassociate from reality and forced his discharge from his command. After several years of working through the trauma he was rated 100% total permanent for PTSD due to his assault.

PTSD/Mental Health/ Emotional Detachment

The effects of the trauma participants experienced were amplified with the lack of support they received from an institution and a system that was supposed to protect them in such situations. One participant stated that “While the command was aware of what I was experiencing, the main concern was being mission/combat ready. I also dealt with my trauma the only way I knew how, was fighting and drinking. I had DUI, and because I preparing to deploy it was thrown out. Also, a pornography and they had people replay

the scenes on each other (P 11). The participant was also diagnosed with PTSD. Another participant stated that

> "I have nightmares about my experience that I wake up, get drunk and call my buddy at any time and he answers to allow me to vent. I just can't believe that my buddy I was hanging out with came back to my house to hang, with my pregnant wife upstairs, I passed out and woke up with my jeans unzipped and down to my ankles and this guy sizing me up and my dick in his mouth and I was like "dude what the fuck?" then he said grab my wiener (P 7).

The participant also said that he and the assailant were on the same ship and now because of that incident he has such prejudice toward men who appear a little fruity. He also stated that "it was a fucked-up thing for me to experience." One participant stated that "that victims who experience this form of assault in the military had a more difficult experience than civilians. At least the civilians have a choice to quit and not return the next day, while enlisted servicemembers are bound by a contract and duty" (P 10). Two participants expressed that it is rather difficult for them to maintain relationships because of sexual dysfunction. "It's hard for me to do stuff. Evey time I try, it causes a problem in the relations. So, I remain alone" (P 10). The other participant expressed that he is still unable to cope, "I'm married, but separated from my wife because I am unable to get past the assault. I was railroaded and not believed because my attacker was a woman" (P 2).

In summary, participants expressed that the dismissal of their experiences and the knowledge of little to no support makes it difficult to even attempt to locate resources. To imagine the backlash, they might receive is traumatic in a sense because they are

associated with those labels. In addition, the disbelief in what occurred, their inability to find trusted resources within their unit, and masking the pain contributed to their trauma. Some reported that if they had the same necessary resources female victims have, dealing and living with the trauma may have been easier. Nevertheless, most participants reported that emotionally detaching from society and isolating themselves from friends and family was easier for them to address and work out within themselves the trauma they experienced while attempting to block out that period from their lives.

Sub Question 2: What Avoidant Coping Mechanisms Do Male Veteran Military Sexual Assault Victims Use to Cope with The Effects of The Assault and The Impact It Has on Their Quality of Life (QOL)?

One theme and two sub themes emerged in response to SQ2: (a) the art of coping and the mechanisms used, (b) drugs and alcohol, (c) risky behavior, homelessness, no established coping mechanism. A summary of these themes is displayed in Table 5.

Table 5

Themes Related to Sub Research Question 2

Theme in the	*n* of participants contributing to the theme (*N* = 12)	*n* of references to theme and sub them in the data
Theme 4: The art of Coping and the Mechanisms used	10	12
Sub Theme 1: Drugs and Alcohol	5	7
Sub Theme 2: PTSD Mental health, emotional Detachment	7	9

Theme 4: The Art of Coping and the Mechanisms Used

The use of coping mechanisms was for most participants was a form of escape form their reality. The codes that occurred several times were drugs and alcohol, risky behavior which included promiscuity, infidelity, and homelessness were viewed as a form of coping for many participants. Moreso, there were several other coping mechanisms and approaches to coping discussed in the interviews. While most participants had similar approaches to coping, others developed their own approach or none.

Drugs and Alcohol

A couple participants discussed that their way of coping with their assault / trauma was expressed by infidelity, displaying risky behavior of driving cars at top speeds on interstates, excessive alcohol, drugs, promiscuity, constant partying, not going

home at night, and even showing up to work under the influence of alcohol. One participant expressed that because he had to remain in the environment, the only way he could cope was being to be drunk every day he showed up and he became very good at masking the effects. He stated, "I was drinking during active duty. I showed up to work drunk, no one said anything. If I did my job no one says anything" (P 4).

Another participant said, "I was emasculated and to help restore how I felt, I practiced destructive behavior by looking for love in all the wrong places with other women." (P 1). He also expressed, that during these actions, he realized that he could not recognize himself. That was the time he realized he needed help. Another participant said, "I coped with the use of pot. The weed helped. It kept my mind occupied and the more it was done it kept the demons away" (P 13). One participant reported that the use of alcohol was taught and encouraged to drown out pain so he could forget his troubles.

Risky Behavior/ Homelessness/ No Established Coping Mechanism

While drugs and alcohol may be the most common forms of coping mechanisms used, some study participants used other coping tools like sex, leaving their families and becoming homeless to escape, some avoided certain situations and environments, and one was unable to identify anything that he thought may help him cope with his experience. A few participants said that they became more hypervigilant when they got out. Two of them discussed how they felt around women, stated that they did not trust them. One even said that he avoided being alone with women alone in an elevator. "If I had to use the elevator, and the door open and a woman was inside alone, I would take the next one, or got off if a women entered" (P 6). Another participant expressed that "I am more

careful. I am aware now that females can sexually assault guys and I try not to put myself in that situation where it can happen again" (P 8).

Some participants stated that their coping mechanism of choice was isolation. The psychological effects like PTSD and depression they experienced triggered their desire to be isolated from everyone, and few of them have even become homeless. One participant said, "it's been hard. I had to go in person therapy for 8 weeks because of the issues I was experiencing. I have attempted doing something to myself 2-3 times" (P 10). Another participant said, "I have not coped that is why I am in the situation I am in right now. Unemployed, homeless and I have medication and the medication is making my mental better" (P 2). This participant also stated that he knows people who want to sleep outdoors, but he does not, but it's just his reality right now. Two participants found a way of escape by watching television for countless hours without leaving the room. Just getting lost in whatever they were watching help their minds to drift.

Most participants have fund or established some form of coping mechanisms they use to help them navigate their circumstance. Moreover, based on the results of all the interviews, some participants explained that their coping mechanism often created more barriers or negative thoughts that led to them becoming isolated and delay seeking help for their negative experience.

Sub Question 3: How do Male Veterans Who Have Experienced Military Sexual Trauma Describe their Military Experience and Their Current Quality of Life?

One theme and two sub themes also emerged from SQ 3: (a) desire for significance/improve quality of life, (b) personal journey, (c) improvement of quality of life. The themes are summarized in Table 6.

Table 6

Themes Related to Sub Research Question 3

Theme in the	*n* of participants contributing to the theme ($N = 12$)	*n* of references to theme and sub them in the data
Theme 5: Desire for Significance/improve Quality of life	12	12
Sub Theme 1: Personal journey	12	12
Sub Theme 2: Improve Quality of life	12	12

Theme 5: Desire for Significance/Improve Quality of Life (QOL)

Joining the military for most participants was based on their desire for significance and to improve their quality of life. Some wanted to be part of a lifelong brotherhood. Others wanted to test their physical abilities, develop structure, be part of the best of the best, carry-on family tradition, and some saw it as a way of escape from their previous life circumstance to either take part of their family or escape a path that would have been detrimental to their life.

Personal Journey

All the participants had a specific reason for joining the military, whether it was to carry on family tradition, have a lifelong career, develop the structure the needed, develop new skills, or be in an environment that will inspire them to do great things. Whatever the reason behind their decision, they all seem to have a goal to be significant. One participant stated,

> "Before I joined the military, I was not aware of anything outside my surroundings. I was only limited to what was available to the residents in my rural city which spanned for only 20 miles. Joining the military allowed me to escape the usual path of going to the local college, graduating, and driving a forklift which is the current occupation of 75% of my former classmates" (P 6).

One participant discussed the fact that joining the military helped him to develop the discipline to become a finisher. He explained that prior to joining the military he would develop new interest and then quit, never looking back. Another participant said that he joined the Marine Corp because he felt that it was the toughest branch, he was physically fit and built to be a Marine. Another participant also stated that he felt it was the hardest branch, and he was inspired to join because of that reason. One participant said,

> "I was sitting in my American Government class discussing the history of the U.S. Marines and two recruiters walked in, and when I saw them in their dress blues, I was impressed, and I wanted to be one of those guys based on their appearance" (P 1).

Another participant said, “I was inspired to join the Marine Corp because it was harder than the Navy or Army. What also made it difficult was that it was a male dominant unit, no females, and I had to work much harder to advance” (P 5).

Improvement of Quality of Life (QOL)

The improvement of the quality of life for some participants was found to be a constant work in progress as they work past their trauma making efforts to reclaim their lives since their incident. For others it was still difficult as they are still struggling with the effects of their traumatic experience. One participant said, “Because of the nightmares and what happened it’s difficult at times for me to be in a relationship. It’s difficult for me to function sexually” (P 10). Some participants described their QOL as a little better as they are older, have sought help and now have a support system. “I’m so glad that I have my sister and the veterans support group to help me stay present. I understand that I am not alone” (P 3). Although it is a long personal journey to fully recovering from their ordeal, they are still striving to be better people for themselves and their loved ones and working on staying present. However, there were a few participants who had different perspectives where one stated that, “I died that day and now living as a ghost” (P 13). Another said “When I joined at 18, I knew who I wanted to become. Now the feeling is not good, waking up does not excite me. Before I woke up with a purpose and I had goals” (P 2).

The participants all referred to their desire for significance based on the branch of service they joined and why, and their QOL on their current support system, mental health, and their overall motivation to heal. One participant even became a sexual assault

resource counselor (SARC) so he can help debunk the myths of male victims by volunteering to tell his story. He believes that more emphasis must be placed on developing resources for male victims to avoid other men from experiencing the same circumstances. One participant said

> "I do know the military has gotten better about some to this, but I do think there needs to be more emphasis put out about male-on-male sexual assault or sexual harassment in the military. Even in the real world outside the military it's not one that looked at or talked about because they don't want to believe it happens and the only one, they care about is male on women. Again, I'm no saying it's not important, but all you hear is you could never rape a guy. People don't know what to do with a gun to back of your head. Some people cherish life, and some don't" (P 10).

