2019

Military Sexual Trauma Survivors' Experiences and Perceptions of Cognitive Processing Therapy

Sally A. Mead
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Sally Mead

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. Debora Rice, Committee Chairperson, Social Work Faculty
Dr. Jeanna Jacobsen, Committee Member, Social Work Faculty
Dr. Cynthia Davis, University Reviewer, Social Work Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

Military Sexual Trauma Survivors' Experiences and Perceptions of Cognitive Processing Therapy

by

Sally A. Mead

MSW, University of Houston, 1990

BA, Brigham Young University, 1983

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

August 2019

Abstract

Military sexual trauma (MST) has been associated with poor emotional and psychological well-being, less overall life satisfaction, and poorer health in general as well as higher rates of posttraumatic stress disorder (PTSD). The Department of Veterans Affairs provides treatment for veterans who experienced MST and recommends cognitive processing therapy (CPT) as a preferred treatment modality. Quantitative studies have shown that CPT can decrease symptoms of PTSD; however, a neglected area of study concerns the experiences of veterans who receive CPT for MST-related PTSD. In this generic qualitative study, the perceptions and experiences of female veterans who were survivors of MST and received CPT from a VA provider through a feminist lens were explored. Twenty-one female veterans who were survivors of MST and who sought treatment at the VA and received CPT were asked to complete a written questionnaire. The research questions explored the participants' experiences with CPT, changes in their symptoms, social lives and relationships, and general functioning and well-being after receiving CPT. Thematic analysis was used to identify 3 themes. Findings revealed that although participants described their experience of deciding whether to participate in CPT and receiving CPT as difficult, they reported increased quality of life and improved well-being after CPT. The results from this study will increase understanding of the experiences of veterans with CPT. Finally, scholar practitioners may be able to use findings from this study to enhance awareness of perceptions of clients, improve practice, and better serve clients who have experienced MST.

Military Sexual Trauma Survivors' Experiences and Perceptions of Cognitive Processing Therapy

by

Sally A. Mead

MSW, University of Houston, 1990

BA, Brigham Young University, 1983

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

August 2019

Dedication

I dedicate this study to our brave and honorable United States military members and veterans who risked their lives to serve our country and fight for our freedom. Thank you for your service.

Acknowledgments

My sincere thanks are extended to Dr. Debora Rice, my chairperson for this project. I asked her many questions, expressed my frustrations often, and even argued with her about the purpose of the study yet she persisted and encouraged me to continue. I appreciate Dr. Pablo Arriaza who, before he left Walden University, told me how to narrow down my topic and suggested that this research project did not have to be my life's work. Finally, I thank my mother, Ann Brown, who tolerated spending time alone so that I could work on this project.

Table of Contents

List of Tables

Section 1: Foundation of the Study and Literature Review

Military sexual trauma (MST) has been described as a psychological trauma which results from sexual harassment, unwanted physical contact of a sexual nature, or rape that took place while an individual was serving in the military (Suris & Smith, 2013). Researchers have proposed varying definitions of MST and have focused primarily on women who experienced MST rather than on male victims (Suris & Smith, 2013). The United States Department of Veterans Affairs (2015) has defined MST as aggressive sexual provocation or assault that transpired while the victim was an active member of the armed forces. Just as sexual assault in mainstream society has been downplayed or overlooked, MST has been ignored (Allard, Nunnick, Gregory, Klest, & Platt, 2011). The Department of Veterans Affairs (2015) reported that one of four women experience MST. Poor emotional and psychological well-being, less overall life satisfaction, and poorer health in general as well as higher rates of posttraumatic stress disorder (PTSD) have been linked to MST (Katz, 2016). It is estimated that as many as 45.9% of women and 65% of men who experience military sexual trauma are diagnosed with PTSD, which represents greater numbers than those with combat-related trauma (Knoedel, 2014; Voelkel, Pukay-Martin, Walter, & Chard, 2015).

In 1991, at a Naval Convention called the "Tailhook" convention, a scandal broke out when over 80 enlisted servicemen and women reported inappropriate sexual advances ranging from harassment to sexual assault made by superior officers (Suris & Smith, 2013). The negative attention surrounding this event resulted in increased public awareness and a congressional law, Public Law 102.585, which defined MST and began

a series of laws and guidelines for reporting, prosecuting, and treating survivors and perpetrators (Department of Veterans Affairs, 2015). Public awareness coupled with more veterans coming forward and reporting their assaults as well as pressure from Congress impelled the VA to open programs specifically for the treatment of MST. Cognitive processing therapy (CPT) was already in wide-spread use for treatment of combat trauma making it a ready choice.

Originally developed by Resick and Schnicke (1993), CPT is a protocol for treating PTSD in civilians who experienced sexual assault. CPT has proven to be effective for reducing symptoms of posttraumatic stress after experiencing other types of trauma, such as combat, childhood abuse, or civilian sexual trauma (Resick & Schnicke, 1993). CPT is grounded on a social cognitive theory of PTSD and centers on how a person adapts or assigns significance to a traumatic event (Monson et al., 2006). The Department of Veterans' Affairs and the International Society for Traumatic Stress Studies Practice affirmed cognitive processing therapy as an evidence-based practice in recent years citing it as an efficacious treatment (Suris, Link-Malcolm, Chard, Ahn, & North, 2013; Williams, Galovski, Kattar, & Resick, 2011). The assumption has been made that since CPT has demonstrated a reduction of symptoms of PTSD in clients who were survivors of sexual assault as well as with veterans with combat-related trauma, it would also be successful in helping MST survivors. (Department of Veterans Affairs, 2015). In fact, research on this treatment modality with MST survivors has been scarce (Allard, Nunnink, Gregory, Klest, & Platt, 2011; Suris et al., 2013; Voelkel et al., 2015).

Provision of health care and mental health counseling was mandated in 1992 for individuals who had experienced MST (Katz, 2016; U.S. Department of Veterans Affairs, 2015). As awareness of the continued occurrences of MST increased, mental health care professionals began to seek practice-based evidence for the most effective treatment for the deleterious effects of experiencing MST (Katz, 2016; Kelly, Skelton, Patel, & Bradley, 2011). The U.S. Department of Veterans Affairs has continued to provide its mental health providers with training and supervision in cognitive processing therapy, which is sanctioned as an evidence-based practice for intervention with veterans living with PTSD secondary to military-related trauma (Department of Veterans Affairs, 2015). Despite the movement toward evidence-based practice, research that is distinctively aimed at determining the level of impact that CPT has in reducing trauma symptoms for MST survivors is insufficient (Allard et al., 2011; Suris et al., 2013; Williams, et al., 2011).

The institution of the military has its own unique culture which has a far-reaching influence in the lives of its members. The military becomes a member's workplace, family, social life, and community. Military culture is composed of many features such as a shared objective, formal and informal rules and values, a fixed power structure, and a rigid disciplinary code that governs every activity of its members' lives (Coll, Weiss, & Yarvis, 2011). A prominent distinctive characteristic of the military is that its chief objective or mission is to risk life and limb to protect our nation and our freedom, even foregoing one's own self-interests for that of the greater good (Wilson, 2008). Since

military culture is, by definition, linked with violence and masculinity, sexual aggression is a consistent repercussion (Callahan, 2009).

Barrett (1996) suggested that military culture is hyper-masculine and therefore, promotes and emphasizes traditional male roles. This extreme masculinity which pervades the military is based on championing of stereotypical gender roles and formidable esteem placed on control, competition, power, pain tolerance, and compulsory heterosexuality (Turchik & Wilson, 2010). While these hyper-masculine traits of the military institution may serve a purpose in promoting toughness and aggression, status and achievement, and control over others, they also propagate sexual violence (Burns, Grindlay, Holt, Manski, & Grossman, 2014). The singular culture of the military promotes aggression, restricted emotionality, and sexual brutality (Burns et al., 2014). Due to the exclusive culture of the military, scholar-practitioners have long regarded a sexual trauma occurring in the military as markedly different from any other form of sexual trauma (Kelly et al., 2011; Zaleski, 2015). Enlisted individuals are burdened with a high risk of punishment, disbelief, and retaliation should they dare to tell anyone about their trauma (Caplan, 2013; Gillibrand, 2013; Northcut & Kienow, 2014). While civilians who experience sexual trauma may encounter disbelief when reporting assault, military members may face punishment, such as demotion or discharge, or retaliation in terms of negative treatment by fellow members (Burns et al., 2013; Dinneen, 2015; Grassbaugh, 2014).

MST is known to cause a host of adverse issues such as decline of mental health, physical health, and social functioning (Baltrushes & Karnik, 2013). Survivors of MST

are more often diagnosed with PTSD, depression, and anxiety than other trauma survivors (Bell, Street, & Stafford, 2014). While CPT is considered an evidence-based practice in the treatment of psychological consequences of experiencing trauma, many differences exist between the experience of MST in comparison to other traumatic experiences which gives impetus to conducting research into survivors' perceptions of CPT for reducing trauma symptoms, specifically in military sexual trauma survivors (Allard et al., 2011; Kelly et al., 2011; Suris et al., 2013).

The overall project consists of four sections including literature review and study foundation, research design and data collection, presentation of findings and finally, application for practice and impact on social change. In Section 1, the study is introduced through problem and purpose statements, significance and theoretical framework, and review of the literature. In Section 2, research design, methodology, and data analysis are explained. Section 3 covers data analysis techniques and findings. The findings are summarized in Section 4 regarding their application to professional practice, recommendations for social work practices, and implications for social change.

Problem Statement

Research has established that MST results in detrimental repercussions for survivors (Katz, 2016) and a few studies have evaluated the effectiveness of being treated with the approaches most often used for MST-related PTSD. The Department of Veterans Affairs (2015) confirmed CPT as an evidence-based practice for the treatment of PTSD. Studies have concluded that CPT is effective for treating PTSD; however, scholar-practitioners have indicated that MST-related PTSD may be incomparable due to the

unique culture of the military and the betrayal trauma that results (Chard, Ricksecker, Healy, Karlin, & Resick, 2012). Betrayal trauma occurs when a person upon whom a person depends, even for survival, or to whom they are significantly attached, violates the trust in a critical way. Childhood physical or sexual abuse perpetrated by a parent or caregiver and MST are examples of betrayal traumas. Studies that explore the perceptions of veterans with MST-related PTSD who received CPT at a veteran's affair (VA) facility are needed to look beyond the scores on a PTSD standardized test and into the lived experiences of this population.

A few studies have explored CPT for MST-related PTSD compared to other interventions, such as person-centered therapy, and found that scores on scales that measure symptoms of PTSD or depression drop more significantly after CPT than other treatment modalities (Voelkel et al., 2015). However, research is needed to elucidate the experience of receiving CPT specifically in treating MST-related PTSD compared to treatment of PTSD secondary to other traumatic experiences and to explore the perspectives of MST survivors who receive CPT. Social workers provide services at Vet Centers and other VA facilities to treat veterans who are living with PTSD, related to combat trauma or MST. The Department of Veterans Affairs (2015) provides training in CPT and encourages its mental health professionals to use it in treating veterans who have PTSD. Due to the dearth of research on the experience of receiving CPT for treatment of MST-related PTSD, I proposed a generic qualitative study to explore survivors' perceptions of CPT with MST-related PTSD.

The scope of the problem is far reaching as poor emotional and psychological well-being, less overall life satisfaction, and poorer health in general as well as higher rates of PTSD has been linked to MST (Katz, 2016). The VA reported that one in four women experience MST (Department of the VA, 2015). It is estimated that as many as 45.9% of women and 65% of men who experience military sexual trauma are diagnosed with PTSD, which represents greater numbers than those with combat-related trauma (Knoedel, 2014; Voelkel et al., 2015).

Purpose Statement

The purpose of this generic qualitative study was to explore the experiences of MST survivors who received CPT for treatment of their trauma. Participants were female veterans of the United States military who reported having experienced MST and who received CPT from a VA provider. I collected written responses to questions from study participants to gain an understanding of their perceptions of the impact of CPT on their lives.

The Department of Veterans Affairs began to offer free treatment for survivors of MST in 1992 after a senate veteran affairs committee mandated it (Reisman, 2016). The VA was already using CPT to treat combat-related PTSD and since CPT was originally developed to treat civilian sexual trauma, it was quickly adopted as a first-line approach for the treatment of MST (Holliday, Link-Malcolm, Morris, & Suris, 2014). Scholar practitioners have conducted quantitative studies to examine the effectiveness of CPT in reducing symptoms of PTSD and other mental health disorders with MST survivors, concluding that it is effective (Reisman, 2016). Qualitative studies that explore MST

survivors' perceptions and experiences with CPT, however, are lacking. It is important to study the perceptions of veterans with MST-related PTSD who receive CPT to inform treatment and to enhance informed consent by providing information about what others have perceived as strengths or limitations of CPT.

This study explored the perspectives of survivors of MST who have been treated with CPT. The purpose of this study was to guide and inform practitioners in providing the treatment approach to MST survivors that has the most positive impact of these survivor's lives from their own perspective, or at a minimum, to improve informed consent by offering the strengths and limitations of CPT experienced by others.

Research Questions

RQ1: What are the experiences of CPT as a treatment modality for female veterans with MST-related PTSD?

RQ2: What do female veterans with MST- related PTSD perceive as strengths, and or ineffectual, or potentially damaging aspects of CPT?

RQ3: What changes do female veterans with MST-related PTSD perceive in their experience of life, relationships, thoughts, and symptoms after receiving CPT?