Male Victim Perception

During the interviews, the male participants were asked a few questions like "Do you think men and women encounter the same barriers seeing help? How do they feel about who you are now compared to when you first joined the military? Why did you join the specific branch? How has your lifestyle changed? While not discrediting the female victim experience, 10 of the 12 participants believed it is easier for women to received help for sexual assault. For example, women do not have to worry about the stigma of being too strong to be overpowered, more attention is directed to a female victim than male victim or being referred to using a homophobic gesture or judged when they seek help. One participant stated, "If a male assaults a female that's 100% bad, but they are

not considered gay or broken if a male does it to a female" (P 10). One participant said that "It's difficult for a man to open because of the societal labels and beliefs of what a man is and what he can or cannot experience" (P 6). One of the participants believed that women experienced the same barriers seeking help like men. The other participant believed that women had a more difficult experience seeking help.

Several participants chose their branch based on it being the toughest, ability to travel, family tradition, or simply away out of their past circumstances at that time. All participants felt like they have developed a keen sense of responsibility and growth since joining the military. They all have become much wiser and striving to become a better version of themselves. One participant stated that his lifestyle has changed due to the different feelings he experiences at different times of year. I stated that he could go without being intimate or having sex for years. It takes a great deal of time for him to develop trust because as soon as he is intimate his nightmares resurface.

Summary

In chapter 4, I presented the research findings on the experiences the help-seeking experiences of male veteran victims of military sexual trauma/assault. The research setting, demographics, data collecting process, data analysis, evidence of trustworthiness, along with the themes and subthemes. All participants were allowed to provide a detailed description of the experiences seeking help for MSA/MST while on active duty. Their overall experiences were pertinent to the decision to seek help or not. All the participants discussed their challenges with seeking help within the military culture and how it impacted their decision. Furthermore, discover themes were used to guide the workings

of the data analysis. The themes included personal journey, false hope in institution, no faith in the reporting process, revictimization, trauma, fear, and lack of available resources. The additional questions asked in the interview that did not fit in categories were branch of choice, male vs female barriers to seeking help, and personal injury. Some of the sub themes include subthemes included questioned masculinity and sexuality, fear of homophobic labeling, stigma, viewed as weak, judging, personal barriers, lack of training among healthcare and mental health providers, insufficient programs and prevention programs, institutional reprisal, sensitivity and disconnect, difficulties surrounding assault, isolation and homelessness, desire to heal, and personal journey. I also discussed credibility, transferability, dependability, and confirmability. The research questions were answered by breaking down the collected data.

Chapter 5: Discussion, Conclusion, and Recommendations

This study was conducted based on the premise that there is a gap in the literature on the help-seeking experiences of male veteran survivors of military sexual trauma or assault and why they male victims have a more difficult time seeking help than their female counterparts as identified in Chapter 1. For this reason, their experiences prior to joining the military, when they joined, and after their incident were explored to gain a better understanding of the barriers that contributed to their help seeking experiences. In addition, their ability to cope with the psychological, emotional, social, and personal damage caused by the trauma and whether their experience pose a lifelong effect on their overall self-perception and quality of life. In this chapter, I will review and discuss the purpose of the study in detail along with the themes I discovered and developed during the data analysis process. The chapter also concludes with a discussion of the limitations of this study, areas for future research, and a summary. In addition, I will conclude with the implications for positive social change.

This chapter contains discussion and future research to help determine the answers to the research questions:

RQ: What are the help-seeking experiences of male veteran survivors of military sexual trauma who were active duty and between the ages 18-65 years old at the time of the assault?

Sub Q 1: What are the barriers that impede on male veteran military sexual trauma survivor’s decision to not report or seek help for the effects of the trauma?

Sub Q2: What avoidant coping mechanisms do male veteran military sexual assault male victims use to cope with the effects of the assault and the impact it has on their quality of life?

Sub Q3: How do male veterans who have experienced military sexual trauma describe their military experience and their current quality of life?

Military sexual trauma and assault (MST/MSA) is not new phenomenon among male and female servicemembers. The screening rates have displayed striking similarities between male and female reports which can be related to the fact that there are more men in the military than women (Schry et al., 2015; Kimmerling et al., 2007). It was not until the Tailhook Scandal that occurred in 1992 that guidelines that offered services for both male and female victims were established (Hoyt et al., 2012). Nevertheless, even though universal screening is in effect, there are no set guidelines to assess male MST victims, and additionally, they have received less financial support than female MST programs (Hoyt et al 2012; Leskela et al., 2001). Based on the interviews conducted with the 12 male victims seeking help for their assault/trauma and their experiences, I identified five themes that displayed the barriers to seeking help for military sexual assault/trauma: (a) obstacles to seeking help, (b) institutional betrayal and cultural influences, (c) Trauma, (d) the art of coping and the mechanisms used, and (e) desire for significance/improve quality of life (QOL).

Based on their responses, I found that male victims experience negative outcomes seeking help due to lack of trust in the system, revictimization, personal barriers, and no available resources for men. Additionally, 10 participants shared their views on the

availability of resources allotted to women and the lack of resources available for men. One participant stated that female victims' experiences far worse stigma than male victims. The other participant stated that both male and female participants experience similar outcomes when seeking help. Overall, all the participants were very vocal about their lack of trust in the leadership in the military and described that due to their inability to trust it contributed to the negative outcomes related to seeking help for their assault/trauma.

Interpretation of the Findings

This section comprises of an interpretation of the findings identified from Chapter 4. This section is structured based on one main research question and three sub questions and five generated themes. The research questions and themes are presented, and reflections are made using the literature presented in Chapter 2. More importantly, thought is given to the alignment of the findings along with the theoretical framework apprising the study

Primary Research Question 1

The main research question was used to identify if male MST survivors sought help for their assault/trauma, and to identify any positive of negative effects on their decision seek help or not seek help. Five themes emerged in repose to RQ 1. The themes included obstacles related to seeking help, personal barriers of anger (shame and guilt, others perception, fear of negative outcomes), fear of homophobic labeling (stigma, judging); institutional betrayal and cultural influences including institution disconnect of the male MST experience, lack of male specific resources, the myriad of resources

available to women, institutional reprisal, lack of trust in the system and sensitivity to reports made. Male MST victims may equate their consequences of reporting to include punishment for other violations, decreased chance of promotion, and not being believed (O'Brien et al., 2015).

Theme 1: Obstacles Related to Seeking Help

Findings from this study concludes that there are plausible obstacles that impede on a male MST/MSA victim to seek help while on active duty. All participants discussed the obstacles they encountered with seeking help for military sexual assault/trauma they experienced while on active duty. They elaborated on their fear of reporting due to their lack of trust in the reporting process, fear of being viewed as weak, and others perception of them due to the experience. All participants described their experience as a traumatic ordeal with no form of support while on active duty.

The finding in this study is like those of Monteith et al (2019); Holland et al. (2016); O'Brien et al (2015); Turchik et al., (2013, who found that underreporting of MST among men may stem from their concerns surrounding stigma, shame, rape myths, lack of past empathetic responses to disclosure of MST, and the perception of reporting that may question their masculinity and sexuality. Monteith et al., (2019) also emphasized that men who were assaulted by women are experience their own personal barriers when it comes to reporting. Those men are exposed to the stigma that men cannot be raped by a woman, or that form of assault is not one that should be taken seriously, or that male victim is weak, gaining less empathy and sympathy from his peers (O'Brien et al., 2015). Holliday and Monteith (2019) also highlighted that it may be difficult for male

MST victims to seek help from institutions such as Veteran Affairs is an adverse emotional response they believe relates to the military. In fac, many veterans are not aware that DoD and VA Healthcare are two different systems.

It was also discussed that the existing barriers of stigma, fear of questioned masculinity, lack of trust, eligibility for services, and the lack of resources available for male victims, along with the shame and guilt they feel deter them from seeking help. Male victims have a fear of not being believed or dismissed (Holliday & Monteith, 2019). Most participants in the study were reluctant to report their incident. There were fearful of the backlash they would receive. In addition, to the belief that nothing would be done if they reported. However, the ones who did, experienced negative feedback and felt betrayed by the institutions and their leadership.

Overall, the main conclusion that can be determined from Theme 1 is that most participants chose to remain silent about their assault until they left the military. While those who reported had to undergo hostile work environments, harsh treatment, and the feeling of abandonment. In addition, they were not privy to learn of any resources that were available to assist with their traumatic experience. Most male victims chose to remain silent and suffer in silence. While this is not by choice, the military culture and environment is male dominant and the idea a male seeking help in that environment may constitute as a sign of weakness on the victim’s part.

Theme 2: Institutional Betrayal and Cultural Influences

While all participants expressed their fear with reporting, regardless of being assaulted by a man or woman, expressed their worse fear of being betrayed by the

institution they felt connected to when they enlisted. In this study, there were participants who were assaulted by males and females. The participants who were assaulted by males seem to have a more difficult time with processing what transpired. Their fear of reporting the incident stemmed from the alpha male perception of a man in the military and the cultural influences of the strength a man should possess and the ability he should have against situations like sexual assault and trauma.

The participants who were assaulted by women questioned whether what they experienced was truly assault. They were the ones who were more likely to keep the incident a secret for fear of being judged and thought of as being weak. Few participants found that reporting their incidents was not conducive to their wellbeing. They felt more victimized that assisted by their military leadership and comrades. Specifically, the results of the study included the following statements (a) I did not receive any support from my command, (b) I was afraid of the backlash and of what could happen, (c) I thought I did the right thing to report, but my command told everyone what happened to me, (d) nobody reports this stuff. It's not like anything would happen to the other person, (e) it's difficult navigating through the culture. Much blow back from the chain of command in a male dominant environment. All these statements exemplify the lack of trust and the betrayal the victims felt by the institutions.

Institutional betrayal (IB) and the cultural influences contribute to the reluctance male victims experience when deciding to report assault or trauma. The emphasis of IB in this study is consistent with the literature related to experiences of male veteran victims of MST/MSA. Holliday and Monteith (2019); Sadler et al., (2003); Zinzow et al., (2007)

research study referenced that it was not until recently that even when service members reported their MST experience, they were still subjected to resume working and or living alongside the perpetrator(s) which was likely to magnify the distress, betrayal, and the potential risk for revictimization. Moreover, MSST victims were expected o adhere to military courtesies when interacting with their attackers, which includes following orders, or trusting the attacker with their safety in combat (Hoyt et al., 2012; Mullins, 2005). I t was also found that victims who made any attempts to flee the situation may suffer escalated trauma, as those who were caught were subjected to harassment, assaulted as punishment, or face criminal charges (Hoyt et al., 2012; Hunter, 2007; Kennedy, 1995; Shilts, 1993).