Nature of the Doctoral Project

I proposed a generic qualitative study design, questioning MST survivors in the Southwest about their experiences with CPT. A generic qualitative study approach focuses on answering the how and why questions about the experiences that MST survivors have in receiving CPT. This approach also addresses the contextual conditions, such as MST-related PTSD, as compared to CPT for other types of trauma, which may be

relevant to the perceptions of these survivors (Creswell & Poth, 2018). Twenty-one female veterans who reported having experienced MST and who have been treated with CPT by a VA provider responded to written questions and submitted their responses to me. Although MST among male and transgender veterans occurs and is thought to be vastly underreported, this study focused on cis-gender female veterans (see Department of Veterans Affairs, 2015). Additional dynamics surrounding masculinity and stigma, as well as other considerations, add complexity to exploring the treatment experience of male or transgender veterans and therefore, this research would be better served in a separate study. Recruitment emails were sent to non-VA programs where CPT is offered. Flyers were mailed to these centers announcing the study and seeking participants. Additional emails were sent to CPT providers listed in the national CPT provider directory asking that the project be posted in their workplace and shared with their MST clients. Veteran service organizations and social media were also used to announce the study and recruit potential participants. Veterans who expressed interest in participating received a more detailed description of the project. After the participants were selected and provided informed consent, they each received the questionnaire and could choose whether to answer the questions and mail the responses to me or respond by email.

The data collected was exploratory in nature and sought to identify meaning and constructs which emerged from the participants' experiences. Each response of the participants was reviewed and coded looking for common themes and concepts related to the participants' experiences with CPT. Participants' responses were grouped into coding clusters and then descriptions were composed. All codes were placed on a code

spreadsheet and meanings were abstracted from the emerging themes (see Tashakkori & Teddlie, 2003).

Significance of the Study

It is estimated that as many of 45.9% of women and 65% of men who experience MST are diagnosed with PTSD, which represents greater numbers than those with combat-related trauma (Knoedel, 2014; Voelkel et al., 2015). CPT has proven to be effective for reducing symptoms of PTSD after experiencing other types of trauma (Resick & Schnicke, 1993). The Department of Veterans' Affairs and the International Society for Traumatic Stress Studies Practice affirmed CPT as an evidence-based practice in recent years citing it as an efficacious treatment (Suris et al., 2013; Williams et al., 2011).

The assumption has been made that since CPT has demonstrated a reduction of symptoms of PTSD in civilians who were survivors of sexual assault as well as with veterans with combat-related trauma, it would also be successful in helping MST survivors (Department of Veterans Affairs, 2015). In fact, research on this treatment modality with this specific client population has been scarce (Allard et al., 2011; Suris et al., 2013; Voelkel et al., 2015). As awareness of the continued occurrences of MST increased, mental health providers began to seek practice-based evidence for the most effective treatment for the deleterious effects of experiencing MST (Katz, 2016; Skelton, Patel, & Bradley, 2011). The search for effective treatment approaches, however, has not explored the experiences of clients who receive the treatment to elucidate the strengths and limitations of a modality.

The study may be significant in its potential to help agencies determine strengths and limitations of CPT for working with individuals with MST. Agency administration may learn how veterans with MST-related PTSD experience CPT. Agency staff may gain a better understanding of how CPT is perceived by veterans with MST-related PTSD which may assist them in selecting a treatment approach and enhance the information they share with a client when seeking to obtain informed consent. The study's findings will demonstrate MST survivors' perceptions of CPT. The study will provide insight for social workers to enable them to provide better and more client-informed treatment. The findings of the study may provide social workers with what they need to know about a survivor's experience in treatment to aid them in improving services to this population.

Mental health professionals within the Department of Veterans Affairs alone provide services for more than 1.6 million veterans who have experienced military sexual trauma (Department of Veterans Affairs, 2015). The Department of Veterans Affairs (2015) has recommended the provision of cognitive processing therapy as an evidence-based practice for all veterans who seek help for posttraumatic stress symptoms due to traumatic experiences of any kind. Scholar practitioners have an ethical obligation to establish practice-based evidence to support the effectiveness of cognitive processing therapy in treating survivors of military sexual trauma (Chard et al., 2012). Social workers have an obligation to explore beyond treatment effectiveness and inquire into the lived experiences of veterans with MST-related PTSD who turn to the VA, a branch of the same institution that traumatized them, for help and recovery. By researching how veterans with MST-related PTSD perceive CPT, an EBP for PTSD according to the VA, I

increase my understanding of the experiences of these veterans. By publishing the research, the community of VA trauma treatment providers will gain increased understanding, which scholar practitioners are obligated to apply to treatment approaches, our skills, our goal of creating a safe and trusted environment to help our veterans, and our role as advocates for those who are survivors of MST. This project has the potential to bring about positive social change for veterans with MST-related PTSD, their families, and the treatment community through its research, publication, and dissemination of information designed to increase understanding of how this population experiences CPT which the VA has designated as an evidence-based approach.

Theoretical Perspective/ Conceptual Framework

To gain a better understanding of the experience of CPT for treatment of MST from the perspective of the veteran survivors, I used general feminist theory. Feminist theorists postulate that a patriarchal society exists in which gender and power inequality, objectification; especially sexual objectification, oppression, and discrimination are pandemic and often even condoned (Richmond, Geiger, & Reed, 2013). When applied to the issues of providing treatment for survivors of MST, feminist theory supports the idea that sexual violence occurs in general, and particularly in the military, due to societal attitudes of male dominance and adversarial, oppressive beliefs toward women (see Katz, Cojucar, Beheshti, Nakamura, & Murray, 2012). Since gender roles are socially constructed, women experience subordination in every societal institution, intersected with racism, heterosexism, and oppression based on class, ethnicity, and age (Ryan, 2011).

CPT is based on the premise that when a person experiences a traumatic event, their view of self, others, and the world are significantly altered resulting in cognitive distortions (Monson et al., 2006). This therapeutic approach guides the client toward changing their altered negative cognitions about safety, trust, esteem, power, and intimacy. Feminist theory views cognitions regarding self, others, and the world as having been already distorted by social learning that is constructed and dominated by women's roles in society and men's assumptions (Richmond et al., 2013). By examining the use of CPT, one of the primary treatment approaches used to treat combat trauma, with people who have experienced MST from a feminist theory perspective, I gained understanding of MST survivors' experiences with CPT. A feminist theory-informed understanding encompasses the broad societal assumptions about the roles of men and women as well as the roles of military men and women, providing context for the occurrences of MST.

Feminist Theory

According to Brown (2004), feminist theory relocated the issue of violence against women from its place as a problem arising from within the individual to a result of a misogynistic society which enacted its dominance through patriarchy's actions. Since the theoretical framework in a study is the lens through which the research questions are investigated, it helped me determine what the exploration explains and how it accomplishes the task. For instance, it guided how the questions were phrased and acknowledged that participants may have been conflicted between the values and ideas prevalent in the male-dominant society and personal experiences. In keeping with a

general feminist lens, I listened beyond the answers to the research questions to hear any struggles between self-concept and societal norms as well as what is not stated to attend to the meaning of the participants' experiences (see Postmus, 2013). Feminist theory uses a constructivist approach to understand the individual (Brown, 2004). Everyone creates knowledge and reality through their own personal life experiences and therefore, the sociological, political, and cultural influences that inform the individual's experience must be considered to gain an understanding of that individual's worldview (Webster & Dunn, 2005).

Research conducted from a feminist paradigm focuses on women's, as well as other marginalized groups, experiences of oppression, discrimination, powerlessness, and limitations that are due to gender and role stereotyping (Turchik & Wilson, 2010). Sexual assault has been considered by feminist theorists to be a mechanism for advancing male domination and control as well as reinforcing subordination (Donat & D'Emilio, 1992). Sexual assault that occurs in the military exists in a setting with its own unique culture. MST has the added complexity of taking place in the context of an environment that has historically prospered with a highly definitive patriarchal structure (Mattocks, Haskell, Krebs, Justice, & Yano, 2012). Military culture is directed by rank structure or superior/subordinate roles, paternalistic values, and a top-down organization (Valente, 2007). By using a feminist theory perspective to examine the experiences of CPT, one of the primary treatment approaches used to treat combat trauma with people who have survived MST, I gained understanding of how power, subordination, and inequality are reflected in the MST survivors' experiences with CPT. CPT is based on the premise that

when a person experiences a traumatic event, his or her view of self, others, and the world are significantly altered resulting in cognitive distortions (Monson et al., 2006). This therapeutic approach guides the client toward changing their altered negative cognitions about safety, trust, esteem, power, and intimacy. Feminist theorists view cognitions regarding self, others, and the world as having been already distorted by social learning that is constructed and dominated by women's roles in society and men's assumptions (Richmond et al., 2013). A feminist theory-informed understanding encompasses the broad societal assumptions about the roles of men and women as well as the roles of military men and women, providing context for the occurrences of MST. The review of the literature included in a later section revealed that survivors of MST experienced many, if not all, of the concerns considered by feminist theory (Vanburen, 2016). Therefore, feminist theory was an appropriate paradigm to guide this inquiry.

Values and Ethics

The values and ethics of the social work profession in evaluation and research were respected in this study. The first ethical consideration was that the research must enhance the participants' well-being and do no harm (National Association of Social Workers [NASW] Code of Ethics, 5.02, d and k, 2017). Through a feminist lens, there are a few challenges inherent in collecting responses to questionnaires with veterans who have MST-related PTSD. Reinharz and Chase (2002) pointed out that while all women's experiences are gendered, no two women's experiences are perfectly identical. A feminist researcher must listen to what participants say as well as to what remains unsaid. A researcher inquiring about the experiences of women who have MST-related PTSD must

be careful to attend to safety, building trust and rapport, and ensuring that resources are available to participants since she holds the power to interpret their stories and to do no harm. Research conducted from a feminist perspective must bear in mind that women's perspectives are likely to be entangled in a worldview that reflects a male-dominant cultural position warring with her own personal experiences (Anderson & Jack, 1991). Doing no harm when asking participants to talk about a triggering topic that carries the potential to retraumatize requires conscientious attention to safety, provision of services after the questionnaires are completed, and a commitment to disseminate the information discovered for eliciting positive social change.

Secondly, the research participants were informed about the research and gave their voluntary consent before becoming study participants (NASW Code of Ethics, 5.02, e, g, and h, 2017). Informed consent, in this study, included reassurance that a participant's private health information would be kept confidential and that her name or other identifying information would not be used. She was informed that counseling services will be available to her as well as how the information gathered in the study would be used, which would include publication of the findings without identifying information to enact positive change.

Finally, the research participants would have their privacy protected, the opportunity to withdraw from the study, and their well-being monitored throughout the study (National Association of Social Workers Code of Ethics, 5.02, i. and j, 2017). I had planned to create safety and trust during the interviews by validating participants' concerns about the stigma of receiving mental health services, about confidentiality, and

the potential for retraumatization. The change in data collection methodology from interviews to written questionnaires will be addressed in Section 3 in terms of how the concern for participants safety and confidentially were protected. Participants were made aware that they could withdraw from the study at any time and that supportive services would be available during and after the project.

The values of social work are evident in the purpose of this project as experiences receiving CPT were explored, and each participant was informed about the research and given the opportunity to participate voluntarily. Each participant's privacy was respected and withdrawal from the study was voluntary. This project fully supports that NASW Code of Ethics in that the well-being of each participant was paramount. The findings of this study fully support social work values since the quality, appropriateness, and overall experience of the treatment provided to survivors of MST are more fully understood (NASW, 2008).

Review of the Professional and Academic Literature

The strategy employed to search literature and relevant documents addressing MST and CPT included using key words such as *MST, sexual trauma, PTSD, CPT, cognitive-behavioral therapy,* and *feminist theory*. The information gathered was organized into categories and was collected from, although not limited to, the following databases and resources: APA database and resources, dissertations and theses database at Walden University, SAGE publications database, PsychARTICLES, PsychINFO, the U.S. Department of Veterans Affairs, and Google Scholar.

In this section, literature pertaining to MST, CPT, treatment modalities for trauma, MST as compared to other types of trauma, and CPT for MST, each viewed through a feminist paradigm lens, are reviewed.

CPT

Originally developed by Resick and Schnicke (1993), CPT is a protocol for treating PTSD in civilians who have experienced sexual assault. Literature to date that demonstrates the effectiveness of CPT in treating survivors of civilian sexual assault is abundant (Resick & Schnicke, 1990, 1992,1996; Shields, Resick, & Hanneke, 1990). In 1992, Resick and Schnicke used the Structured Clinical Interview for DSM (SCID: First, Gibbon, Spitzer, & Williams, 1996), the Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) and the Symptom Checklist- 90-Revised (SCL-90-R: Derogatis & Unger, 2010), to evaluate participants pre- and post-CPT, finding that PTSD and depression both improved significantly after CPT. The Clinician Administered PTSD Scale (CAPS: Blake et al., 1990), the Posttraumatic Stress Symptom Scale (PSS, Foa, Riggs, Dancu, & Rothbaum, 1995) and BDI were used to evaluate the effectiveness of CPT in female, civilian rape survivors and found that levels of symptoms of PTSD, depression, and guilt reduced significantly after the participants received CPT (Resick, Nishith, Weaver, Astin, & Feuer, 2002); Shields et al. (1990) conducted a study specifically with survivors of marital rape and found that depression and PTSD decreased significantly after CPT was provided. CPT has been quantitatively researched and demonstrates effectiveness in decreasing symptoms of PTSD and depression in civilian survivors of sexual assault.