Holliday and Monteith (2019) concluded that due to the elements of distrust and lack of safety, MST victims continue to avoid any resources related to military sexual trauma healthcare. The participants in this study expressed their discontent with the lack of trust and confidentiality of military institutions as MST victims. However, there were some participants who are ow willing to seek help for their experience, but others are still reluctant. Theme 2 indicates that participant found it difficult to trust their leadership to report assault or trauma. This in turn creates internal struggles and makes it difficult for them to effectively function at their job and within their workspaces.

While conducting the interviews, all participants had the common responses of lack of trust in their branch of service leadership. Participants experienced the emotional rollercoaster of questions of their masculinity, toughness, self-reliance, and self-identity (Eckerlin et al., 2016). Additionally, four participants discussed the internal discussion

they had with themselves regarding their sexual identity and their masculinity. Three of the four participant continue to struggle forming relations at present.

Sensitivity and revictimization were common concerns among all study participants. The fear and anxiety they possessed in not knowing if they can divulge what occur and the worry of the imminent backlash they feared was crippling. This result was supported by Hoyt et al., 2012; O'Brien et al., 2018 and Sherman, 2005) discussed that men with PTSD and MST indicated that they must suffer stoically without emotional expression. According to O'Brien et al., (2015) men are less likely to gain support or sympathy when the perpetrator is female. This form assault is less likely gain any traction with reporting as it attempts to debunk the myth that men cannot be assaulted by women.

Sub Research Question 1

Sub research question one touches on the barriers that male MST survivors encounter in their decision-making process to report or to seek help. One theme emerged in response to Sub Question 1. The theme highlighted the trauma men experience because of their assault and seeking help. The most common factors that mentioned by participants surrounding trauma were the responses of disbelief surrounding the assault, masking of their pain, emotional detachment, depression, nightmares, and sleep disturbances.

Theme 3: Trauma

All participants discussed their level of trauma. Some participants were more vocal about their traumatic experiences than others. The participants who were vocal, went into grave details of the traumatic experiences, when where and how. Other

participants, appeared to be very careful of what they shared, but wanted to ensure that they were heard. Most participants mentioned that living through the actual assault was traumatic, but the most difficult traumatic experience was living through a period where the people/institution they thought would protect them caused the most pain by what was done and the treatment they received in the aftermath of their assault. According to O'Brien et al., (2015) and Kimerling et al., (2002), civilian studies of male sexual assault victims suggest that when male victims are compared to female victims, men have a significantly higher rate of being hospitalized psychotic breakdowns and distress. In addition, it was found that the male psyche was severely impacted that female regarding sexual harassment because it unexpected among male victims and has a greater stigmatizing effect and may be more detrimental (O'Brien et al., 2015 & Vogt et al., 2005).

The current study, discussing the effect trauma and how it impedes on the male survivor's decision to report their experience. A few participants discussed how seeking help amplified their trauma, because they reported the incident and the backlash of being ostracized, revictimized and labeled they received was extremely humiliating. Other participants chose to suffer in secrecy because of what they previously saw happened to other victims, and the fact that they felt that the thought of being stigmatized and labeled was not worth the additional pain. Men who experience MST are likely more subjected to additional traumatic feelings as there is less likely for them to have an avenue of escape or barriers regarding safety and trust, with the additional feeling that they are alone in their experience (Hoyt et al., 2012).

One participant reported that his mode of escape was failing the drug test so he can be kicked out to avoid the shame and the perception of others. Another participant stated that he would get so drunk and behave so recklessly, get into fights which he was taught to do, and he was kicked out. However, both participants informed me during the interview that they are in mental health programs seeking help. Schry et al., (2015) found that there a possibility that males who experience MST delay seeking help when needed which may compound their difficulties. Male victims should feel secure in reporting MST based on its sensitive nature and how this experience negatively affects the person's life.

The issues surround trauma and how victims may be unable to avoid the incident can be associated with terror that may cause induced state of tonic immobility causing victims to be incapable of speaking or move, let alone warding off or fleeing form the perpetrator (McNally 2022). The study participants who were assaulted by women did declare their immobility during the incident. Other participants discussed the issue of being drugged or drunk. Waking up and finding oneself in a compromising position and gaining knowledge of being sexually assaulted is difficult to understand. Hence, many participants tend to isolate themselves form other and mask the effects of the assault. Emotional detachment, masking the pan and disbelief surrounding the assault were subthemes because it was nor described as part of the trauma, but were reported by participants as the effects to the trauma related to barriers seeking help.

Sub Research Question 2

The second sub question pertained to the types of avoidant coping mechanisms that were used by the male victims and how it helped them to deal with the effects it had on their quality of life. One theme emerged related to the coping mechanisms used by male MST victims. The theme was the art of coping and the mechanisms used. This theme revealed the positive and negative coping choices the participants either established themselves or was advised to use to help combat their assault or trauma. The elements within the established them that were common among the participants were illicit drugs, risky behavior, abstinence, risky behavior, and promiscuity.

Theme 4: The Art of Coping and the Mechanism Used

All participants in the study discussed the specific elements and strategies of how they coped and continue to cope and the mechanisms they used or continue to use. One participant stated that

> "I sleep outside, not because I want to, I just don't do well with people. My mind is just changed to where I don't seek joy. My interactive social skills are not up to par. I want to work, but it's hard to coexist with the world" (P 2).

A few participants mentioned that alcohol was their coping mechanism of choice. They drank until they became numb to the thoughts and memories of the incident. One participant said, "It's hard for me to do stuff and be in relations." As a result, he chooses to practice abstinence because of the dysfunction he experiences in relationships and the time of intercourse arises. Elder et al., (2017) discovered that following the MST men are likely to experience some form of sexual dysfunction which may include avoidance of

sexual activities, discussions related to sex, and sexual dysfunction. Elder et al., (2017) also went on to state that this is a response based on the anxiety and the compounded frustration exhibited by their sexual partner and the worry that their impairment would lead to relationship problems.

Another participant stated that after he was discharged, he sought help two years later and his therapist encouraged him to change his environment. He said stated that he travelled to 21 different countries to binge watch Netflix, but the elements of his trauma were still present. As stated by Morris et al., (2014), men report more trauma symptoms low sex drive or unpleasurable sexual experiences, than women at baseline, and they exhibit longer lasting symptoms compared to female victims like sexual problems and sexual trauma symptoms.

Sub Research Question 3

Sub research question 3 pertains to how male MST veteran victims equate their overall military experience and their current quality of life. The single them that emerged from this sub question was Desire for significance and improved quality of life (QOL). The theme revealed that despite the victim's negative experience on active duty, they are still striving to be better and to improve their quality of life. The elements within the established theme were personal journey to overcome the trauma, desire to heal and inspire other victims, and advocacy for new programs specific to male victims.

Theme 5: Desire for Significance/Improve Quality of Life (QOL)

All participants in this study expressed their desire to be someone or something great. This is the reason they joined the military. They all stated that improving their

QOL was the goal when they joined. One participant said, “I wanted to be the best of the best,” but that desire halted after his assault and revictimization by his command. Most of the participants now are receiving treatment for their assault/trauma. One reported that after receiving treatment he is now happy about his accomplishments and continues to attempt to rebuild is moral compass. He now views himself as “An individual outside of titles.” He’s a lot happier and more connected with a great deal of support.

Findings from the current study also revealed that participants who were also diagnosed with PTSD non-MST related try to make strides to be better so they can be advocates for others. One participant said’ “I took a risk-taking therapy. It helped me make healthy choices. I am better that I can make health choices. At the end of the day my children benefited from my health choices” (P 1). He also went on to say that a lot of the ethos that he and values he acquired in the miliary came into effect, because now he is a role that allows him to mentor and help other who have had the same experiences. The findings of poor quality of life suggested in the research by McCarthy et al., (2019) shows a correlation with sleep disorders, depression, and PTSD with poor quality of life. The desire for significance is associated with the passion to serve one’s country, to accomplish a goal they believe they could not accomplish in the civilian world. Or to use the military as a tool so they can obtain what they desire in the civilian world to be significant.

Alignment With Theoretical Framework

The research findings are elaborated upon the theoretical frameworks I used to illuminate the research. This study was ground in Institutional Betrayal Theory (IBT) and

Betrayal Blindness Theory (BBT). Institutional betrayal theory has been dissected in research studies to identify and understand the role it has on help-seeking options for MST victims and the barrier it erects to utilizing MST related healthcare (Holliday & Monteith, 2019). Holliday and Monteith (2019) also stated that MST survivors feel betrayed by the branch in which they served after the occurrence of the MST due to their responses or the perception that the institution failed to prevent the assault.

This theoretical approach minimizes the possibility of MST victims feeling safe to report incidents due to distrust and beliefs concerning their safety (Holliday & Monteith, 2019). Betrayal blindness reflects upon the disassociation by the perpetrator, victim, and witness to preserve relationships, institutions, and social systems in which they depend (Freyd, 2008). Moreover, it is maintaining a business-as-usual attitude for all involved displaying types of inequities within the workplace (Freyd, 2008). The inequities in this instance may include better resources for one sex than the other or one sex is more likely to be believed than the other.

This study distinctly demonstrates that IBT and BBT are elements that play a significantly intricate role in the decision-making process to report an MSA/MST occurrence for victims. The findings presented in this study shed light into the importance of sensitivity training on military sexual assault and trauma for men and the specific training and empathy needed by the healthcare professionals providing the care for male victims. Institutional betrayal may also harness distrust in institutions like the military and VA among survivors (Monteith et al., 2021). As stated by Smith and Freyd (2014), institutional betrayal is a concept that has broad applications to many forms of social

harm and injustice. Injustices may include omission of statements or overlooking of the incident. In addition, the societal taboo that distinguishes what a man can experience and what he cannot needs to also be addressed. Institutional betrayal and betrayal blindness theories exposes the institutional actions and inactions that contribute to a victim's traumatic experience (Smith & Freyd 2014).

Betrayal blindness can be a bit more complexed as most people have a solid belief in their institution of affiliation and can find it difficult to believe what may have occurred because they focus on the professional credibility and the enrichment of collective interests (Tang 2015). Being aware that men who experience MSA/MST are undergo a significant amount of internal and external pressures related to reporting their incident. Men frequently consider the thoughts others may have on their masculinity, sexual preference, and most of all the disbelief they have in themselves thinking "how did this happen to me?" To understand the choices and decisions male victims must consider to either report or conceal their victimization is critical in this study.