CPT is grounded on a social cognitive theory of PTSD and centers on how a person adapts or assigns significance to a traumatic event (Monson et al., 2006). CPT is a predominately cognitive therapy which treats individuals with PTSD and related symptoms, such as depression, anxiety, and guilt (Chard et al., 2012). The protocol is based on the theory that people sometimes do not recover from traumatic experiences because they draw faulty conclusions about the causes and the meanings of the events and this results in their becoming *"stuck"* with their symptoms (Resick, 2015 p. 18). CPT consists of 12 sessions which are delivered in a manualized format, usually weekly or biweekly. In the first four sessions, clients are asked to write impact statements exploring the meaning of their traumatic experiences, why they think the circumstance occurred, and how the event has molded their understanding of themselves, others, and the world (Schumm, Dickstein, Walters, Owens, & Chard, 2015). During this exploration of the client's beliefs related to the trauma, five areas of focus are maintained, including safety, trust, power and control, self-esteem, and intimacy (Resick & Schnicke, 1996). According to Ehlers and Clark (2000), these areas are the most significantly impacted by a traumatic experience. CPT, a treatment protocol originally intended to treat the sequelae of sexual trauma in civilians, has been effective in treating a variety of traumatic experiences, focusing on negative cognitions which arise from the survivor's attempts to process or make sense of the trauma.

Following the completion of the impact statement, clients are educated in the connection between events, thoughts, and feelings using homework assignments and are assisted by the therapist to begin to identify places where

they have become stuck in their thinking. The client begins to identify these *stuck points* and how they relate to safety, trust, power/control, esteem, and intimacy (Sobel, Resick, & Rabalais, 2009). Iverson, King, Cunningham, and Resick (2014) reported that traumatic experiences lead to cognitive distortions which are, in turn, accommodated, assimilated, or even overaccommodated as the individual attempts to reconcile the experience with their previously held beliefs. Accommodation is altering one's beliefs to incorporate the new information acquired from experiencing the traumatic event. For example, "I made a bad decision to go out drinking with the guys. Most of the time I make good decisions." Altering the new incoming information to match prior beliefs after a traumatic event is assimilation. An example of assimilation is thinking, "A bad thing happened to me, so I must be bad, and I am being punished." Finally, overaccommodation involves changing one's beliefs about oneself, others, and the world to the extreme to feel safer and in control. "All people are evil and dangerous. I can never trust my own judgement," are examples of overaccommodation. These cognitive distortions act to maintain and even increase PTSD symptoms, primarily by compelling avoidance behaviors which interfere with recovery (O'Donnell, Elliott, Wolfgang, & Creamer, 2011).

CPT strives to aid trauma survivors in modifying dysfunctional cognitions to achieve a reduction in symptoms of PTSD. Based on social cognitive and information processing theoretical frameworks, CPT works toward a reduction of distorted cognitions that are associated with emotional distress and intrusive symptoms which will lead to a

subsequent decrease in PTSD symptoms (Dalgleish, 2004). A strength of CPT is the introduction period before a therapist starts CPT with a client allowing the client to build rapport and needed trust with the therapist. The therapist will offer as many sessions as needed to answer questions for the client before beginning CPT. The use of Socratic questioning to facilitate cognitive restructuring, leading to increased trust and self-confidence, and decreased feelings of shame and depression is also a strength of CPT (Resick, Monson, & Chard, 2017).

CPT and Trauma

After the effectiveness of CPT in reducing PTSD symptoms in survivors of civilian sexual assault was validated, researchers delved into other types of trauma, inquiring about its effectiveness with these survivors. Scholar practitioners have provided extensive studies on the efficacy of CPT for reducing the symptoms of PTSD in individuals who have experienced combat trauma in the military (Castillo, Lacefield, C'deBaca, Blankenship, & Qualls, 2014; Chard et al., 2012; Department of Veterans Affairs, 2015; Voelkel et al., 2015). In 2008, Resick et al. published findings from a randomized clinical trial to evaluate the efficacy of CPT for PTSD in female victims of interpersonal violence which demonstrated a significant reduction in symptoms of PTSD, depression, anxiety, shame and guilt, and dysfunctional cognitions. The researchers used the CAPS (Blake et al., 1990), the SCID (First, Gibbon, Spitzer, & Williams, 1996), the BDI (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the PSS (Foa, Riggs, Dancu, & Rothbaum, 1995) and other scales to evaluate the participants' symptoms before, during, and after CPT.

Several scholar practitioners have investigated the effectiveness of CPT in reducing PTSD symptoms in survivors of childhood sexual abuse (Owens, Pike, & Chard, 2011; Chard, 2005; Resick, Nishith, & Griffin, 2003). Studies on the use of CPT with traumatized refugees have shown a reduction in symptoms (Marques et al., 2016; Shulz, Huber, & Resick, 2006). All these studies conducted with participants who had been diagnosed with PTSD showed a reduction of symptoms; however, they were limited by not examining symptoms individually but viewing symptoms as a whole. A single subject study used CPT to treat PTSD secondary to motor vehicle accidents with positive outcomes (Galovski & Resick, 2008). Additionally, CPT has been found to be effective in reducing symptoms of PTSD in incarcerated adolescents (Ahrens & Rexford, 2002). Other studies demonstrate the effectiveness of CPT in reducing PTSD symptoms for trauma survivors with co-occurring disorders (Falsetti, Resick, Davis, & Gallagher, 2001). CPT has also been shown to be effective for helping survivors of physical violence (Galovski, Blain, Mott, Elwood, & Houle, 2012; Wachen, Dondanville, Pruiksma, & Resick, 2016).

MST Versus Other Types of Trauma

It is postulated that due to the highly unique culture of the military, the experience of MST is quite different from any other traumatic event (Kelly et al., 2011; Zaleski, 2015). The military can be considered to have a culture of its own since it has values, beliefs, traditions, norms, and perceptions that are fundamentally different and unique to it (Coll, Weiss, & Yarvis, 2011). Individuals who are socialized into the military "family" adopt the core values of honor, courage, integrity, commitment and loyalty (Coll et al.,

2011). There is a deep bonding that transpires, and the system is one of patriarchal hierarchy with a clear social status based on rank (Hall, 2011). Sacrifice of the self for the greater good of the community is paramount (Hall, 2011). This military cultural environment does not lend itself to reporting a sexual assault. Survivors who report are often punished by the system with its higher value on familial structure, the good of the community, hyper-masculinity, and maintaining the appearance of honor among soldiers (Leatherman, 2011). Although reporting a sexual assault has been found to be a step toward healing, the culture and circumstance surrounding military sexual trauma curtail disclosing an assault substantially (Katz, 2016). Additionally, the context in which MST occurs is both the workplace and the social arena for its survivors, making reporting even more risky (Stander & Thomsen, 2016).

Northcut and Kienow (2014) suggested that there are three factors that compound and complicate the experience of MST which they refer to as the "trauma trifecta" (p. 247). The authors postulate that in addition to the negative sequelae of experiencing any trauma, MST survivors face the challenges of loss of identity, both personal and professional, efforts to regain some control through self-harming behaviors, and repeated re-traumatization via having to continue to work side-by-side or under the authority of her perpetrator, not being believed or even being punished when reporting the MST, and then having to seek treatment from the Department of Defense or the VA (Northcut, & Kienow 2013). While each of these challenges may surface for MST survivors, there are also commonalities between MST-related trauma and other types of trauma.

Similarities between the symptoms of MST and other types of trauma include avoidance, intrusive memories, mood and cognition impairments, and functional deterioration (Northcut & Kienow, 2013). Researchers suggest that an MST survivor also must manage loss that extends from their personal to their professional lives, feelings of negative self-worth and betrayal, and re-traumatization (Hyun, Pavao, & Kimerling, 2009; Kimerling, Gima, Smith, Street, & Frayne, 2006; Mattocks et al., 2012; Northcut & Kienow, 2013). Other researchers proposed that the uniqueness of MST-related trauma lies in the fact that MST is not only trauma but is also a personal betrayal trauma as well as an institutional betrayal trauma (Katz, 2014; Smith & Freyd, 2013; Suris, Lind, Kashner, & Borman, 2007)

MST as compared to civilian sexual assault is a personal betrayal because it is perpetrated by an individual or individuals upon whom a victim depends for getting basic needs met and even for survival, often a superior (Smith & Freyd, 2013). Military members are not only dependent on fellow members and commanding officers for protection and survival, they also must continue to work side-by-side with their offenders. Researchers have indicated that traumas that have a personal betrayal component, such as MST and childhood physical and sexual abuse when perpetrated by a caregiver or parent are associated with increased negative physical health and psychological distress symptoms such as dissociation, PTSD, depression, disturbed sleep, and overall poorer health (Klest, Freyd, & Foynes, 2013; Martin, Cromer, DePrince, & Freyd, 2013).

Institutional betrayal trauma is another aspect of MST since a military member depends on the military institution for structure, identity, employment, social life, values, and purpose (Haaken & Palmer, 2012). Institutional betrayal, according to Smith and Freyd (2014), results in higher incidences and degrees of anxiety, dissociation, and physical health problems including sexual dysfunction. Compounding the trauma even further, the MST survivor must return to the same institution that betrayed them and ask for help to recover from the trauma.

Viewed through a general feminist theory lens, the military is a patriarchal institution which depends on hegemonic masculinity and sexual violence is a strategy used to reaffirm the domination and power of men and to subjugate women (Leatherman, 2011). As a weapon of war, sexual violence aims to regain power, domination, humiliation, expulsion, and even extermination of a targeted group, in this case, those considered weaker among them (Skjelsback, 2001). MST must be viewed through this radical feminist lens and with an understanding of military and war culture, and therefore differentiated from non-MST-related traumas. In planning treatment of MST-related trauma, the systemic patriarchal structure of the military, the social status based on rank, the familial nature, and the group over the individual ethos, each an integral component of military culture, must be given importance.

CPT for MST

Relatively few studies have examined the effectiveness of CPT for intervention with persons who experienced MST. Voelkel, Pukay-Martin, Walter, and Chard (2015) published a study comparing the results of CPT for treating individuals with MST and

those with other types of traumatic experiences. The study supported CPT in a residential setting or on an outpatient basis for veterans who had experienced military sexual trauma and showed a higher level of psychopathology for MST survivors (Voelkel et al., 2015). Another randomized clinical trial was conducted showing preliminary evidence for the effectiveness of CPT in treating MST, however, treatment model fidelity and participant dropouts impacted the findings (Suris et al., 2013). Holliday et al. (2014) conducted a study which examined the effect of CPT for reducing negative cognitions in persons who experienced MST. Finally, Allard et al. (2011) in a proposed agenda for research into MST and effective interventions stated that while many studies have supported the efficacy of CPT in trauma treatment, few have provided outcomes specific to MST survivors. Due to the unique military culture, the fact that MST occurs in both the work and social environment of a survivor, and the challenges faced if a survivor chooses to report the assault, it is essential that these exceptional issues be considered in selecting the best treatment approach for providing care to MST survivors. Research shows that CPT is effective with civilian sexual assault as well as with many other types of trauma. Scholar practitioners have an ethical responsibility to explore the experiences and perceptions of veterans with MST-related PTSD in receiving CPT from a VA provider. This study will examine the experiences of MST survivors who have been treated with CPT.

Summary

The dearth of research studies that are specific to the experience of CPT by individuals who have experienced MST creates a gap in treatment protocols for social

workers who treat MST survivors. This study attempts to narrow the gap and examines these questions from a general feminist theoretical lens. Social work practitioners will have access to a broader research base as they provide mental health services for individuals who have experienced MST.

The intention of this qualitative study was to explore the experiences of veterans with MST-related trauma who have received CPT, their understanding of its effectiveness or impact, and their evaluation of improvement or lack of improvement in their lives, through a feminist framework. The goal and design of this exploration is to contribute to the understanding of trauma; specifically, MST, from a feminist theoretical perspective and to increase knowledge of the experience of CPT for these survivors, while simultaneously raising consciousness and inspiring positive social change. Through this study, I am attempting to make a positive contribution towards filling the gap in the scarce body of literature on the experience of CPT with MST survivors, and to provide significant experiential knowledge to mental health clinicians who serve them. The following section will describe my specific research design and methodology.

Section 2: Research Design and Data Collection

The purpose of this generic qualitative study was to add to the current body of knowledge concerning the use of CPT with veterans with MST-related PTSD by exploring perceptions and experiences related to CPT. An understanding of the perceptions of veterans with MST-related PTSD who receive CPT is important for social workers who are making decisions about which treatment approach to use, as well as to enhance informed consent, in working with veterans who are struggling with PTSD, depression, negative cognitions, and other psychosocial ramifications of MST. This project provides additional understanding about the experiences of veterans who have survived MST and received CPT intended to treat the resulting PTSD and other negative psychosocial sequelae. Participants were female veterans of the United States military who reported having experienced MST and who received CPT from a VA provider. I asked study participants to complete questionnaires to gain an understanding of their perceptions of the impact of CPT on their lives.

The Department of Veterans Affairs began to offer free treatment for survivors of MST in 1992 after a Senate Veteran Affairs committee mandated it (Reisman, 2016). The VA was already using CPT to treat combat-related PTSD and since CPT was originally developed to treat civilian sexual trauma, it was quickly adopted as a first-line approach for the treatment of MST (Holliday et al., 2014). Scholar practitioners have conducted quantitative studies to examine the effectiveness of CPT in reducing symptoms of PTSD and other mental health disorders with MST survivors, concluding that it is effective (Reisman, 2016). Qualitative studies that explore MST survivors' perceptions and

experiences with CPT, however, are lacking. It is important to study the perceptions of veterans with MST-related PTSD who receive CPT to inform treatment and to enhance informed consent by providing information about what others have perceived as strengths or limitations of CPT.

This study explored the perspectives of survivors of MST who have been treated with CPT. The purpose of this study was to better understand the experiences and perspectives of female veteran survivors of MST who received CPT.

This section of the project provides information on the research design and the methodology used. Study participants, data analysis, and ethical procedures, will also be described.