Limitations of the Study

While this study is believed to make a significant contribution to the understanding of the male MSA/MST victim experience, one limitation was that not all participants were prepared to discuss the true feelings of seeking help and not all sought help. They were all limited to stating that seeking help was not an option. Therefore, the study findings are specific to the participants who sought help while on active-duty and not generalized as it is applicable to group being studied and the participants who discussed their help-seeking experiences. It is also important to understand that the

participants were all veterans who have retired or been discharged five years or more, and their responses may not generalize to active duty servicemembers or veterans who have retired or discharged less than a year. In this research purposeful snowball sampling was used to recruit participants. This sampling method relied on participant referrals and Facebook group referrals and allowed with telephone and in person interviews.

The participants volunteered to share their experiences. The number of participants represented in the study may not reflect the full help seeking experience of other male MSA/MST survivors. Another limitation may be that I was female speaking to male victims of sexual assault. Although the participants represented different branches, the core values, and the reflected culture as it relates to men who experienced MSA/MST appeared to be the same. As such the lack of trust in imminent regardless of the branch of service among victims. Street et al., (2011) states that sexual assault or harassment in the military may be particularly damaging due to the conflicts with core values of being strong, tough, and physically powerful affects male personal self-identity.

Each interview was between 30 – 45 minutes in length. If all participants were willing to go a little deeper and not try to rush the interview questions, it may have been 60 minutes. I believe if I had taken a quantitative approach to this study, more male victims would have been opened to participating because of the overall anonymity and confidentiality. The approach of no contact may have been more conducive to a greater number of male victims volunteering.

Recommendations

Based on the limitations identified in this research study, a few recommendations can be made for future research and practice. First, due to all the participants being male veterans who have held a veteran status for over five years, research with recent veterans who have experience MSA/MST while on active duty may be beneficial. Recruiting a more recent sample for this study may yield more robust findings that can be beneficial for this population. Another suggestion would be to compare the help-seeking experiences of Vietnam and Desert Storm veterans with Post 9/11 veterans to determine if there are any differences in their decision to seek help or not.

Another recommendation worth further exploration is the differences in the male and female victim experience seeking help, and though the branches of service may be different, yet the ethos of the leadership is similar. Interviewing military leadership, mental health, and other healthcare providers may help to establish a need for future studies, such as theoretical approach of IBT within the military culture and how the improvement of military leadership can aid in creating a better environment where victims feel safe to report. This research can also be conducted using quantitative method that may be more conducive to recruiting participants to discuss IBT and recently retired veterans to discuss their experiences.

Implications for Social Change

Positive social change is the driving force of ideas and action that can improve the social conditions of an environment or society. Understanding the help-seeking experiences of male MSA/MST victims can promote positive social change in an

institutional, societal, and family level to establish a specific support system for them. The study findings provided a deeper insight of the issue surrounding the help seeking experiences of male veteran MST/MSA victims. However, not much research has been done on the male veteran experience and how they navigate through the system, and their decision-making process to either report their incident or not. It is apparent that MST among men is not openly discussed, reports may be ignored and may not be held or regarded as confidential, and social and military connections can impede further investigation (Sadler et al., 2021).

Moreover, the findings offer insight to the approach military institutions can take to either lower victim occurrences or create an environment where victims feel safe to report. The comments I received from the study participants, indicates that creating an environment of trust, providing proper education on the impact of sexual assault or trauma among men, and leadership training to manage these types of incidents can help male veterans feel safer to report, establish a support system to encourage and reiterate that they are not alone. Eckerlin et al., (2016) suggests that having access to social support may help reduce the negative impact of a traumatic experience.

Educating society as well to minimize the stigma of the male ethos will also help with male victim reporting. What must be remembered is that for most male children adolescents, the characters they emulate growing up are warriors who glorify the role of soldiers (O'Brien et al., 2015) like GI Joe and Rambo. They study findings also recommend that DoD, VA, and other military healthcare systems should reevaluate their current processes and policies to ensure that male victims receive the same benefits and

have the same resources available to them like their female counterparts. Military leadership should be trained on sexual assault, healthcare provides should have specific training to accommodate male victims, in addition to sensitivity training. The participants in the present study were also extremely vocal about the differences in the availability of resources for females compare to males, and the greater acceptance of female victims as it is expected that females can be assaulted in a male dominant environment.

Conclusion

Military sexual trauma is not limited to any specific sex or gender. However, the prevalence of reporting incidents that occurred are primarily reported on the effects on female victims. Research on male victims is scant compared to research on female victim reports, as men are less likely to report and incident due to the fear of being stigmatized or labeled as gay which can be emasculating (O'Brien et al., 2015). However, military sexual assault/trauma among male servicemembers has gained more traction and attention that revised policies and the reduction in stigma and beliefs that may occur.

The qualitative case study explored the help seeking experiences of male veterans who experienced military sexual assault/trauma to gain an understating on the effects seeking help had on male victims. In addition, I wanted to understand why it is so much more difficult for men to seek help than it is for women to seek help for MSA/MST. The research question and sub questions crated a clear path for the research to focus on the experiences of male veterans seeking help for MSA/MST. The experiences of the study participants differed as they discussed the obstacles, they faced with seeking help. Some of the obstacles were related to personal barriers, some were the lack of trust they had in

their institution, and the others were related to the stigma, and the trauma they experienced. To better understand why there is such inconsistent research and reporting among male victims compared to female victim, the male experiences must be further explored.

The research study provided insight to further understand the help-seeking experiences of male veteran MSA/MST survivors, as well as their decision to seek help. The findings could help military and Veteran Affairs institutions to meet and discuss policy and legislation that help establish male specific programs to better serve male victims and to bring about awareness and lessen the occurrences of these attacks. N essence, the finding of this study can be used to promote positive social change in military leadership approaches and healthcare facilities.

The sanctity on military culture is important to servicemembers who volunteer their service. However, the aspect of not being protected or feeling safe by what most may consider their second family can be debilitating. The findings this study offers, displays the importance of leadership, privacy, confidentiality, and the relationship between victim, superiors, and advocates. Male veterans who have been assaulted and seeking help should feel a sense of security and trust to come forward at any time without judgement. Men should not be placed in a box that society or any institutions determines what and who they should be. When a man is victimized by military sexual assault or trauma, or even as a civilian, their experiences and situation should be treated as such a victim of sexual assault or trauma.

References

Andresen, F. J., Monteith, L. L., Kugler, J., Cruz, R. A., & Blais, R. K. (2019). Institutional betrayal following military sexual trauma is associated with more severe depression and specific posttraumatic stress disorder symptom clusters. *Journal of Clinical Psychology*, 75(7), 1305–1319. https://doi-org.ezp.waldenulibrary.org/10.1002/jclp.22773

Avcıoğlu, M. M., Karanci, A. N., & Soygur, H. (2019). What is related to the well-being of the siblings of patients with schizophrenia: An evaluation within the Lazarus and Folkman's Transactional Stress and Coping Model. *International Journal of Social Psychiatry*, *65*(3), 252–261. https://doi-org.ezp.waldenulibrary.org/10.1177/0020764019840061

Barth, S. K., Kimerling, R. E., Pavao, J., McCutcheon, S. J., Batten, S. V., Dursa, E., Peterson, M. R., & Schneiderman, A. I. (2016). Military sexual trauma among recent veterans: Correlates of sexual assault and sexual harassment. *American Journal of Preventive Medicine*, *50*(1), 77–86. https://doi-org.ezp.waldenulibrary.org/10.1016/j.amepre.2015.06.012

Bastian, L.D., Lancaster, A.R., Reyst, H.E. Department of defense 1995 sexual harassment survey defense manpower data center, Arlington, VA (1996) Google Scholar

Bastick, M., Grimm, K., & Kunz, R. (2007). Sexual violence in armed conflict: Global overview and implications. Geneva: Geneva Center for the Democratic Control of

Armed Forces. Retrieved from http://www.peacewomen.org/assets/file/Resources/NGO/vaw_sexualviolenceandconflict_dcaf_2007.pdf.

Baumeister, R., Smart, L., Boden, J. (1996). Relation of threatened egotism to violence and aggression: The dark side of high self-esteem. Psychological Review, 103, 5–33.

Bell, M., Turchik, J. & Karpenko, J. (2014). Impact of Gender on reactions to military sexual assault and harassment. Health & social work. 39. 25-33. 10.1093/hsw/hlu004.

Bennett, J. (2018). Combating sexual assault with the military ethic: Exploring culture, military institutions, and norms-based preventive policy. *Armed Forces & Society*, *44*(4), 707–730. https://doi.org/10.1177/0095327X17735520.

Berkowitz, A. D., Burkhart, B. R., & Bourg, S. E. (1994). Research on college men and rape. New directions for student services, 65, 3–19. http://dx.doi.org/10.1002/ss.37119946503

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking. Qualitative Health Research, 26(13), 1802–1811. https://doi-org.ezp.waldenulibrary.org/10.1177/1049732316654870

Blais, R. K., Brignone, E., Fargo, J. D., Galbreath, N. W., & Gundlapalli, A. V. (2018). Assailant identity and self-reported nondisclosure of military sexual trauma in partnered women veterans. *Psychological Trauma: Theory, Research, Practice & Policy*, *10*(4), 470–474.

Blais, R. K., & Geiser, C. (2019). Depression and PTSD-related anhedonia mediate the association of military sexual trauma and suicidal ideation in female service members/veterans. *Psychiatry Research*, *279*, 148–154. https://doi-org.ezp.waldenulibrary.org/10.1016/j.psychres.2018.12.148

Block, J., Block, J., & Keyes, S. (1988). Foretelling drug use in adolescence: Early personality and environmental precursors. Child Development 59, 336–355.