Research Design

Social workers provide services at Vet Centers and other VA facilities to treat veterans who are living with PTSD, related to combat trauma or MST. Research is needed to describe the experience of receiving CPT specifically in treating MST-related PTSD. The Department of Veterans Affairs (2015) provides training in CPT and encourages its mental health professionals to use it in treating veterans who have PTSD. Due to the dearth of research on the experience of receiving CPT for treatment of MST-related PTSD, I proposed a generic qualitative study that would explore survivors' perceptions of CPT with MST-related PTSD. This study explored these perceptions and experiences by asking female veteran participants to describe their experiences and the changes they perceive after receiving CPT. The experiences and perspectives that were explored by this study are exclusively related the CPT. Participants were not asked to talk

about their experience of trauma. Changes perceived after receiving CPT refer to changes in experience of life, relationships, thoughts, and increase or reduction in symptoms of PTSD, such as hypervigilance, nightmares, intrusive thoughts, insomnia, blunted emotions, difficulty concentrating, and other sequelae that disrupt or impair life function. The research questions are as follows:

RQ1: What are the experiences of CPT as a treatment modality for female veterans with MST-related PTSD?

RQ2: What do female veterans with MST- related PTSD perceive as strengths, and or ineffectual, or potentially damaging aspects of CPT?

RQ3: What changes do female veterans with MST-related PTSD perceive in their experience of life, relationships, thoughts, and symptoms after receiving CPT?

I proposed a generic qualitative study design, questioning MST survivors in the Southwest about their experiences with CPT. A generic qualitative study approach focused on answering the *how* and the *why* questions about the experiences that MST survivors have in receiving CPT (Kahlke, 2014). This approach also addresses the contextual conditions (Creswell & Poth, 2018), such as MST-related PTSD as compared to CPT for other types of trauma, which may be relevant to the perceptions of these survivors.

Since the purpose of this study was to explore the perceptions and experiences of female veterans with MST-related PTSD who have received CPT from a VA provider, it aligned with a generic qualitative approach using a feminist approach to questioning participants. Generic qualitative studies search for understanding about how people

define, engineer, and create meaning from their experiences (Kahlke, 2014). Feminist approaches to interviewing coincides by honoring subjective realities shared by participants without judgement and acknowledging power imbalances (Hesse-Biber, 2013). Given the lack of studies seeking to understand the experiences of female veteran MST survivors with the chosen treatment approach of the VA, the generic qualitative approach offers the flexibility to work outside established methodologies and uncover novel information (Kahlke, 2014). A generic qualitative approach aligned with this study in which the experiences and perceptions of a specific population were explored to gain understanding of the worldview that they have designed (Caelli, Ray, & Mill, 2003). Questionnaires which participants could answer in writing that explored experiences and sought to describe perceptions, aligned well with both a feminist approach to questioning and a generic qualitative approach to research design (Merriam & Tisdell, 2015).

Key Aspects and Operational Definitions

Key eligibility criteria for participants in this study included (a) female, (b) veteran, (c) experienced MST, (d) diagnosed with PTSD, and (e) received CPT from a VA provider.

Operational definitions for the study included the following terms.

Cognitive processing therapy (CPT): A therapy approach based on cognitive behavioral therapy, created by Resick (1996) to treat symptoms of PTSD related to sexual assault and considered to be an evidence-based practice by the VA (Department of Veterans Affairs, 2015).

Military sexual trauma (MST): Sexual assault or repeated threatening sexual harassment that occurred during a veteran's military service (Department of Veterans Affairs, 2015).

MST-related posttraumatic stress disorder (PTSD): PTSD diagnosed by a mental health provider as being precipitated by an MST experience (Department of Veterans Affairs, 2015).

Methodology

The data collected was exploratory in nature and sought to identify meaning and constructs which emerge from the participants' experiences. Originally, I planned to interview the participants to explore their experiences with CPT in depth including body language, facial expressions, and pauses in their responses. Potential participants expressed their reluctance to participate in interviews citing fears of re-experiencing the trauma. Many of the participants suggested that they would be willing to answer questions in written format, so I changed the data collection approach to meet their needs. Individual responses to questionnaires were used because they aimed to illuminate the experiences, gain understanding of the constructed worldviews related to the experiences, and to explore the perceptions of the participants focusing specifically on the study's research questions (see Ravitch & Carl, 2016). Each response of the participants was reviewed and coded looking for common themes and concepts related to the participants' experiences with CPT.

Participants

Purposive and convenience sampling was used to identify participants. Purposive sampling is an intentional selection of participants who will most accurately inform the study regarding the research questions being explored (Creswell & Poth, 2018). Participants for this study included 21 cis-gender female veterans of the U.S. military who live in Arizona, Colorado, or New Mexico and received CPT for MST-related PTSD from a VA provider. Each participant in this study completed the full 12 sessions plus at least two follow-up sessions required to adhere to the CPT protocol. Location was proximate to me and provided convenience for recruiting and distributing questionnaires. Because this study was exploratory in nature, I chose 20-25 as the potential number of participants, increasing the number of participants to account for the change in data collection from interviews to questionnaires, as the sample size to allow flexibility in the numbers of questionnaires distributed, appropriateness for the study's duration and allocated resources, ease of study replication and saturation, per guidance by Robinson (2014). Saturation was reached once no new information was being gathered through the questionnaires. The sample size is less important than rigorously, ethically, and thoroughly answering the research questions (Mason, 2010).

Recruitment e-mails were sent to non-VA clinics where CPT was offered and community veteran support groups where veterans gathered for social connection. Veteran service organizations, such as American Veterans and the Disabled American Veteran, private practitioners, and vet centers offer support groups for veterans with MST-related PTSD that are not affiliated with the VA. Flyers were mailed to these

centers announcing the study and seeking participants. Veteran service organizations and social media, specifically Twitter, was also used to announce the study and recruit potential participants. Veterans who saw the flyer could contact me to express interest in participating through my contact email and phone number and I provided a more detailed description of the project. After the participants were selected and provided an initial informed consent, the questionnaire was provided for them to complete and return to the researcher by e-mail or U.S. mail.

I asked participants to complete the 8-item questionnaire as honestly as possible. The questions did not take precedence over information the participants wanted to share related to the topic (Hesse-Biber, 2013). A feminist perspective was used to craft the questions to uncover subjective information from the participants that revealed their experiences and perceptions about CPT. I asked questions to gather data that participants may not have considered or shared before. This approach to information gathering also considers the relationship between researcher and participants and seeks to recognize and reduce, if possible, any power imbalance (Hesse-Biber,2013).

Instrumentation

Based on my experience as a therapist providing CPT for MST survivors, I developed open-ended interview questions to obtain information about the experiences and perceptions related to the treatment modality, not the individual trauma. The questions were informed by my experience, general feminist theory, and the literature review. My research committee provided reflection on the questions and assisted with revisions. In changing the format from interviews to written responses to questionnaires, I

used the same interview questions, added more to the written introduction asking participants to go into as much detail as possible, and followed up with e-mails or calls to the participants to clarify some of their responses. The questionnaire provided the frame for the responses but did not restrict the participants from adding information not specifically covered in the questions. The questionnaires were distributed after adequate informed consent was obtained, volunteers agreed to participate, and resources for supportive care during or after the completion of the questionnaires. Participants were given a choice to receive, complete, and return the questionnaire by e-mail, in person if applicable, or U.S. mail.

Data Analysis

The data collected consisted of written responses to questionnaires with informed participants. The responses were then examined using thematic analysis described by Braun and Clarke (2006) to highlight codes and sort key data points. I reviewed each of the responses myself to immerse myself in the data before I began coding. I used Microsoft Excel to store and organize the responses (see Meyer & Avery, 2009). After dividing the data into groups by question, by sentence, and by participant, I began coding using emergent codes, including descriptive and in-vivo codes. In-vivo coding uses verbatim words or phrases from the participant to code their data (Saldana, 2016). Throughout the coding process, I used memoing to capture my thoughts and ideas about the codes and explore connections between codes (see Ravitch & Carl, 2016). I kept track of code revisions and definitions as needed. I also highlighted any questions that developed as I mapped codes to categories and categories to themes.

The codes were organized into main categories and then into themes. The themes were evaluated as to the degree they did or did not answer the research questions. Through inductive analysis, the emerging themes related to the experiences of the participants were identified. Inductive analysis, also called bottom-up analysis, uses the participants' own language to stay as close to the intended information as possible (Ravitch & Carl, 2016). Qualitative data analysis provides a more comprehensive understanding of the participants' perceptions because it is interpretive, naturalistic, and focuses on making sense of interpretations of the socially constructed meanings that people create (Fortune, Reid, & Miller, 2013). Member checking began once theme generation was complete. I emailed each participant asking them to review a brief summary of the initial themes generated and provide observation on whether the themes accurately reflected their perceptions and experiences without judgment or bias.

According to Toma (2006), there are four components that constitute trustworthy or rigorous qualitative data, including credibility, dependability, transferability, and confirmability. Credibility is equivalent to the believability of the data or the accurate and authentic reporting of the participants' experiences (Fortune et al., 2013). Credibility in qualitative research is like internal validity in quantitative studies (Ravitch & Carl, 2016). Dependability, like quantitative reliability, relates to the degree to which the researcher follows a systematic process (Miles, Huberman, & Saldana, 2014). I used an audit trail to track each aspect of data collection and analysis to demonstrate systematic research processes were followed and to allow an outside observer to evaluate the authenticity of my process. Parallel to quantitative external validity, transferability means that the reader

has enough information to transcend the specific research particulars and apply them to similar contexts (Creswell & Poth, 2018); I provided adequate detail to assist the reader in making their own determination of transferability. Confirmability indicates that the researcher has not invented data, but provides confirmable or objective data (Miles et al., 2014).

The trustworthiness of the data gathered in this study was safeguarded by reviewing the data multiple times on various days to completely immerse myself in the data, checking the interpretation of the data with participants, using peer debriefing, and maintaining records that would support an external audit (Barbour, 2001). Checking the data interpretation with the participants, known as member checking or participant validation, is simply allowing participants to review the initial themes and give their own feedback to the researcher about its accuracy (Creswell & Poth, 2018). Member checking was accomplished after initial theme generation by emailing study participants a brief summary of the themes generated and asking them to review.

Peer debriefing involves asking a third person to review the data for clarity and credibility (Maxwell, 2013). Two peers, who are VA providers for veterans with PTSD but are not connected in any way with the study participants, reviewed the collected responses with all identifying information removed, to challenge my interpretations and check for bias.

Additional techniques to strengthen data trustworthiness included triangulation, exploring discrepant cases, and thick description or rich descriptions, and interpretations of the study's results (Ravitch & Carl, 2016). Triangulation is defined as the use of

different sources, including more than one participant, to challenge or confirm the data (Lincoln & Guba, 2000). Triangulation in this study involved questioning 21 unique participants separately. Using different sources, in this case, 21 different individuals, to challenge or confirm themes, enhances the realism of the study findings (see Creswell, 2009). Negative or discrepant cases, if any emerged in the study, would be presented in the study as points of discussion. Discussion of discrepant cases demonstrates my attempt to reduce researcher bias of finding only what I expected to find. Participant validation and peer debriefing helped to increase trustworthiness of the interpretation. Reflexive journaling was used to critically check for biases (see Porter, 2010). Reflexive journaling is a way for a researcher to track thoughts, ideas, and biases during the process of questioning participants, collecting data, and coding to enhance and enrich the interpretation of the information gathered (Ravitch & Carl, 2016).

Because the researcher is integral in qualitative research and serves as the primary instrument for data collection, reflexivity is crucial (Probst, 2015). As such, it is important for me to share my position and plan for reflexivity. I have been providing mental health services to veterans with readjustment challenges and trauma for several years. I have been trained and certified as a CPT therapist by the VA and have provided CPT to many veterans with PTSD, including those who experienced MST. As a female therapist, I have observed that veterans who experienced MST are often referred to me. I have seen quantitative evidence that CPT reduces symptoms of PTSD for veterans in general. However, I am not aware of the experiences or perspectives of veteran with MST-related PTSD who have received CPT. From a feminist perspective, I wanted to go

beyond the statistics and explore the experience. To set aside my own bias regarding the experiences of female veterans with CPT, I maintained a reflexivity journal to track my own feelings, thoughts, and responses as I conducted and coded the written responses.

I used a reflexive journal to write down the personal thoughts and feelings that I experienced while reviewing the responses of participants. In the findings section, I also used reflexivity to present my role as researcher and assumptions to position myself in relationship to the research. I provided the reader with an understanding of the experiences, values, and attitudes I hold, which may have influenced the research process and findings. After reviewing each response, I made notes reflecting my experiences as I reviewed the participant responses including feelings, ideas, potential biases, and questions about my interpretations.

Ethical Considerations

Research participants signed the informed consent before I distributed questionnaires. The informed consent document described the purpose of the study as well as the researcher's expectations of the participants. The informed consent also reviewed the participant's right to withdraw from the study without consequence and ensured that resources were made available for follow-up counseling. The informed consent is presented in Appendix C. The research procedure ensured the ethical protection of participants. According to the NASW Code of Ethics (2017), it is a social worker's duty to provide informed consent and to respect the confidentiality and anonymity of research participants. This study respected individuals and regard their

perceptions and experiences as a foundation for creating a collaborative environment that fosters common goals and positive social change.