Blosnich, J. R., Mays, V. M., & Cochran, S. D. (2014). Suicidality among veterans: Implications of sexual minority status. *American Journal of Public Health, 104(S4), S535–S537*. doi:10.2105/AJPH.2014.302100

Brown, S.E.V. and Battle, J., S. (2019). Ostracizing targets of workplace sexual harassment before and after the #MeToo movement. *Equality, Diversity and Inclusion*, Vol. 39 No. 1, pp. 53-67. https://doi-org.ezp.waldenulibrary.org/10.1108/EDI-09-2018-0162

Brownstone, L. M., Holliman, B. D., Gerber, H. R., & Monteith, L. L. (2018). The phenomenology of military sexual trauma among women veterans. *Psychology of Women Quarterly*, *42*(4), 399–413. https://doi-org.ezp.waldenulibrary.org/10.1177/0361684318791154

Bryan, C. J., Bryan, A. O., & Clemans, T. A. (2015). The association of military and premilitary sexual trauma with risk for suicide ideation, plans, and attempts. Psychiatry Research, 227(2-3), 246-252. doi:10.1016/j.psychres.2015.01.030

Burns, B., Grindlay, K., Holt, K., Manski, R., & Grossman, D. (2014). Military sexual trauma among US servicewomen during deployment: A Qualitative

Study. *American Journal of Public Health*, *104*(2), 345–349. https://doi-org.ezp.waldenulibrary.org/10.2105/AJPH.2013.301576

Cacace, S. C. (2020). Be all that you can be: Building a cohesive model of military identity in early-career and veteran U.S. military service members. *Journal of Behavioral & Social Sciences*, *7*(1), 12–22.

Chapleau, K. M., Oswald, D. L., & Russell, B. L. (2008). Male rape myths: The role of gender, violence, and sexism. *Journal of Interpersonal Violence,* 23, 600-615. doi:10.1177/0886260507313529

Cheng, D., Amarnani, R., Le, T., & Restubog, S. (2019). Laughter is (powerful) medicine: The effects of humor exposure on the well-being of victims of aggression. *Journal of Business & Psychology*, 34(3), 389–402. https://doi-org.ezp.waldenulibrary.org/10.1007/s10869-018-9548-7

Creech, S. K., & Borsari, B. (2014). Alcohol use, military sexual trauma, expectancies, and coping skills in women veterans presenting to primary care. *Addictive Behaviors*, *39*(2), 379–385. https://doi-org.ezp.waldenulibrary.org/10.1016/j.addbeh.2013.02.006

Creswell, J, W., & Creswell, J. D. (2017). *Research design (5th ed).* Qualitative, quantitative, and mixed methods approach. Sage Publications, Thousand Oaks, CA

Cromer, L. D., Vasquez, L., Gray, M. E., & Freyd, J. J. (2018). The relationship of acculturation to historical loss awareness, institutional betrayal, and the

intergenerational transmission of trauma in the American Indian experience. *Journal of Cross-Cultural Psychology*, *49*(1), 99.

D'Ambrosio-Woodward, T. (2014). Military sexual assault: A comparative legal analysis of the 2012 department of defense report on sexual assault in the military: What it tells us, what it doesn't tell us, and how inconsistent statistic gathering inhibits winning the "invisible war." *Wisconsin Journal of Law, Gender & Society*, *29*(2), 173–211.

Daniel, S., Neria, A., Moore, A., & Davis, E. (2019). The impact of leadership responses to sexual harassment and gender discrimination reports on emotional distress and retention intentions in military members. *Journal of Trauma & Dissociation: The Official Journal of the International Society for the Study of Dissociation (ISSD)*, *20*(3), 357–372. https://doi-org.ezp.waldenulibrary.org/10.1080/15299732.2019.1571887

Depraetere, J., Vandeviver, C., Beken, T. V., & Keygnaert, I. (2020). Big boys don't cry: A critical interpretive synthesis of male sexual victimization. *Trauma, Violence & Abuse*, *21*(5), 991–1010. *https://doi-org.ezp.waldenulibrary.org/10.1177/1524838018816979*

Department of Defense Directive 6495.01. (2012). Sexual assault prevention and response (SAPR) program. Retrieved from http://www.dtic.mil/whs/directives/corres/pdf/649501p.pdf

DiRosa, G. A., & Goodwin, G. F. (2014). Moving away from hazing: the example of military initial entry training. *The Virtual Mentor: VM*, *16*(3), 204–209.

https://doi-org.ezp.waldenulibrary.org/10.1001/virtualmentor.2014.16.03.msoc1-1403

Do, J. J., & Samuels, S. M. (2021). I am a warrior: An analysis of the military masculine-warrior narrative among U.S. air force officer candidates. *Armed Forces & Society*, *47*(1), 25–47. https://doi.org/10.1177/0095327X20931561

Duchesne, S., Seyller, M., & Chariot, P. (2018). Male sexual assaults in the Paris, France area: An observational study over 8 years. *Forensic Science International*, *290*, 16–28. https://doi-org.ezp.waldenulibrary.org/10.1016/j.forsciint.2018.06.018

Dunivin, K. O. (1994). Military culture: Change and continuity. Armed Forces & Society, 20(4), 531–547.

Elder, W.B., Domino, J. L., Rentz, T. O., & Mata-Galan, E. L., (2017). Conceptual model of Male military sexual trauma. *Psychological Trauma: Theory, Research., Practice, and Policy, 9(Suppl 1), 59-66*. https://doi-org.ezp.waldenulibrary.org/10.103/tra0000194.

Eckerlin, D. M., Kovalesky, A. & Jakupcak, M. (2016). Military sexual trauma in male service Members. *AJN American Journal of Nursing, 116(9), 34-45.* https//doi-org.ezp.waldenulibrary.org/10.1097/01.NAJ.0000494690.55746.d9

Ellison, J. (2011). The Military's Secret Shame. *Newsweek*, *157*(15), 40–43.

Fenell, D. 2008. A distinct culture: Applying multicultural counseling competencies to work with military personnel. *Counseling Today*, 50(12) June: 8–9. 35 [Google Scholar]

Fillo, J., Heavey, S., C., Homish, D. L., & Homish, G., G. (2018). Deployment-related military sexual trauma predicts heavy drinking and alcohol problems among male reserve and national guard soldiers. *Alcoholism, Clinical and Experimental Research*, *42*(1), 111–119. https://doi-org.ezp.waldenulibrary.org/10.1111/acer.13528

Freyd, J. J. (2008). Betrayal trauma theory. Retrieved from. https://dynamic.uoregon.edu/jjf/institutionalbetrayal/index.html

Freyd, J. J., & Birrell, P., J. (2013). Blind to betrayal. New York, NY: John Wiley.

Forkus, S. R., Rosellini, A., J., Monteith, L., L., Contractor, A., A., & Weiss, N., H. (2020). Military sexual trauma and alcohol misuse among military veterans: The roles of negative and positive emotion dysregulation. *Psychological Trauma: Theory, Research, Practice & Policy*, *12*(7), 716–724.

Funk, R. E. (1993). Stopping rape: A challenge for men. Philadelphia, PA: New Society Publishers.

Gaher, R. M., O'Brien, C., Smiley, P., & Hahn, A. M. (2016). Alexithymia, coping styles and traumatic stress symptoms in a sample of veterans who experienced military sexual trauma. *Stress and Health: Journal of the International Society for the Investigation of Stress*, *32*(1), 55–62. https://doi-org.ezp.waldenulibrary.org/10.1002/smi.2578

Gray, H. (2018). Rape and sexual assault in Japan: Potential gender bias in pre-trial procedures. *Reinvention: An International Journal of Undergraduate Research*, *11*(1), 1.

Greene, T., Buckman, J., Dandeker, C., & Greenberg, N. (2010). The impact of culture clash on deployed troops. Military Medicine, 175, 958 –963. http://dx.doi.org/10.7205/MILMED-D-10-00146

Gross, G. M., Ronzitti, S., Combellick, J., L., Decker, S. E., Mattocks, K. M., Hoff, R. A., Haskell, S. G., Brandt, C. A., & Goulet, J., L. (2020). Sex differences in military sexual trauma and severe self-directed violence. *American Journal of Preventive Medicine*, 58(5), 675–682. https://doi-org.ezp.waldenulibrary.org/10.1016/j.amepre.2019.12.006

Groth, A. N., & Burgess, A., W. (1980). Male rape: Offenders and victims. *The American Journal of Psychiatry*, 137, 806-810. doi:10.1176/ajp.137.7.806

Groves, C. (2013). Military sexual assault: An ongoing and prevalent problem. *Journal of Human Behavior in the Social Environment,* 23:6, 747-52, DOI: 10.1080/10911359.2013.795064

Gurung, S., Ventuneac, A., Rendina, H., J., Savarese, E., Grov, C., & Parsons, J., T. (2018). Prevalence of military sexual trauma and sexual orientation discrimination among lesbian, gay, bisexual, and transgender military personnel: A descriptive study. *Sexuality Research & Social Policy: A Journal of the NSRC*, *15*(1), 74–82. https://doiorg.ezp.waldenulibrary.org/10.1007/s13178-017-0311-z

Haskell, S. G., Papas, R. K., Heapy, A., Reid, M. C., & Kerns, R., D. (2008). The association of sexual trauma with persistent pain in a sample of women veterans receiving primary care. Pain Medicine, 9, 710 –717. http://dx.doi.org/10.1111/j.1526-4637.2008.00460.x

Hennink, M., Hutter, I., & Bailey A., (2011). *Qualitative research methods*. Sage Publications. Thousand Oaks, CA.

Hickey, T. R., Kirwin, P. D., Gardner, E. C., & Feinleib, J. (2017). Patient-centered perioperative care for a victim of military sexual trauma. Military Medicine, *182*(5–6), E1807–E1811. https://doi-org.ezp.waldenulibrary.org/10.7205/MILMED-D-16-00242

Himmelfarb, N., Yaeger, D., & Mintz, J. (2006). Posttraumatic stress disorder in female veterans with military and civilian sexual trauma. *Journal of Traumatic Stress, 19, 837– 846. http://dx.doi.org/10.1002/jts .20163*

Holland, K. J. (2020). Correlates of college women's intentions to use formal campus support for sexual assault. Psychology of Violence, 10(2), 245.

Holland, K. J., & Cipriano, A. E. (2019). Bystander response to sexual assault disclosures in the U.S. Military: Encouraging survivors to use formal resources. *American Journal of Community Psychology*, *64*(1/2), 202–217. https://doiorg.ezp.waldenulibrary.org/10.1002/ajcp.12333

Holland, K. J., Rabelo, V. C., & Cortina, L. M. (2016). Collateral damage: Military sexual trauma and help-seeking barriers. *Psychology of Violence*, *6*(2), 253–261. https://doi-org.ezp.waldenulibrary.org/10.1037/a0039467

Holliday, R., & Monteith, L. L. (2019). Seeking help for the health sequelae of military sexual trauma: a theory-driven model of the role of institutional betrayal. *Journal of Trauma & Dissociation: The Official Journal of the International Society for*

the Study of Dissociation (ISSD), *20*(3), 340–356. https://doi.org/10.1080/15299732.2019.1571888

Hoyt, T., Klosterman Rielage, J., & Williams, L. F. (2011). Military sexual trauma in men: A review of reported rates. *Journal of Trauma & Dissociation, 12, 244 –260*. http://dx.doi.org/10.1080/15299732.2011 .542612

Hoyt, T., Rielage, J. K., Williams, L. F. (2012). Military sexual trauma in men: Exploring treatment principles. Traumatology, 18(3), 29-40. doi:10.1177/1534765611430724

Hunter, M. (2007). Honor betrayed: Sexual abuse in America's military. Fort Lee, NJ: Barricade Books

Jakupcak, M., Blais, R. K., Grossbard, J., Garcia, H., & Okiishi, J. (2014). "Toughness" in association with mental health symptoms among Iraq and Afghanistan war Veterans seeking Veterans Affairs health care. Psychology of Men & Masculinity, 15, 100 –104. http://dx.doi.org/ 10.1037/a0031508

Johnson-Freyd, S., & Freyd, J. J. (2013). Revenge and forgiveness or betrayal blindness? *Behavioral and Brain Sciences, 36*(1), 23–24. https://doi.org/10.1017/S0140525X12000398

Kakhnovets, R., Holohan, D. R. (2007). Addressing military sexual trauma: Initial steps in treating the male patient. Federal Kameg, B. N., & Fradkin, D. (2020). Military Sexual Trauma: An Update for Nurse Practitioners. *The Journal for Nurse Practitioners*. https://doiorg.ezp.waldenulibrary.org/10.1016/j.nurpra.2020.09.010

Kang, H., Dalager, N., Mahan, C., & Ishii, E. (2005). The role of sexual assault on the risk of PTSD among Gulf War veterans. Annals of Epidemiology, 15, 191–195. http://dx.doi.org/10.1016/j.annepidem.2004 .05.009 Practitioner, 24, 16–29.

Kanter, R. (1977). Men and women of the corporation. Wiley.

Katz, J. (2006). The macho paradox: Why some men hurt women and how all men can help. Naperville, IL: Sourcebooks.

Katz, L. S., Bloor, L. E., Cojucar, G., & Draper, T. (2007). Women who served in Iraq seeking mental health services: Relationships between military sexual trauma, symptoms, and readjustment. Psychological Services, 4, 239 –249. http://dx.doi.org/10.1037/1541-1559.4.4.239

Katz, L. S., Cojucar, G., Beheshti, S., Nakamura, E., & Murray, M. (2012). Military sexual trauma during deployment to Iraq and Afghanistan: prevalence, readjustment, and gender differences. *Violence and Victims*, *4*, 487.

Katz, L. S., Huffman, C., & Cojucar, G. (2017). In her own words: Semi-structured interviews of women veterans who experienced military sexual assault. *Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy*, *47*(3), 181–189. https://doi-org.ezp.waldenulibrary.org/10.1007/s10879-016-9349-0

Kaufman A, Divasto P, Jackson R, Voorhees D, Christy J. (1980). Male rape victims: noninstitutionalized assault. Am J Psychiatry. 137(2):221-3. doi: 10.1176/ajp.137.2.221. PMID: 7352580.

Kennedy, J. (1995). About face: A gay officer's account of how he stopped prosecuting gays in the Army and started fighting for their rights. New York, NY: Birch Lane Press.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. Archives of General Psychiatry, 52, 1048 –1060. http://dx.doi.org/ 10.1001/archpsyc.1995.03950240066012

Khan, A. J., Holder, N., Li, Y., Shiner, B., Madden, E., Seal, K., Neylan, T. C., & Maguen, S. (2020). How do gender and military sexual trauma impact PTSD symptoms in cognitive processing therapy and prolonged exposure? *Journal of Psychiatric Research*, *130*, 89–96. https://doi-org.ezp.waldenulibrary.org/10.1016/j.jpsychires.2020.06.025

Kim, J., Kim, J., & Park, S. (2019). Military hazing and suicidal ideation among active-duty military personnel: Serial mediation effects of anger and depressive symptoms. *Journal of Affective Disorders*, *256*, 79–85. https://doi-org.ezp.waldenulibrary.org/10.1016/j.jad.2019.05.060

Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2007). The Veterans Health Administration and military sexual trauma. *American Journal of Public Health, 97, 2160 –2166*. http://dx.doi.org/10 .2105/AJPH.2006.092999

Kimerling, R., Rellini, A., Kelly, V., Judson, P. L., & Learman, L. A. (2002). Gender differences in victim and crime characteristics of sexual assault. *Journal of*

Interpersonal Violence, 17, 526 –532. http://dx.doi .org/10.1177/0886260502017005003

Kintzle, S., Schuyler, A. C., Ray-Letourneau, D., Ozuna, S. M., Munch, C., Xintarianos, E., Hasson, A. M., & Castro, C. A. (2015). Sexual trauma in the military: Exploring PTSD and mental health care utilization in female veterans. Psychological Services, 12(4), 394–401. https://doi.org/10.1037/ser0000054

Kline, N. K., Berke, D. S., Rhodes, C. A., Steenkamp, M. M., & Litz, B. T. (2021). Self-blame and PTSD following sexual assault: A longitudinal analysis. *Journal of Interpersonal Violence*, *36*(5–6), NP3153–NP3168. https://doi.org/10.1177/0886260518770652

Lathrop, A. (1998). Pregnancy resulting from rape. JOGNN Principles and Practice, 27, 25–31.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer.

Leskela, J., Dieperink, M., & Kok, C. (2001). Group treatment with sexually assaulted male veterans: A year in review. Group, 25, 303-319.

Maguen, S., Ren, L., Bosch, J. O., Marmar, C. R., Seal, K. H. (2012). Gender differences in mental health diagnoses among Iraq and Afghanistan veterans enrolled in Veterans Affairs health care. *American Journal of Public Health, 100, 2450–2456*. doi:10.2105/AJPH.2009.166165

Martin, J.A. and McClure, P. 2000. “Today's active-duty military family: The evolving challenges of military family life”. In *The military family: A practice guide for*

human service providers, Edited by: Martin, J.A., Rosen, L.N. and Sparacino, L.R. 3–24. Westport, CT: Praeger Publishers. [Google Scholar]

Martin, L., Rosen, L. N., Durand, D. B., Knudson, K. H., & Stretch, R. H. (2000). Psychological and physical health effects of sexual assaults and nonsexual traumas among male and female United States Army soldiers. Behavioral Medicine, 26, 23–33. http://dx.doi.org/10_.1080/08964280009595750

MacGregor, A. J., Dye, J. L., & Dougherty, A. L. (2020). Gender differences in mental health screening outcomes among U.S. marines in combat support occupations. *Women's Health Issues*, *30*(6), 470–476. https://doiorg.ezp.waldenulibrary.org/10.1016/j.whi.2020.08.004

McCarthy, E., DeViva, J. C., Norman, S. B., Southwick, S. M., & Pietrzak, R. H. (2019). Self-assessed sleep quality partially mediates the relationship between PTSD symptoms and functioning and quality of life in US veterans: Results from the National Health and Resilience in Veterans Study. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(8), 869–876. https://doi.org/10.1037/tra0000436.supp (Supplemental)

McManus, E. S., Cuccurullo, L.-A. J., Uddo, M., & Franklin, C. L. (2018). MMPI-2-RF characteristics of veterans seeking treatment for military sexual trauma. *Psychological Assessment*, *30*(4), 561–566. https://doi-org.ezp.waldenulibrary.org/10.1037/pas0000527

McNally, R. J. (2022). Are memories of sexual trauma fragmented? *Memory (Hove,*

England), *30*(1), 26–30. https://doi.org/10.1080/09658211.2020.1871023

McNeeley, S. (2015). Lifestyle-routine activities and crime events. *Journal of Contemporary Criminal Justice*, *31*(1), 30–52. https://doi.org/10.1177/1043986214552607

Miles, M., Huberman, A., & Saldana, J. (2014). *Qualitative research design: An interactive approach* (3rd ed.). Los Angeles, CA: Sage.

Military Sexual Trauma Support Team. (2015). Military sexual trauma (MST) screening report, fiscal year 2014. Washington, DC: Department of Veterans Affairs, Office of Patient Care Services, Mental Health Services.

Monteith, L. L., Bahraini, N. H., Gerber, H. R., Dorsey Holliman, B., Schneider, A. L., Holliday, R., & Matarazzo, B. B. (2020). Military sexual trauma survivors' perceptions of veteran's health administration care: A qualitative examination. Psychological Services, 17(2), 178–186. https://doi-org.ezp.waldenulibrary.org/10.1037/ser0000290

Monteith, L. L., Gerber, H. R., Brownstone, L. M., Soberay, K. A., & Bahraini, N. H. (2019). The phenomenology of military sexual trauma among male veterans. Psychology of Men & Masculinities, 20(1), 115–127. https://doi-org.ezp.waldenulibrary.org/10.1037/men0000153

Monteith, L. L., Holliday, R., Schneider, A. L., Miller, C. N., Bahraini, N. H., & Forster, J. E. (2021). Institutional betrayal and help-seeking among women survivors of military sexual trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(7), 814–823. https://doi.org/10.1037/tra0001027.supp (Supplemental)

Morral, A. R., Gore, K. L., & Schell, T. L. (2016). Sexual assault and sexual harassment in the U.S. military: Volume 2. Estimates for Department of Defense service members from the 2014 RAND Military Workplace Study. Retrieved from http://www.rand.org/pubs/research_reports/RR870z2-1.htm

Morris, E. E., Smith, J. C., Farooqui, S. Y., & Surís, A. M. (2014). Unseen battles: the recognition, assessment, and treatment issues of men with military sexual trauma (MST). *Trauma, Violence & Abuse*, *15*(2), 94–101. https://doi-org.ezp.waldenulibrary.org/10.1177/1524838013511540

Mullins, C. (2005). Understanding sexual assault in the United States Military culture. Connections, 7, 8-11.