As I distributed the questionnaires, I reminded the participants that even though there were not any questions that related to the traumatic experience, the potential for being triggered existed. Since completing the study questionnaire was not a counseling session, participants were given a list of local support services, such as the Vet Center, VA trauma therapists, and free resources such as community support groups that were available if needed. As stated in section 2, a feminist researcher must listen to what is said by the participants as well as what is left unsaid. Due to the change in protocol, I wanted to respect the unwritten aspects of the participants' experiences as much as possible before labeling the written format as a study limitation. I did this by talking with the participants in depth prior to their answering the questionnaires and answering their questions. I wanted to build trust and help them feel comfortable sharing their views even if they were negative. I also followed up with participants whose responses seemed to allude to something deeper than their written responses showed after I began to analyze the data. Participants were advised to take their time responding to the questions and take breaks as needed. A gift card with a $20 value to the participant's choice of Starbucks, Walmart, or Amazon, were provided when the responses were collected.

Participants' confidentiality was respected by not gathering identifying information such as social security numbers, birth dates, or addresses and by safeguarding any identifying information I received such as names and email addresses. Questionnaire responses are being stored on a password protected hard drive at my home

and informed consents, a research journal, and all hand-written documents are being kept in a locked file cabinet. Stored material will be maintained for a minimum of 5 years and will be destroyed by shredding or similar means. Approval for the protection of human subjects was acquired from the Institutional Review Board (IRB) at Walden University with the approval code 07-31-18-0628969.

Summary

The purpose of this generic qualitative research project was to explore the perceptions and experiences of female veterans of the U.S. military with MST-related PTSD who received CPT from a VA provider. I collected the data by distributing questionnaires to participants in person, by email, or by U.S. mail, whichever the participant preferred. The data collected through the questionnaires was analyzed and organized into themes. All data were rigorously coded according to recognized procedures for analyzing qualitative research data. In the next section, I discuss data analysis techniques and the research findings.

Section 3: Presentation of the Findings

The purpose of this generic qualitative study was to add to the current body of knowledge concerning the use of CPT with veterans with MST-related PTSD by exploring perceptions and experiences related to CPT. An understanding of the perceptions of veterans with MST-related PTSD who receive CPT is important for social workers who are making decisions about which treatment approach to use, as well as to enhance informed consent, in working with veterans who are struggling with PTSD, depression, negative cognitions, and other psychosocial ramifications of MST. This project provides additional understanding about the experiences of veterans who have survived MST and received CPT intended to treat the resulting PTSD and other negative psychosocial sequelae. Participants were female veterans of the United States military who reported having experienced MST and who received CPT from a VA provider. I asked study participants to complete questionnaires to gain an understanding of their perceptions of the impact of CPT on their lives.

I explored the experiences of female veterans who were treated for MST-related PTSD with CPT. I used a generic qualitative research design employing gather information relevant to the study's research questions. Participants were limited to female veterans of the U.S. military who received CPT from a VA provider for MST-related PTSD, lived in Arizona, New Mexico, or Colorado, and who volunteered to participate after informed consent was provided. The responses to the questionnaire were collected by mail, in person, and by e-mail. The information collected from the participants,

exclusively by me, revealed common themes across study participants, which I manually coded.

The following section describes the data analysis, validation, and legitimization processes used throughout the project. Following these sections, I present qualitative findings gathered from study participants and organized according to themes. Finally, I present important learning points, specific findings that will affect social work practice, and unexpected results from this study.

Data Analysis Techniques

Recruitment began in July 2018 with flyers posted at community veterans' service organizations, on Twitter, on Facebook veterans' groups, VFW and American Legion locations. By October, I had no volunteer participants. Some potential participants were asking if they could respond to the interview questions in writing. I understood this request from the perspective of a therapist who had provided treatment of CPT for MST-related PTSD. Potential participants had never met me, and I was asking to be allowed to explore their personal experiences and lives. Given that trust and safety are issues of great concern to those who have experienced trauma, I could understand that it seemed too risky and not worth the effort to share private perspectives with me. In mid-October 2018, I requested a change in data collection procedures, and this was approved by IRB by late November. I revised the recruitment email and asking participants to complete a questionnaire, submit it to me, and agree to a follow up email or phone call to gain clarification, resent and reposted them and began to receive many responses from veterans interested in participating in the study. While I did not change the questions

planned for the interviews, I did ask participants to elaborate in more detail. I answered questions explaining that I was seeking their honest reports of their experiences in their responses. By December, I had provided informed consent and recruited several candidates and by the end of December and early January 2019, I had 20 participant responses and more responses were still coming in. Most of the participants' chose pseudonyms, I saved these to a password protected file on my home computer under the pseudonyms that were used. Other responses were written by hand and either handed to me or mailed to me. The written responses were locked in a file cabinet. In early January, I began to review, organize, separate into themes, and do initial coding with the responses. I kept track of my questions and returned to the participants to ask them for clarification by email.

I received eight written responses soon after the study was announced. I adjusted the target number of respondents needed for the study due to the change from interviewing participants to receiving their written responses. After receiving 21 written responses to the questionnaires, it was apparent that the responses were becoming increasingly repetitive, indicating that the saturation point had been reached. I began coding after I had collected the responses and checked them for accuracy. I compared the experiences of the participants using constant comparison, which can be described as simultaneously collecting, coding, and analyzing the data in order to generate answers to the research questions (Kolb, 2012). I identified initial codes, or key words that described the participant's experiences, by highlighting them with different colored markers. I identified 35 codes. I then went over each questionnaire response a second time to review

the initial coding and identify questions I needed to ask for clarification. After identifying concepts in the data, common codes across the responses were identified. As I organized the codes into cohesive categories, I identified themes. I transferred the codes to a codebook in which I specified which color I used to highlight the codes for each of the 8 categories. The codes were words or brief phases which described what the participants had reported, such as “less depressed” under the category “changes in symptoms”. I continued to repeat this process for each response until the data began to repeat itself or, in other words, was saturated.

The codebook allowed me to organize the data by themes. Themes identified related to the experiences of female veterans who received CPT for MST-related PTSD included making the decision to receive CPT, the experiences of receiving CPT, and overall improved life experience. While organizing the themes, I kept count of the frequency with which a common response was repeated. Code frequency counting or noting the frequency with this a code appears in the data and how widespread it is, allowed categories or patterns to be identified which were then narrowed down to three main themes.

Validation and Legitimization Process

The validation procedures I used in the study included member checking, peer debriefing, triangulation, and reflexive journaling. I employed validation procedures throughout the data collection and analysis phases of the study. I conducted participant validation, or member checking, to verify the data interpretation with the participants by allowing participants to review the initial themes and give their own feedback to the

researcher about its accuracy (Creswell & Poth, 2018). Member checking was accomplished after initial theme generation by emailing study participants a brief summary of the themes generated and asking them to review them for accuracy of their intended response interpretations. Eighteen of the participants responded to the member checking and none suggested any changes in the interpretation of their data. I explained to the participants that it was important to make their voices heard and many of them responded by expressing their appreciation for allowing them to share their experiences. Member checking provided an opportunity for participants to add more depth to the expression of their experiences. I requested and received further explanation of written responses from 14 of the participants to ensure that their perspectives were accurately represented. The additional clarifying data that was obtained by member checking was added to the original collected information and stored in my personal computer with password protection.

Peer debriefing was conducted by asking two VA PTSD treatment providers to review the collected data to challenge my interpretations and check for bias. Sharon B. and Ruth O. both are VA social work professionals who work with veterans who have experienced MST and are seeking treatment for MST-related PTSD. I did not reveal the true identities of the participants and neither of the peers work directly with any of the study participants. Both peers reported that after reviewing each participant's responses and my interpretation of the data, they did not see any bias in the interpretation and believed that I had accurately represented the responses.

Triangulation is defined as the use of different sources, including more than one participant, to challenge or confirm the data (Lincoln & Guba, 2000). Triangulation in this study involved questioning 21 unique participants separately. Using different sources, in this case, 21 different individuals, to challenge or confirm themes, enhanced the veracity of the study findings (see Creswell, 2009). Participants ranged in age, ethnicity, and were from different states and towns in the Southwest, United States, with the common factors being all female veterans who experiences MST and received CPT from a VA provider. Negative or discrepant cases, if any had emerged in the study, would have been presented in the study as points of discussion. Discussion of discrepant cases would demonstrate my attempt to reduce researcher bias of finding only what I expected to find. Although some discrepant responses were woven into the data collected, none of the respondents offered clearly diverse or significantly different reports of their experiences. It is important to note that using written responses rather than interviews, the advantage of being able to probe for depth in the responses and to observe body language and facial expressions were lost. In addition, the data richness was limited by the participants' writing ability.

I used a reflexive journal to write down the personal thoughts and feelings that I experienced while reviewing the responses of participants. In the findings section, I also used reflexivity to present my role as researcher and assumptions to position myself in relationship to the research. I provided the reader with an understanding of the experiences, values, and attitudes I hold, which may have influenced the research process and findings. After reviewing each response, I made notes reflecting the experience of

reading the written responses including feelings, ideas, potential biases, and questions about my interpretations. The journal helped me realize that although the participants' responses reflected an overall positive experience with CPT, I was not injecting personal bias into the findings, but rather allowing these veterans to share their perspectives and have their voices heard.

Limitations of the Current Study

The first problem I encountered was during the recruitment phase of the study. I had planned to conduct interviews with the participants to gather the data; however, volunteers told me that they were uncomfortable with the idea of being interviewed and asked if they could respond to the questions in writing. I was concerned with creating safety and trust in interviews and with the change to questionnaires, although the change was based at least partially on the need of the participants for safety and trust, I had to reconsider how to create safety for the participants as they answered questions about their experiences in writing. Whether using written questionnaires instead of interviews was a study limitation or contributed to an increased sense of safety and ease of trust was unknown. I sought approval for the change of procedure and, once I received it, informed respondents that they were welcome to answer the study questions in writing. As mentioned previously, the written response format did not allow the advantage of in-depth probing or of seeing body language or facial expressions and was limited by the participants' writing abilities which may have contributed to my understanding of their experiences. Additionally, using a questionnaire format may have lost some rich description of the experience of engaging in CPT related to the difficulties of the

treatment, staying in the treatment, and arriving at an outcome that is viewed as a strong positive experience.

Another potential limitation was that I only included participants who lived in Arizona, New Mexico, or Colorado. This may have yielded different results than if veterans from all over the country were included. There was no way of knowing whether female veterans who chose to participate in the study would have responded differently than those who did not volunteer to participate. It is possible that those who did not participate may have had more negative experiences with CPT and therefore did not want to share their perspectives. The study findings are limited to the volunteers who were willing to respond to the study questions in writing. It is difficult to ascertain whether the participants were representative of all female veterans who received CPT for MST-related PTSD or if, for example, only those who had a positive experience with CPT came forward to participate in the study.

Demographics of the Participants

All the study participants chose a pseudonym to protect their identity. All were female veterans of the United States military and their ages ranged from early 20's to late-60's. Four of the respondents lived in New Mexico, eight lived in Arizona, and nine lived in Colorado. The branch of military service to which each veteran belonged varied and each major branch was represented. Some of the participants had served in Vietnam, some in Iraq or Afghanistan, and a smaller number served in the United States or other countries. Ethnic groups that were represented included White, Black, Latina, and American Indian.

Findings

The study's research questions were (a) what are the experiences of CPT as a treatment modality for female veterans with MST-related PTSD, (b) what do female veterans with MST-related PTSD perceive as strengths, and/or ineffectual, or potentially damaging aspects of CPT, and (c) what changes do female veterans with MST-related PTSD perceive in their experiences of life, relationships, thoughts, and symptoms after receiving CPT? Female veterans of the U.S military who have received CPT from a VA provider as treatment for MST-related PTSD and participated in this study, found CPT to be a difficult experience that ultimately yielded positive results including decreased symptoms, improved relationships and self-confidence, and enhanced life experiences. After a careful review of the data, a total of three primary themes and 11 key terms emerged from the data. The primary themes included making the decision to receive CPT, the experience of receiving CPT, and outcomes of receiving CPT. An outline of the study themes and key terminology is found below:

Table 1

Study Results Primary Themes and Key Terminology

Theme 1: Making the Decision to Receive CPT	Theme 2: The Experience of Receiving CPT	Theme 3: Outcomes
resistance	painful	decreased symptoms
trust	remembering trauma	increased self confidence
fear	difficult	improved relationships
shame	enlightening	

The quotes from participant's presented in this study represent the exact responses they reported with no editing.

Theme 1: Making the Decision to Receive CPT

This theme represents the barriers to deciding to engage in CPT as well as the ambivalent feelings about facing and working through the trauma. This study did not ask participants how they decided to ask for help to cope with MST-related PTSD. This study explored how female veterans decided to engage in CPT specifically. The first research question, what are the experiences of CPT as a treatment for female veterans with MST-related PTSD, began to be addressed within this theme. Participants expressed the challenges of deciding to engage in CPT, considering they would have to recall their traumatic experience, the fear, shame, and emotional pain they felt, whether they trusted and felt safe with the therapist, and even whether they felt they "deserved" to feel better. Study participants shared their experiences in deciding whether to receive CPT. The voices below represent feelings of resistance, fear, shame, and risk of trusting the therapist that were expressed by participants. Luisa, a 20-year-old Latina Air Force veteran shared, "I was very hesitant- scared honestly. I was afraid of what would come out- too much pain and anger!" Donna shared,

> I was leery at first. My superior in the Army assaulted me repeatedly and I was going to let the VA get into my head? Okay, I was terrified and defensive.

Amy expressed her fears about being able to trust her therapist stating, "She worked for the VA. I wondered if I could trust her. People I had trusted before hurt me." Niara, a 65-year-old Air Force veteran reported,

> I didn't want to do it. Too risky. I literally ran out the office when my therapist told me about CPT. I just felt like I had already been hurt enough so why sign up for more?

Shame also came up in this theme. Janie reported,

> I was very resistant. I was so ashamed of what role I might have played in the assault. I was drinking with the guys. I brought it on myself.

Participants shared experiencing hesitance to trust, fear, shame, and ambivalence while deciding whether to engage in CPT. The experiences described by participants in making the decision to engage in CPT, began to answer research question 2 also. The design of CPT, offering introductory sessions to assist the client in deciding to engage in CPT, leads to increased trust and self-confidence, and decreased feelings of shame and depression, which is a strength of CPT. Some aspects of CPT, such as the requirement that the client relive their trauma, produces fear, hesitation, and feelings of shame. This is a potential barrier to seeking help. Research question 2, what do you identify as strengths, ineffective aspects, or damaging aspects of CPT, is answered further in theme 2.

Theme 2: The Experience of Receiving CPT

The experience of receiving CPT speaks to the core of this study. The research was intended to explore the experiences of female veterans with MST-related PTSD who received CPT for treatment. This theme provides answers to the research question, what are the experiences of veterans with MST-related PTSD who receive CPT? As a researcher and as a therapist, I had concerns that engaging in CPT could re-traumatize a person with MST-related PTSD because of the requirement of retelling the experience of

trauma. Although participants described feeling pain, resistance, fear, and reliving the trauma, all of them reported that they did not feel re-traumatized by the end of the treatment. The following responses emphasize the pain, resistance, and fear that some participants felt while engaging in CPT. Beth, a 29-year-old Air Force veteran, reported, "The experience of getting CPT was like giving birth- painful but then totally worth it- with the help of my coach- to a new me. I am now stronger-less afraid" Sharon, a 57-year-old Air Force veteran, shared, "I cried a lot. I spent more time with myself and with God. I felt pain rising in me and then flowing out. My brain started to untangle." A 27-year-old Army veteran, Megan, said "CPT was cathartic. I felt like I fell apart into a million pieces but when it was finished, I felt more whole than I had in a long time." Sarah, a 31-year-old Navy veteran, shared "It was terrifying. The only thing scarier was the assault. I cried a lot. I found a peaceful place by a river to write my assignments. When I finished, I felt like a weight was lifted off me." A 38-year-old Army veteran, Jessica, shared her experience, "Doing CPT was like having a root canal. It was painful- very uncomfortable. But after we finished, I felt much better." Participants shared that their experiences with CPT demonstrated for them that it might be necessary to struggle with their pain and shame to genuinely heal.

Shame was mentioned as part of the experience of engaging in CPT, both as a challenge and then as a strength when the feelings of shame lessened, as evidenced by the following responses. "I feel less ashamed after CPT. It was NOT my fault what happened to me," wrote Christina a 39-year-old African-American Army veteran. Denise, a 32-year-old American Indian woman who served 8 years in the Army, reported, "I don't

blame myself like I used to and suffer with the shame of having been raped. I used to tell myself that it was my fault that I was raped because I was hanging out and drinking with the guys. CPT was good for me because I no longer have shame." Increased awareness of thoughts and emotions, increased trust, and self-confidence were described as strengths of CPT for some participants, as shown by participants' reports that engaging in CPT was an enlightening and educational experience and they felt more confident and trusting after the therapy. None of the participants identified the experience of CPT as damaging and only one reported that it may have been a neutral experience stating, "The experience of CPT was neutral in that it didn't take away what happened to me. But it was positive in terms of my outlook of the world."

Theme 3: Outcomes

Outcomes can be defined as the reduction of negative symptoms resulting from surviving MST, the increase of positive attributes such as self-esteem or socialization, or the overall life experience after receiving CPT for MST-related PTSD. This theme speaks to the overwhelming perception of the strength of the CPT experience. Participants reported that strengths of the CPT experience included feeling stronger, braver, wiser, and more courageous. They reported feeling safer, more trusting, and less ashamed. Participants also stated that strengths of CPT were its ability to reduce their symptoms and make life more enjoyable. This theme also answers the research question, what changes do veterans with MST-related PTSD perceive in their experience after receiving CPT? All but one respondent described her CPT experience as positive. One respondent reported that CPT was neutral for her because she experienced positive

outcomes while the process of receiving CPT was difficult. Since all the other participants described their experiences with CPT as positive, it is impossible to know whether this sole participant who described her experience as neutral was simply a discrepant result or whether it might be more indicative of the general population's experience.

Many outcomes were described including increased self-confidence and a more active social life realizing that the trauma was not their fault, feeling proud of their service, trusting others more, feeling stronger, having a more positive outlook, less isolation, and increased socialization. Jeanine, a 59-year-old Air Force veteran, shared "I have changed for the better, but I feel like I need refresher courses. I think more optimistically now. I am more confident. So much of myself was stolen when it happened. Today I have my faith back." Sharon, a 57-year-old Air Force veteran, stated,

> I used to sleep a lot, avoid people, and hide at home. I didn't even want to be around my family. I felt like no one understood. I thought I couldn't have PTSD because I was not in combat. Now, I am not so depressed.

Megan, a 27-year-old Army veteran shared,

> I now feel strong and confident. I am not afraid of going out in the world and being around people. Before CPT, I wouldn't even enter a place with men in it (and that's a lot of places), especially if they were in uniform.

Some of the participants reported that they are dating again like Janie, a 40-year-old Army veteran. She shared, "My symptoms have decreased a lot! I'm dating again. I want to have a family." Veterans also shared feeling stronger and more confident like

Vanessa, a 23-year-old Marine Corps veteran who said, “I feel less afraid and more confident. I guess I’d say I feel overall stronger. It took a lot of strength to do CPT but much more to live through the assault.” MaryAnn, a 71-year-old Navy veteran who served in Vietnam stated, “I think I’m a little less anxious and I’m able to accomplish more. I’ve been able to mend relationships with my children. My son, Jeremy, knows that his father was my rapist.” Luisa, a 30-year-old Air Force veteran, shared “Very positive (CPT). I feel like I am freer to be myself and be happy. I haven’t forgotten what he did to me, but I’ve let go. I like to be around people again” Brittany, a 33-year-old Air Force veteran shared “I have changed. I am more outgoing, back to doing things I loved, and I’ve added new interests. I am more social, more trusting, and stronger. I go out with friends.”

Participants overwhelmingly reported that their symptoms lessened or disappeared after CPT. Anxiety, nightmares, hypervigilance, depression, and substance abuse decreased. Motivation, socialization, feelings of strength and pride increased. Christina, who served in the Army and is 39-years-old, reported, “I am a lot better after CPT. I am less depressed, I quit drinking, and I am working on quitting smoking. I am able to go out and be around people.” Neldra, a 29-year-old Army veteran, shared “I am a lot less depressed. I don’t try (so hard) to avoid my feelings, people, and situations. I still get triggered, but I have coping tools. I know my stuck points really well which helps me manage.” Denise, a 32-year-old Army veteran, said “Everything has improved. I am less isolated, less depressed, and more productive”. Many respondents reported a decrease in symptoms of depression and anxiety. A 29-year-old African-American Air Force veteran,

Beth, shared, “I remember before CPT, I had bad PTSD and depression. I didn’t go anywhere or trust anyone. Today, I don’t often have any symptoms. I still get triggered, but I have the tools to handle it.” Donna, a 72-year-old Army veteran, said “I think I am a little less anxious and I am able to accomplish more. My symptoms have definitely decreased. I am sometimes depressed but before CPT I was always depressed.” Niara, a 55-year-old Air Force veteran, shared “I am less anxious and no more nightmares! The psychiatrists at the VA tried to give me pills to take for the nightmares and I just wouldn’t do that. CPT worked. No more nightmares, hypervigilance, and no more crying every night.” Kelly, a Marine Corps veteran who is 34-years-old and identifies as Latina said, “My symptoms are much better. Now I only occasionally feel anxious or depressed. Everybody feels that sometimes, right? I feel normal and that is an amazing feeling.”

The women reported improvement in their overall life experience. They reported living with less fear, less anger, and improved relationships. Participants described having a brighter outlook, seeing more opportunities and possibilities, and liking others and themselves more. Women veterans spoke of the overall improvement they experienced in their lives after CPT. Vanessa, a 32-year-old who served 4 years in the US Marine Corps, told me,

> I am stronger and more confident since doing CPT. I am close to being the person I used to be but still different. I am okay. I am wiser, stronger, braver. I feel courageous. I am less afraid. I still struggle with intimacy, but I am at least willing to try.

Mollie, a 37-year-old Army veteran, said,

> I have more energy now and I am more motivated. I have more interests and I pursue them. I am less isolated and moody. Also, less angry. I am not eating too much, smoking weed, sleeping all the time, and isolating like before. I used to walk my property every night with my firearm cocked and ready. Now I am going out with friends and even dating.

Kelly, a 34-year-old Marine Corps veteran, summed it up, "the world is more colorful and worthwhile now. I am not isolating or having suicidal thoughts anymore. Now I feel human and I love life." Niara, a 55-year-old Air Force veteran, said,

> I see the world as friendlier and more welcoming. It is less frightening and dangerous. I no longer sleep a lot and hide out at home. I avoided my own family and now I spend time with people who love me for me.

Brittany, a 33-year-old American Indian Air Force veteran, seemed to speak as a representative for others by saying, "I sleep better, eat healthier, care about myself. I trust others now- slowly. I let people in. I feel that I matter. Life is good."

Unexpected Findings

I expected to find that female veterans with MST-related PTSD experienced CPT to be difficult and even painful. I expected them to be resistant to seeking care at the VA for MST since they had already experienced institutional betrayal while serving in the military. I also expected veterans who had experienced MST to struggle with having to think about and talk about their trauma even with a trusted therapist. An unexpected finding was that despite these challenges, the women felt CPT was worth it and felt that it

improved their lives. I kept an open mind to the possibilities of their experience with CPT and as mentioned previously, I knew that quantitative research demonstrated a significant decrease in PTSD symptoms after receiving CPT. However, I questioned whether the experience would be viewed as positive for a veteran with MST-related PTSD. I did not expect the positive findings that resulted in this study.

Summary

The research questions for this project sought to explore the perspectives and experiences of female veterans who received CPT for MST-related PTSD. The study asked questions about the experience of receiving CPT, what veterans perceive as the strengths, ineffectual, or potentially damaging aspects of CPT, and finally, what changes do female veteran perceive result from CPT for MST-related PTSD. The project findings showed that the experience of receiving CPT is viewed as challenging, yet worth the effort. Participants saw CPT as positive and found even the most difficult aspects of CPT to be rewarding. Finally, female veterans with MST-related PTSD described their experience with CPT to have lessened their symptoms, improved their self-confidence, and enhanced their lives in many positive ways. In the next section, I will discuss the study participants and will offer some reasonable implications of the findings identified by this project as well as applying the findings to the professional practice of social work.

Section 4: Application to Professional Ethics and Implications for Social Change

The purpose and nature of this generic qualitative study was to add to the current body of knowledge concerning the use of CPT with veterans with MST-related PTSD by exploring perceptions and experiences related to CPT. An understanding of the perceptions of veterans with MST-related PTSD who receive CPT is important for social workers who are making decisions about which treatment approach to use, as well as to enhance informed consent, in working with veterans who are struggling with PTSD, depression, negative cognitions, and other psychosocial ramifications of MST. This project provides additional understanding about the experiences of veterans who have survived MST and received CPT intended to treat the resulting PTSD and other negative psychosocial sequelae.

Twenty-one female veterans of the U.S. military who received CPT for treatment of MST-related PTSD, all of who live in Arizona, New Mexico, or Colorado, responded to a questionnaire designed to explore their perspectives and experiences with receiving CPT. The questions asked the women what it was like to receive CPT, whether they felt it had strengths, was ineffectual or had a damaging impact on their lives, and how it changed their thoughts, life experience, and symptoms. While none of the study participants reported that CPT had a damaging effect in their lives, one reported that her experience with CPT was neutral and the others all felt that CPT had many strengths that helped them resolve trauma. The study's findings regarding the strengths of CPT

included providing increased insight and understanding, improving self-confidence, trust, and ability to maintain an intimate relationship, and decreasing fear, shame, and symptoms such as depression and anxiety. The participants' responses yielded three themes including making the decision to receive CPT, the experience of engaging in CPT, and outcomes of receiving CPT. The study participants described the challenges of making the decision to engage in CPT as their own resistance, fear of the emotional pain of having to remember their traumatic experiences, fear of trusting their therapist with their darkest secrets, and their feelings of self-blame and shame. Re-traumatization, which is one of the challenges of receiving CPT, was reported to have occurred for some of the respondents although they did not claim to have felt retraumatized by the completion of CPT. Self-confidence and improved social lives was reported as increased pride, self-esteem, and personal strength as well as being more sociable after receiving CPT. Participants also described their experience with CPT as resulting in decreased symptoms of depression and PTSD and improved positive attributes such as energy and motivation. Finally, the veterans described a high level of improvement in overall life satisfaction.

The first research question asked by this study was related to the experience of female veterans in receiving CPT. The participants described the experience as "difficult", "challenging", and even painful, however, they also reported "it was worth it", "insightful", and "enlightening". Participants reported that their experience with CPT resulted in feeling less fear and shame, feeling stronger and more confident, and being able to participate more fully in society, for example, relating with others and finding

employment. To sum up the response to this research question, female veterans who received CPT for MST-related PTSD found the experience to be challenging and painful yet worth the effort and yielding many personal and life improvements. The second research question sought understanding of what aspects of CPT female veterans found to be strengths, potentially damaging, or ineffective. Respondents almost universally reported that CPT had many strengths and many benefits. Strengths of CPT experienced by the participants included increasing feelings of confidence, courage, and wisdom, while decreasing shame and fear. Participants shared that they experienced less problems in the areas of trust, safety, intimacy, self-esteem, and their sense of power or control, which they viewed as a strength of CPT. One respondent reported CPT as neutral, stating that although she felt the results of CPT were positive, the process of participating in the therapy was difficult. None of the participants in this study reported that their experience with CPT was damaging.