Ntoumanis, N., Edmunds, J. & Duda, J., L. (2009). Understanding the coping process from a self-determination theory perspective. *British Journal of Health Psychology*, 14(2), 249–260. https://doi-org.ezp.waldenulibrary.org/10.1348/135910708X349352

O'Brien, C., Gaher, R., Pope, C., & Smiley, P. (2008). Difficulty identifying feelings predicts persistence of trauma symptoms in a sample of veterans who experienced military sexual trauma. Journal of Nervous and Mental Disease, 196, 252-255

O'Brien, C., Keith, J., & Shoemaker, L. (2015). Don't Tell: Military Culture and Male Rape. Psychological Services, *12*(4), 357–365. https://doi-org.ezp.waldenulibrary.org/10.1037/ser0000049

O'Brien, B. S., & Sher, L. (2013). Military sexual trauma as a determinant in the development of mental and physical illness in male and female

veterans. *International Journal of Adolescent Medicine and Health*, *25*(3), 269–274. https://doi-org.ezp.waldenulibrary.org/10.1515/ijamh-2013-0061

O'Cass, A., & Griffin, D. (2015). Eliciting positive social change: Marketing's capacity to drive prosocial behaviours. *Marketing Intelligence & Planning*, *33*(5), 826–843. https://doi-org.ezp.waldenulibrary.org/10.1108/MIP-02-2014-0027

Parnell, D., Ram, V., Cazares, P., Webb-Murphy, J., Roberson, M., & Ghaed, S. (2018). Sexual assault and disabling PTSD in active-duty service women. *Military Medicine*, *183*(9–10), e481–e488. https://doi-org.ezp.waldenulibrary.org/10.1093/milmed/usy048

Penn, N (2014): "Son, men don't get raped." *GQ: Gentlemen's Quarterly*, *84*(9), 244–1.

Percy, W., H., Kostere, K., & Kostere, S. (2015). Generic qualitative research in psychology.The Qualitative Report, 20(2) 76-85. Retrieved from http://nsuworks.nova.edu/tqr/v0120/iss2/7

Powell, R., & Lever, J. (2017). Europe's perennial 'outsiders': A processual approach to Roma stigmatization and ghettoization. *Current Sociology*, *65*(5), 680–699. https://doi.org/10.1177/0011392115594213

González-Prats, M. C. (2017). Accountability, complacency, or obfuscation? An analysis of the U.S. military's prevention and response efforts to military sexual trauma. *Public Integrity*, *19*(5), 483–499. https://doi-org.ezp.waldenulibrary.org/10.1080/10999922.2017.1278668

Rabelo, V. C., Holland, K. J., & Cortina, L. M. (2019). From distrust to distress: Associations among military sexual assault, organizational trust, and occupational health. *Psychology of Violence*, *9*(1), 78–87.

Ravitch, S. M., & Carl, M, C. (2016). *Qualitative research.* Bridging the conceptual, theoretical and methodological. Sage Publications. Thousand Oaks, CA

Reger, M.A., Etherage, J.R., Reger, G.M. and Gahm, G.A. 2008. Civilian psychologists in an Army culture: The ethical challenge of cultural competence. *Military Psychology*, 20: 21–35. [Taylor & Francis Online], [Web of Science ®], [Google Scholar]

Rice, S. M., Kealy, D., Treeby, M. S., Ferlatte, O., Oliffe, J. L., & Ogrodniczuk, J. S. (2018). Male guilt - and shame-proneness: The personal feelings questionnaire (PFQ-2 Brief). *Archives of Psychiatry & Psychotherapy*, *20*(2), 46–54. https://doi-org.ezp.waldenulibrary.org/10.12740/APP/86488

Romaniuk, J. R., & Loue, S. (2017). Military sexual trauma among men: A review of the literature and a call for research. Best Practice in Mental Health, 13(1), 80–104.

Sadler, A. G., Cheney, A. M., Mengeling, M. A., Booth, B. M., Torner, J. C., & Young, L. B. (2018). Servicemen's perceptions of male sexual assault and barriers to reporting during active component and reserve/national guard military service. *Journal of Interpersonal Violence,* 886260518780407. https://doi-org.ezp.waldenulibrary.org/ 10.1177/0886260518780407.

Sadler, A. G., Cheney, A. M., Mengeling, M. A., Booth, B. M., Torner, J. C., & Young, L. B. (2021). Servicemen's perceptions of male sexual assault and barriers to

reporting during active component and reserve/national guard military service. *Journal of Interpersonal Violence*, *36*(7/8), NP3596-NP3623. https://doi-org.ezp.waldenulibrary.org/10.1177/0886260518780407

Scarce, M. (1997). Male on male rape: The hidden toll of stigma and shame. New York, NY: Insight Books.

Schmid, M. N. (2010). Combating a different enemy: Proposals to change the culture of sexual assault in the military. *Villanova Law Review*, *55*(2), 475–507.

Schry, A. R., Hibberd, R., Wagner, H. R., Turchik, J. A., Kimbrel, N. A., Wong, M., Elbogen, E. E., Strauss, J. L., & Brancu, M. (2015). Functional correlates of military sexual assault in Male veterans. Psychological Services, 124(4), 384-393. https://doi-org.ezp. Waldenulibrary.org/10.1037/ser0000053.

Schuyler, A. C., Kintzle, S., Lucas, C. L., Moore, H., & Castro, C. A. (2017). Military sexual assault (MSA) among veterans in Southern California: Associations with physical health, psychological health, and risk behaviors. *Traumatology*, *23*(3), 223–234. https://doi-org.ezp.waldenulibrary.org/10.1037/trm0000098

Sherman, N. (2005). Stoic warriors: The ancient philosophy behind the military mind. New York, NY: Oxford University Press.

Shilts, R. (1993). Conduct unbecoming: Gays and lesbians in the U.S. Military. New York, NY: St. Martin's

Smith, C. P., & Freyd, J. J. (2014). Institutional betrayal. American Psychologist, 69, 575-587

Smith, D., Frueh, B., Sawchuck, C., Johnson, M. (1999). Relationship between symptom over-reporting and pre- and post-combat trauma history in veterans evaluated for PTSD Depression & Anxiety. View Record in ScopusGoogle Scholar

Steiger, D., Chattopadhyay, M., Roa, M., Green, E., Nemeckay, K., & Yen, E. (2010). Findings from the 2010 prevalence/incidence survey of sexual assault in the Air Force. Retrieved from http://www.afpc.af.mil/shared/ media/ document/AFD-110317-008.pdf

Stermac, L., del Bove, G., & Addison, M. (2004). Stranger and acquaintance sexual assault of adult males. *Journal of Interpersonal Violence*, *19*(8), 901–915. https://doi.org/10.1177/0886260504266887

Street. A & Stafford, J. (2004). Military sexual trauma: Issues in caring for veterans. Retrieved from https://www.globalsecurity.org/military/library/report/2004

Struckman-Johnson, C., & Struckman-Johnson, D. (1992). Acceptance of male rape myths among college men and women. Sex Roles, 27, 85-100. doi:10.1007/BF00290011

Struckman-Johnson, C., Struckman-Johnson, D., Rucker, L., Bumby, K., & Donaldson, S. (1996). Sexual coercion reported by men and women in prison. *Journal of Sex Research*, *33, 67-76*.

Tang, S., S. (2015). Blindness to the institutional betrayal by the APA. *British Medical Journal* (online) London Vol. 35. DOI:10.1136/bmj.h4172 Retrieved from.

https://www-proquest-com.ezp.waldenulibrary.org/docview/1777792794/322C3937A6A44FE5PQ/1?accountid=14872

Tiet, Q. Q., Leyva, Y. E., Blau, K., Turchik, J. A., & Rosen, C. S. (2015). Military sexual assault, gender, and PTSD treatment outcomes of U.S. veterans. *Journal of Traumatic Stress*, *28*(2), 92.

Tewksbury, R. (2007). Effects of sexual assaults on men: Physical, mental and sexual consequences. International Journal of Men's Health, 6, 22–35

Torres, F (2020). What is post-traumatic stress disorder? American Psychiatric Association. Retrieved from. https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd

Turchik, J. A., & Edwards, K. M. (2012). Myths about male rape: A literature review. Psychology of Men & Masculinity, 13, 211-226. doi:10.1037/a0023207

Turchik JA, & Wilson SM. (2010). Sexual assault in the U.S. military: a review of the literature and recommendations for the future. *Aggression & Violent Behavior*, *15*(4), 267–277. https://doi-org.ezp.waldenulibrary.org/10.1016/j.avb.2010.01.005

Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. Addictive Behaviors, 38(6), 2219–2223. https://doi-org.ezp.waldenulibrary.org/10.1016/j.addbeh.2013.01.027

United States Department of Defense, Sexual Assault Prevention and Response Office. (2012). Annual report on sexual assault in the military. Retrieved from http://www.sapr.mil/public/docs/reports/FY12_DoD_ SAPRO_Annual_Report_on_Sexual_Assault-volume_one.pdf

United States Department of Justice. Bureau of Justice Statistics. (2013, March). Special report: Female victims of sexual assault 1994 –2010. Retrieved from Department of Justice, Bureau of Justice Statistics website: http://www.bjs.gov/content/pub/pdf/fvsv9410.pdf

Valente, S., & Wight, C. (2007). Military sexual trauma: Violence and sexual abuse. Military Medicine, 172, 259 –265. http://dx.doi.org/10 .7205/MILMED.172.3.259

Vogt, D. S., Pless, A. P., King, L. A., & King, D. W. (2005). Deployment stressors, gender, and mental health outcomes among Gulf War I veterans. *Journal of Traumatic Stress,* 18*,* 115–127. http://dx.doi.org/10 .1002/jts.20018

Waters, J. (2015). Snowball sampling: a cautionary tale involving a study of older drug users. *International Journal of Social Research Methodology*, 18(4), 367—380.https ://doi-org.ezp.waldenulibrary.org/10.1080/13645579.2014.953316

Wiblin, J., Holder, N., Holliday, R., & Surís, A. (2021). Predictors of unbearability, unlovability, and unsolvability in veterans with military-sexual-trauma-related posttraumatic stress disorder. *Journal of Interpersonal Violence*, *36*(7/8), 3814–3830. https://doi-org.ezp.waldenulibrary.org/10.1177/0886260518777554

Weiss, N. H., Risi, M. M., Sullivan, T. P., Armeli, S., & Tennen, H. (2019). Post-traumatic stress disorder symptom severity attenuates bi-directional associations between negative affect and avoidant coping: A daily diary study. *Journal of Affective Disorders*, *259*, 73–81. https://doi-org.ezp.waldenulibrary.org/10.1016/j.jad.2019.08.015

Wieland, D. M., Haley, J. L., & Bounder, M. (2011). Military sexual trauma. *Pennsylvania Nurse*, *66*(4), 17–21.