Study participants gave varied responses to Questions 7, 8, 9, and 10 (see Appendix) which related to the third research question about the changes they perceive in their experiences of life, thoughts, and symptoms of PTSD since receiving CPT. They reported less fear and less anger, reduced symptoms of PTSD and depression, improved self -esteem, brighter world views and improved relationships, and finally, an overall positive change in their life experience.

The results of this study can guide and inform practitioners in providing the treatment approach to MST survivors that has a positive impact on survivor's lives from their own perspective, or at a minimum, to improve informed consent by offering the

strengths and limitations of CPT experienced by others. VA social work professionals are encouraged to treat veterans with MST-related PTSD with CPT as an evidence-based therapy (Department of Veterans Affairs, 2015)Scholar practitioners have conducted quantitative studies to examine the effectiveness of CPT in reducing symptoms of PTSD and other mental health disorders with MST survivors, concluding that it is effective (Reisman, 2016). This study contributes to the existing research by providing an exploration of how female veterans experienced CPT. An additional study should be conducted to explore the experiences of veterans who did not complete CPT after they started.

Recommendations for Social Work Practice

In my years of experience providing treatment to veterans, including veterans with MST-related PTSD, I was provided with training in CPT, which is the preferred treatment modality of the Department of Veterans Affairs (see Department of Veterans Affairs, 2015). I participated in many case conferences, staff meetings, and conversations with other social workers who expressed their concerns that CPT might not be the best treatment for survivors of MST due to its structured design and the component which requires a detailed recounting of the traumatic experience. Due to the unique military culture, the fact that MST occurs in both the work and social environment of a survivor, and the challenges faced if a survivor chooses to report the assault, it is essential that these exceptional issues be considered in selecting the best treatment approach for providing care to MST survivors. It appears that CPT is effective with civilian sexual assault as well as with many other types of trauma. Social workers have an ethical

responsibility to explore the experiences and perceptions of veterans with MST-related PTSD in receiving CPT from a VA provider and that was the purpose of this study.

This study is significant in its potential to help agencies determine strengths and limitations of CPT for working with individuals with MST, from the perspective of the survivors who experienced CPT. Agency administration may learn how veterans with MST-related PTSD experience CPT. Agency staff may gain a better understanding of how CPT is perceived by veterans with MST-related PTSD, which may assist them in selecting a treatment approach and enhance the information they share with a client when seeking to obtain informed consent. The study's findings demonstrate MST survivors' perceptions of CPT. My exploration of the experiences of female veterans with MST-related PTSD who received CPT found many strengths in this modality including decreased feelings of shame, fear, and mistrust, increased feelings of self-confidence, strength, and courage, and improved social functioning such as healthier relationships, employment, and less mental health impairment. The study provides insight for social workers to enable them to provide better and more client-informed treatment. The findings of the study may provide social workers with what they need to know about a survivor's experience in treatment to aid them in improving services to this population. Social workers can provide clients who are considering engaging in CPT with findings of this study in general, to help them understand the strengths of the modality while deciding. By pre-educating clients about CPT and the experiences that other female veterans with MST-related PTSD had with receiving it, fears and resistance may be allayed.

Based on the findings of this study regarding the challenges and the strengths of CPT, social workers can prepare the client for the difficulties that can arise in the middle of CPT treatment, Sessions 5 and 6 when the traumatic experience is shared with the therapist in detail, and this can assist with retaining clients through the end of the treatment. In order to achieve the positive outcomes that the participants in this study reported, the social worker can use the study's findings to encourage clients to complete the entire 12 sessions to gain the desired results.

Mental health professionals within the Department of Veterans Affairs alone provide services for more than 1.6 million veterans who have experienced military sexual trauma (Department of Veterans Affairs, 2015). The Department of Veterans Affairs (2015) has recommended the provision of cognitive processing therapy as an evidence-based practice for all veterans who seek help for posttraumatic stress symptoms due to traumatic experiences of any kind. For scholar practitioners, there is an ethical obligation to establish practice-based evidence to support the effectiveness of cognitive processing therapy in treating survivors of military sexual trauma. For workers, there is an obligation to explore beyond treatment effectiveness and inquire into the lived experiences of veterans with MST-related PTSD who turn to the VA, a branch of the same institution that traumatized them, for help and recovery. By researching how veterans with MST-related PTSD perceive CPT, an evidence-based practice for PTSD, according to the VA (citation), I increased my understanding of the experiences of these veterans. By publishing the research, the community of VA trauma treatment providers will gain increased understanding, which should be applied to treatment approaches, skills, the

goal of creating a safe and trusted environment to help veterans, and the role as advocates for those who are survivors of MST. This project has the potential to bring about positive social change for veterans with MST-related PTSD, their families, and the treatment community through its research, publication, and dissemination of information designed to increase our understanding of how this population experiences CPT, which the VA has designated as an evidence-based approach. Veterans benefit from reduced depression, anxiety, fear, and isolation, as well as improved trust, intimacy, and self-esteem (citation). Families of veterans enjoy having their loved ones experiencing symptoms of PTSD less often, improved social functioning, and an ability to be more intimate and focused on their partner and children (Resick et al., 2017).

Social workers have a responsibility to provide the best possible treatment available for their clients. Consequently, quantitative studies which demonstrate positive outcomes in numbers are important, yet do not replace understanding the experiences of clients who engage in CPT. Social workers are obligated to attend to the personal perceptions and experiences of the clients they serve. The findings of this study give insight into the experiences of female veterans with MST-related PTSD who received CPT and contribute to providing better, more sensitive treatment to this vulnerable population.

Application for Professional Ethics in Social Work Practice

According to the NASW (2017), social work ethical principles that underlie the current study are the commitment to the client (1.02), informed consent (1.03), and

integrity of the profession (5.01). The following section explores the application of social work ethics to the current study.

Commitment to Client

Commitment to the client is a fundamental tenet of the profession of social work. As social workers, the best interest of our client is always our first and primary consideration. The NASW (2017) stipulates that social workers will consider the well-being and preferences of the client to be of utmost importance unless a child is being hurt or the client presents a risk to self or others. Veterans who seek treatment for MST-related issues, such as PTSD, at the VA frequently receive CPT as treatment. Scholar practitioners have conducted quantitative studies to examine the effectiveness of CPT in reducing symptoms of PTSD and other mental health disorders with MST survivors, concluding that it is effective (Reisman, 2016). However, as social workers we are obligated to honor our commitment to the client and providing the best treatment for the client goes beyond a statistical reduction of symptoms. This study explored the experience of receiving CPT for female veterans with MST-related PTSD.

Informed Consent

Social workers have a responsibility to provide a clear and valid informed consent to a client prior to treating them. CPT includes a basic explanation of the protocol involving written assignments detailing traumatic experiences. In fact, each session of CPT begins with an explanation of what issues and for what purpose will be addressed during the session and the client can ask questions for clarification. Despite the information that is provided to the client, no experiential information is provided for a

treatment which targets a traumatic experience and is therefore, highly emotional. This study explored the experience and perspective of female veterans who received CPT for MST-related PTSD providing findings that can be shared with new clients as part of a thorough informed consent. A client should be informed that the process of receiving CPT may be difficult, challenging, and even painful. Social workers can explain to clients who are considering engaging in CPT that despite the pain and difficulty working through the treatment, clients who completed CPT report that they experienced positive outcomes. The study findings can also be used to normalize clients' feelings of fear and reluctance to engage in CPT.

Integrity of the Profession

Social workers have a duty to contribute to the integrity of the profession. We should seek to promote high standards of practice by insuring that we are providing the best treatments to our clients. The VA recommends CPT for treatment of veterans with PTSD regardless of the type of trauma they experienced. As social workers, we must maintain and enhance the integrity of the profession by learning how our clients are affected by CPT. This project looked at the experiences of veterans who were treated with CPT for MST-related PTSD. The study findings showed that participants experienced many strengths in CPT and, although challenges were reported during the treatment, the outcomes were described as strengths and positive changes in their lives. The publication of the study's findings will inform social workers who provide treatment to veterans with MST-related PTSD and will thereby contribute to the profession's integrity.

In my experience working in a few different VA settings including a community-based outpatient clinic, a mental health program at a VA medical center, and a Vet Center, which provides readjustment counseling, social workers who provide treatment for PTSD, especially MST-related PTSD, are often reluctant to offer CPT to veterans out of concern for the clients' well-being. Social workers are obligated to provide a thorough and accurate informed consent. This study and its findings should boost providers' confidence in CPT for treating veterans with MST-related PTSD, with the caution that this study is not representative of all veterans who received CPT for MST-related PTSD. Additionally, social workers can share some of the experiences, without any personal identifying information, described by some veterans who received CPT to potential clients as part of a thorough informed consent which is in keeping with the NASW Code of Ethics 1.03, informed consent, and 1.02, commitment to clients (NASW, 2017).

Social workers have an obligation to clients to provide the best treatment available for the client's needs. This study demonstrates that CPT is a challenging experience for female veterans with MST-related PTSD. However, it also showed that these challenged veterans benefit in several ways, such as decreased symptoms, more confidence, and more positive social lives, after receiving CPT. The information about the experiences with CPT of veterans with MST-related PTSD can also be used to improve the process of selecting which veterans will benefit the most from this treatment approach, however, this will require additional research. Currently, a provider will rule out CPT if the veteran is actively using substances, is experiencing psychotic features, or is unable to process thoughts (Monson et al., 2006). Cultural values must be considered

when determining whether to use CPT to treat a veteran for MST-related PTSD. Some cultures do not endorse talking about a traumatic experience from the past, such as Dine (Navajo), believing that bringing up the past can cause it to recur (Kahn-John & Koithan, 2015).

Finally, this study brings many additional research studies to the forefront that should be investigated. Scholar-practitioners may want to explore the experiences of veterans who drop out of CPT prior to its completion, their reasons for not completing, and whether they found another treatment approach that was less threatening. Based on the limitations of this study, future research could explore the experiences of female veterans with MST-related PTSD who started CPT and dropped out prior to completion. Another project might look at the experiences of veterans with MST-related PTSD who received CPT by collecting data through an interview as was originally planned in this study. As social workers, it is incumbent upon us to contribute to the body professional research to honor the integrity of our profession (NASW, 2017, 5.01).

As an advanced practitioner, these findings impact my own practice by increasing my understanding of the experiences my clients may face with a treatment that is considered an evidence-based practice. I will provide a more comprehensive description with informed consent and explore further the experiences of veterans who receive CPT so that I can provide the best treatment for my clients. This study's findings will contribute to my ability to improve the treatment I provide for my clients who are living with MST-related PTSD, especially regarding improving screening for clients who may

benefit the most for CPT, by increasing my understanding of experience of clients who receive CPT.

The transferability of this study is limited due to its narrow focus on female veterans with MST-related PTSD and, even more specifically, only those who received CPT at a VA treatment program in the Southwest United States. The findings of this project can still be useful to the broader field of social work practice by providing insight into the experiences of veterans who have experienced MST and then received treatment at the VA. This study provides future research considerations as well as greater understanding into clients' experiences. Limitations to the usefulness of this study include the lack of experiences of veterans with MST-related PTSD who did not complete the treatment, uncertainty about whether or not veterans who felt that CPT had a negative impact participated in the study, surveying only cis-female veterans who received CPT from a VA provider, and the absence of a comparison between the experiences with CPT to the experience of veterans who opted for another treatment modality.

Recommendations for further research abounds. This study could be revised to explore the experiences of male veterans, transgender veterans, or the perceptions of the social workers who are providing CPT. I started this project with the goal of interviewing the participants and ultimately settled for written responses to the research questions. The change in methodology created an additional study limitation preventing providing an in-depth experience and being limited to what the participants could express in writing. Future research could pursue interviews with the participants. It was important to explore

the experiences of veterans with MST-related PTSD with CPT, however, scholar practitioners should ask the same questions of other treatment modalities that are often provided to these veterans, such as prolonged exposure therapy, EMDR, and group therapy.

I will seek to have the findings of this study published in professional journals to honor the NASW Code of Ethics (2017) standard 5.01, which suggests that social workers should contribute to the integrity of the profession by conducting research and publicizing the findings. The study findings will also be presented to groups of social work professionals to disseminate the information.

Implications for Social Change

A potential implication of this study at the individual or micro level is improving the treatment that we are offering and providing to veterans with MST-related PTSD. By understanding the experiences of veterans who receive CPT for treatment of MST-related PTSD, we can give better information in the informed consent, improve our decisions regarding which clients will benefit most from this treatment approach, and increase our empathy as therapists. This study provides a better understanding of how female veterans with MST-related PTSD experience CPT which can give insight into which criteria to use to decide which clients may benefit the most from this treatment approach. When we use the findings gained in this study, we can contribute to improving the lives of our veterans when we provide CPT for MTSD-related PTSD. Enhancing the lives of individuals has a far-reaching effect, improving the lives of those around them and increasing their ability to function socially as well as to contribute in positive ways to our society.

On the mezzo level, this study has implications for change for social work practitioners and the VA and other agencies who work with veterans with MST-related PTSD. The study findings, which show the strengths of CPT and generally positive outcomes for female veterans with MST-related PTSD who engage in it, can be used to inform and modify treatment strategy selection to best serve the client population. For example, a veteran with MST-related PTSD who reports feelings of fear and shame, depression or anxiety, and a lack of self-confidence which is impacting her relationships, may be considered a good candidate for CPT if she is willing to make the commitment to complete 12 sessions, based on the findings of this study which shows positive outcomes related to these problems. The VA trains its professional treatment providers in evidence-based practice and therefore, can enhance its trainings by including the information gained in this study. The study finding can also inform organizations, trainers and managers, and schools of social work to educate providers and future providers about the experiences of veterans who seek treatment for MST-related PTSD.