Williams-Goodman, R., & Ullman, S. E. (2020). Posttraumatic stress disorder and measurement invariance in a sample of sexual assault survivors: Are symptom clusters stable over time? *Psychological Trauma: Theory, Research, Practice & Policy*, *12*(4), 389–396. https://doi-org.ezp.waldenulibrary.org/10.1037/tra0000509

Wills, T. A., Windle, M., & Cleary, S. D. (1998). Temperament and novelty-seeking in adolescent substance use. *Journal of Personality and Social Psychology, 74, 387–406*

Wills, T. A., Sandy, J. M., & Shinar, O. (1999). Cloninger's constructs related to substance use level and problems in late adolescence. Experimental and Clinical Psychopharmacology, 7, 122–134.

Wills, T. A., Sandy, J. M., Yaeger, A. M., Wills, T. A., Sandy, J. M., & Yaeger, A. M. (2002). Response-Based Coping Inventory. *Journal of Abnormal Psychology*, *111*, 3–21.

Wilson, L. C. (2016). The prevalence of military sexual trauma: A meta-analysis. Trauma, Violence, & Abuse, 1–14. doi:10.1177/1524838016683459.

Wilson, L. (2018). The prevalence of military sexual trauma: A Meta-Analysis. *Journal of Trauma Violence & Abuse*. https://doi-org.ezp.waldenulibrary.org/10.1177/1524838016683459

Melville-Wiseman, J. (2016). The sexual abuse of vulnerable people by registered social workers in England: An analysis of the health and care professions council fitness to practice cases. *British Journal of Social Work*, 46(8), 2190–2207. https://doi-org.ezp.waldenulibrary.org/10.1093/bjsw/bcw150

Weitz, R. (2015). Vulnerable warriors: Military women, military culture, and fear of rape. *Gend. Issues* **32,** 164–183 https://doi.org/10.1007/s12147-015-9137-2

Wolff, K. B., & Mills, P. D. (2016). Reporting military sexual trauma: A mixed-methods study of women veterans' experiences who served from World War II to the war in Afghanistan. *Military Medicine*, *181*(8), 840–848. https://doi-org.ezp.waldenulibrary.org/10.7205/MILMED-D-15-00404

Yalch, M. M., Hebenstreit, C. L., & Maguen, S. (2018). Influence of military sexual assault and other military stressors on substance use disorder and PTS symptomology in female military veterans. *Addictive Behaviors*, *80*, 28–33. https://doi-org.ezp.waldenulibrary.org/10.1016/j.addbeh.2017.12.026

Yin, R., K. (2009). *Case study research*. Design and methods 4th ed. Sage Publications Inc. Thousand Oaks, CA.

Zinzow, H. M., Grubaugh, A. L., Monnier, J., Suffoletta-Maierle, S., & Frueh, B. C. (2007). Trauma among female veterans: A critical review. Trauma, Violence, & Abuse, 8(4), 384–400. doi:10.1177/1524838007307295

Zurbriggen, E. L. (2005). Lies in a time of threat: betrayal blindness and the 2004 U.S. Presidential Election. *Analyses of Social Issues & Public Policy*, *5*(1), 189–196. https://doi-org.ezp.waldenulibrary.org/10.1111/j.1530-2415.2005.00064.x

Appendix A: Interview Questions

Introduction: *Hello, my name is Natasha Blue, and I am a doctoral student at Walden University. I would like to thank you again for volunteering your time to be part of this study to share your experiences. I would also like to personally thank you for your service. I am conducting research on help-seeking behaviors for coping and improvement of quality of life among male veteran survivors of military sexual trauma/assault. The purpose of this research is to understand the male survivor's decision making in with reporting and help-seeking behaviors for coping with the trauma and the improvement of their quality of life.*

Instructions: *Your participation is in this interview is voluntary and you are under no pressure to complete it. If you chose to discontinue the interview, pause for a break, or reschedule, you may do so at any time. No questions asked! You were provided with a consent form via email of your agreement for participation in this interview: do you still consent? Thank you. This interview will be voice recorded and the information will be kept anonymous and under my care. The audio recording will be destroyed immediately after the research dissertation is published. You will be provided with a numeric identifier to protect your identity. This interview will last between 45 – 60 minutes or longer if needed. I will also be taking minor notes during the interview and the recorded transcript will be sent to you for your verification. Do you have any questions? Are you ready to begin? Thank you! I will now begin recording.*

Begin the Recording

Ice Breaker: I am going to ask a few demographic questions:

1 How long have you been a veteran?
   a. What is your age range?
   b. 18-25 years old
   c. 22-35 years old
   d. 36-45 years old
   e. 46 – 55 years old
   f. 56 – 65 years old
   g. What is your race/ethnicity?
   h. What is your highest level of education?
   i. What is your work Status?
   j. What is your marital status?

Interview Questions:

Primary research question: RQ1: What are the help-seeking experiences of male veteran survivors of military sexual trauma who were active duty and between the ages 18 -65 years old at the time of the assault?

Will be answered by the following questions.

   k. What branch did you join?
   l. Why did you join that specific branch?
   m. What was your initial experience in the military like?

n. Did you feel a sense of belonging and camaraderie?
o. Please describe your experiences with reporting and seeking help.
p. Did you seek help while on active duty? If yes, please explain.
q. Are you currently seeking help? If yes, please explain.
r. Please explain why you did not or are not currently seeking help.
s. How many times did you think about seeking help before you did or did not?

Sub-Research Question 1: What are the barriers that impede on male veteran military sexual trauma survivor's decision to not report or seek help for the effects of the experience?

t. Please explain if you encountered barriers seeking help.
u. Tell me about that experience related to barriers.
v. Do you think as a male survivor you experience the same barriers seeking help as female victims? Please explain.
w. What are some barriers you faced seeking help while on active duty and as a veteran?
x. How comfortable are you with discussing your experience with a health care provider?

Sub-Research Question 2: What avoidant coping mechanisms do male veteran military sexual assault victims use to cope with the effects of the assault and the impact it has on their quality of life?

2 How have you coped or coping with the experience?
   a. What coping mechanisms do you currently use?
   b. How do the coping mechanism help?
   c. Is/are the coping mechanisms something you established on your own, or were they tools provided by a health care professional?
   d. Do you feel this coping strategy/mechanisms help?

Sub- Research Question 3: How do male veterans who have experienced military sexual trauma describe their military experience and their current quality of life?

2. Describe your overall military experience and your current quality of life
   a. Do you experience psychological effects, i.e., PTSD or depression because of your traumatic experience?
3. How has your lifestyle changed? Describe what it was like before and what it's like now.
4. How do you feel about who you are now compared to who you were before joining the military?
5. Is there anything you would like to add?

Thank again for participating in the study and sharing your experiences related to military sexual trauma. Is there anything else you would like to share or add? This concludes the interview.

Appendix B: Recurring Codes

Appendix B

This table displays a few of the recurring codes I used and examples of the participant's statements that fell under each code. The codes were then used to formulate the themes.

Code	Statement
Shame and guilt	"I have attempted doing something to myself 2-3 times "I was ashamed and did not know how to discuss what happened" "I told someone I was assaulted, and they blew me off I had mix feelings because it was done by a female"
Personal barrier	"I did not realized what was wrong with me. I moved out and got my own apartment for self-isolation" "I showed up to work drunk no one said anything as long long as I did my job" "It was a struggle for me to open up"
Fear	"Fear of the backlash of what could happen. I knew knew a female who reported, and she was told that was the type of person she is" "It made me feel like bad to that that somebody would not take my word and believe me because of the circumstance female on male"
Seeking help	"It was difficult navigating through the culture. Much blow back from chain of command and there were no women" "I had mixed emotions about it, but I really did not say anything because it was tradition" "I thought about seeking help but felt that if I was not going to physically fight. I needed to let it go"
Hostile work environment	"After my leg healed, I thought I could go back to work but my sergeant told everyone, and I was ostracized, called names, hazed" "After the incident, she would still come around"

(table continued)

Discarded	Due to the way I was treated and discharged, my level of comfort is triggered" "My 1st Sargeant called me a disease" I asked for therapy and I was denied"
Labelled	"I was fucked by another dude and labeled just another faggot" "Yes, people would think if I tell, I'm queer or weak"
Disassociate	" I play the Jetsons song on y head to disassociate From the experience" "I tried to block the experience to try to believe it did not exist" " I also coped by recusing myself by not speaking to anyone"
Risky behavior	"I had destructive behavior, infidelity, not coming home partying, looking for love in wrong places" "I was drinking while on active duty" I showed up drunk and no one said anything. As long as I did my job" "Alcohol, women fast cars, driving fast white knuckling"
Violent	"I dealt with the trauma by doing the only thing I knew to do by repeating what I was taught which was fighting and drinking" "It stirred up because of a scrimmage my wife and I had a disagreement, and she blocked the door and I pushed her. It was not malice it was in self-defense. I saw evil eyes I saw she was becoming combative, and to me I saw her as a threat and I pushed her and she broke her tailbone"
Inadequate leadership	"The people could not be trusted. You would not get the proper or the necessary treatment you need for that particular thing that was going on" "I was told, you just got in and now you are "committing highway robbery" "Leaders were aware but they turned their heads to what was occurring"
Trauma	"I woke up with my jeans zipped down and found this guy sizing me up and I was like dude, what the fuck!"
Ostracized	"After my leg was healed, I thought I could go back I could go back to work, but the Sergeant told everyone and I was ostracized, called names"

(table cont'd)

Degraded	My 1st Sergeant called me a disease in front of peers" "he told the group that if anyone is caught talking to Me, they would be in trouble"
Ignored	"When I reported to Sergeant Major, this is like the second or third person in the command of the whole command"
Revictimized	"When we came to and got back my sergeant on duty asked what was wrong with you? Did you get raped or something in a sarcastic way. I said yes. The sergeant laughed and the San Diego DA dropped the case"
Angry	"This fool literally said because I was way bigger and way stronger. You're big and intimidating. You're 250lbs it's hard to believe that these guys can do this to you"