Although it is not possible to generalize the findings of this study to all veterans with MST-related PTSD, they can contribute to the wider body of knowledge by informing other professionals such as psychologists or marriage and family therapists, to the experiences of these veterans with CPT. CPT provides education to the client on how PTSD occurs, effects the individual, and how it is treated. When a provider is confident in the approach, the outcomes will likely be better.

From a macro perspective, society could benefit from citizens who are well-adjusted, able to contribute to society, and are functioning socially. The findings of this

study indicate that female veterans who engage in CPT for treatment of MST-related PTSD experience an increase in confidence and social interaction, a willingness to pursue intimate relationships, and improved mental health, making them more active members of society.

Veterans fought for freedom. Some return home with PTSD due to MST. These heroes deserve the most effective treatment. Social workers should seek the best potential for healing and positive social change at every opportunity.

Summary

The Department of Veterans' Affairs and the International Society for Traumatic Stress Studies Practice affirmed CPT as an evidence-based practice in recent years citing it as an efficacious treatment (Suris, Link-Malcolm, Chard, Ahn, & North, 2013; Williams, Galovski, Kattar, & Resick, 2011). However, research on this treatment modality with MST survivors has been scarce (Allard, Nunnink, Gregory, Klest, & Platt, 2011; Suris et al., 2013; Voelkel et al, 2015), and research exploring the experiences of veterans who received CPT has been non-existent before this study. Social work practitioners are challenged to provide evidence-based treatment for their clients while respecting their experiences and doing no harm. As professionals who are committed to providing the best possible care for our clients, social workers need to understand how clients experience CPT, especially since the VA strongly encourages this approach for treating veterans with MST-related PTSD. Social workers must be prepared to provide the support clients need as they walk through the traumatic experiences they survived. The findings of this study can be disseminated through professional journals and

educational presentations to add to the knowledge and understanding that guides us all as we provide services and care to the most vulnerable populations in order to effect positive social change.

References

Ahrens, J. & Rexford, L. (2002). CPT for incarcerated adolescents with PTSD. *Journal of Aggression, Maltreatment, and Trauma, 6,* 201-216.doi: 10.1300/J146v06n01_10

Allard, C.B., Nunnink, S., Gregory, A.M., Klest, B., & Platt, M. (2011). Military sexual trauma: A proposed agenda. *Journal of Trauma and Dissociation. 12*, 324-345. doi:10.1080/15299732.2011.542609

Anderson, K., & Jack, D. C. (1991). Learning to listen: Interview techniques and analyses. In Gluck, S. B., and Patai, D., (Eds.), *In women's words: The feminist practice of oral history*. New York, NY: Routledge.

Baltrushes, N., & Karnik, N.S. (2013). Victims of military sexual trauma: You see them too. *Journal of Family Practice. 62*(3), 120-125.

Barbour, R. S. (2001). Checklists for improving rigor in qualitative research: A case of the tail wagging the dog? *British Medical Journal, 322,* 1115-1117. doi:10.1136/bmj.322.7294.1115

Barrett, F. J. (1996). The organizational construction of hegemonic masculinity: The case of the U.S. Navy. *Gender, Health, and Organization, 3*(3), 129-142.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4,* 561-571. doi:10.1001/2rchpsyc.1961.0170120031004

Bell, M., Street, A., & Stafford, J. (2014). Victims' psychosocial well-being after reporting sexual harassment in the military. *Journal of Trauma and Dissociation. 15*(2), 133-152. doi:10.1080/15299732.2014

Blake, D. D., Weathers, F. W., Nagy, L. M., Kaloupek, D. G., Klauminzer, G., Charney, D. S., & Keane, T. M. (1990). A clinician rating scale for assessing current and lifetime PTSD: The CAPS:1. *Behavior Therapist, 13,* 187-188.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Brown, S. (2004). Feminist paradigms of trauma treatment. *Psychotherapy: Theory, Research, Practice, Training, 41,*4, 64-471. doi:10.1037/0033-3204.41.4.464

Burns, B., Grindlay, K., Holt, K., Manski, R., & Grossman, D. (2014). Military sexual trauma among U.S. servicewomen during deployment: A qualitative study. *American Journal of Public Health, 104*(2), 345-349. doi:10.2105/AJP.2013.301576

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods, 2*(2), 1-13. doi:10.1177/160940690300200.201

Callahan, J. (2009). Manifestations of power and control: Training as a catalyst of scandal at the United States Air Force Academy. *Violence Against Women, 15*(10), 1149-1168. doi:10.1177/1077501209344341

Caplan, P. J. (2013). Sexual trauma in the military: Needed changes in policies and procedures. *Women's Policy Journal of Harvard, 10,* 10-21.

Castillo, D.T., Lacefield, K., C'deBaca, J., Blankenship, A., & Qualls, C. (2014). Effectiveness of group-delivered cognitive therapy and treatment length in

women veterans with PTSD. *Behavioral Sciences. 4*, 31-47. doi:10.3390/bs4010031

Chard, K. M. (2005). An evaluation of CPT for the treatment of PTSD related to childhood sexual abuse. *Journal of Consulting and Clinical Psychology, 73*(5), 965-971. doi:10.1037/0022-006x.73.5.965

Chard, K. M., Ricksecker, E. G., Healy, E. T., Karlin, B. E., & Resick, P. (2012). Dissemination and experience with cognitive processing therapy. *Journal of Rehabilitation Research and Development, 49,* 667-678. doi:10.1682/JRRD.2011.10.0198

Coll, J., Weiss, E., & Yarvis, J. (2011). No one leaves unchanged: Insights for civilian mental health care professionals into the military experience and culture. *Social Work in Health Care, 50,* 487-500. doi:10.1080/00981389.2010.528727

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd Ed.), Thousand Oaks, CA: Sage.

Dalgleish, T. (2004). Cognitive approaches to posttraumatic stress disorder: The evolution of multi-representational theorizing. *Psychological Bulletin, 130,* 228-260. doi:10.1037/0033-2909.130.2.225

Denzin, N. K. (2001). *Interpretive interactionism* (2nd ed.). Thousand Oaks, CA: Sage.

Derogatis, L. R. & Unger, R. (2010). *Symptom checklist-90-Revised*. New York, NY: John Wiley & Sons, Inc.

Dinneen, C. M. (2015). Current challenges being faced by female survivors of military sexual trauma: Suggestions for policy change. *Culminating Projects in Social Work,* Paper 1.

Donat, P.L.N. & D'Emilio, J. (1992). A feminist redefinition of rape and sexual assault: Historical foundations and change. *Journal of Social Issues, 48,*1, 9-22. doi:10.1111/j.1540-4560.1992. tb01154.x

Ehlers, A. & Clark, D.M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38,* 319-345. doi:10.1016/S005-7967(99) 00123-0

Falsetti, S. A., Resnick, H.A., Davis, J. A., & Gallagher, N. G. (2001). Treatment of PTSD with co-morbid panic attacks: Combining CPT with panic control treatment techniques. *Group Dynamics: Theory, Research, and Practice, 5*(4), 252-260. doi:10.1023/A:1026522931013

First, M., Gibbon, M., Spitzer, R. L., Williams, J. B. W. (1996). Structured clinical interview for DSM-IV. (SCID). New York State Psychiatric Institute, Biometrics Research Department, New York.

Fortune, A. E., Reid, W. J., & Miller, R. L. (Eds.), (2013). *Qualitative Research in Social Work* (2nd Ed.), New York: NY: Columbia University Press.

Galovski, T. E., Blain, L., Mott, J. M., Elwood, L.S., & Houle, T. (2012). Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 80,* 968-981. doi:10.1037/20030600

Galovski, T. E. & Resick, P. A. (2008). CPT for PTSD secondary to motor vehicle accident: A single subject report. *Cognitive and Behavioral Practice, 15,* 287-295. doi: 10.1016/i.cbpra.2007.11.005

Gillibrand, K. (2013). Should decisions regarding the prosecution of sexual assault cases in the military be removed from the chain of command? *Congressional Digest, 92*(8), 11-31.

Grassbaugh, J. C. (2014b). The opaque glass ceiling: How will gender neutrality in combat affect military sexual assault prevalence, prevention, and prosecution? *Ohio State Journal of Criminal Law, 11*(2).

Haaken, J. & Palmer, T. (2012). War stories: Discursive strategies in framing military sexual trauma. *Psychoanalysis, Culture, & Society, 17*(3), 325-333. doi:10.1057/pcs.2012.7

Hall, L. (2011). The importance of understanding military culture. *Social Work in Health Care, 50,* 4-18. doi:10.1080/00981389.2010.513914

Hesse-Biber, S. N. (2013). *Feminist research practice: A Primer.* Thousand Oaks, CA: Sage.

Holliday, R., Link-Malcolm, J., Morris, E.E., Suris, A. (2014). Effects of CPT on PTSD-related negative cognitions in veterans with military sexual trauma. *Military Medicine 179*(10), 1077. doi:10.7205/MILMED-D-13-005309

Hyun, J. K., Pavao, J., & Kimerling, R. (2009). Military sexual trauma. *PTSD Research Quarterly, 20*(2), 1-7.

Iverson, K. M., Lester, K. M., & Resick, P.A. (2011). Psychosocial treatments. In D.M. Benedek and G. H. Wynn (Eds.), *Clinical Manual for Management of PTSD.* (pp 157-203). Arlington, VA: American Psychiatric Association.

Kahlke, R. M. (2014). Generic qualitative approaches: Pitfalls and benefits of methodological mixology. *International Journal of Qualitative Methods, 13,* 37-53. doi:10.1177/160940691401300119

Kahn-John, M., & Koithan, M. (2015). Living in health, harmony, and beauty: The Dine (Navajo) hozho wellness philosophy. *Global Advances on Health and Medicine. 4*(3), 24-30. doi:10.7453/gahmj.2015.044

Katz, L.S. (2016). *Treating military sexual trauma*. New York, NY.: Springer Publishing Company.

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, 27*(4), 487-499. doi:10.1891/0886-6708.27.4.487

Kelly, J.A., Skelton, K., Patel, M., & Bradley, B. (2011). More than MST: Interpersonal violence, PTSD, and mental health in women veterans. *Research in Nursing and Health.34*(6): 457-467. doi:10.1002/nur.20453

Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. (2006). The Veterans Health Administration and military sexual trauma. *American Journal of Public Health, 97*(12). doi:10.2105/AJPH.2006.092999

Klest, B., Freyd, J. J., & Foynes, M. M. (2013). Trauma exposure and posttraumatic symptoms in Hawaii: Gender, ethnicity, and social context. *Psychological Trauma: Theory, Research, Practice, and Policy, 5,* 409-416. doi:10.1037/a0029336

Knoedel, S. (2014). Military Sexual Trauma. Washington DC.: VA.

Leatherman, J. (2011). *Sexual violence and armed conflict*. Malden, MA: Polity Press.

Lincoln, Y. S. & Guba, E. G. (200). Paradigmatic controversies, contradictions, and emerging confluences. In Y. S. Lincoln & E. G. Guba (Eds.), *Handbook of qualitative research* (p. 163-188). Thousand Oaks, CA: Sage.

Marques, L., Eustis, E. H., Dixon, L., Valentine, S. E., Borba, C., Simon, N., Kaysen, D., & Willsey-Stirman, S. (2016). Delivering cognitive processing therapy in a community health setting: The influence of Latino culture and community violence in posttraumatic cognitions. *Psychological Trauma, 8*(1), 980106. doi:10.1037/tra0000044

Martin, C. G., Cromer, L. D., DePrince, A. P., & Freyd, J. J. (2013). The role of cumulative trauma, betrayal, and appraisals in understanding trauma symptomatology. *Psychological Trauma: Theory, Research, Practice, and Policy, 5,* 110-118. doi:10.1037/a0025686

Mason, M. (2010). Sample size and saturation in PhD studies using qualitative interviews. *Qualitative Social Research, 11*(3), 1-15. doi:10.17189/fqs.11.3.1428

Mattocks, K.M., Haskell, S. G., Krebs, E.E., Justice, A. C., & Yano, E. M. (2012). Women at war: Understanding how women veterans cope with combat and

military sexual trauma. *Social Science and Medicine, 74,*537-545. doi: 10.1016/j.socscimed.2011.10.039

Maxwell, J. A. (2013). *Qualitative research design: An interactive approach* (3rd ed.). Thousand Oaks, CA: Sage.

Meyer, D. Z. & Avery, L. M. (2009). Excel as a qualitative data analysis tool. *Field Methods, 21*(1), 91-112. doi:10.1177/1525822X08323985

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook.* Thousand Oaks, CA: Sage.

Monson, C.M., Schnurr, P.P., Resick, P.A., Friedman, M.J., Young-Xu, Y., & Stevens, S.P. (2006). Cognitive processing therapy for veterans with military-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology. 74*,898-907. doi:10.1037/0022-006x.74.5.898

National Association of Social Workers. (2017). Code of Ethics. NASW.

Northcut, T. B., & Kienow, A. (2014). The trauma trifecta of military sexual trauma: A case study illustrating the integration of mind and body in clinical work with survivors of MST. *Clinical Social Work Journal, 42,* 247-259. doi:10.1007/s10615-014-0479-0

O'Donnell, M. L., Elliott, P., Wolfgang, B. J., & Creamer, M. (2007). Posttraumatic appraisals in the development and persistence of posttraumatic stress symptoms. *Journal of Traumatic Stress, 20,* 173-182. doi:10.1002/jys.20198

Owens, G. P., Pike, J. L., & Chard, K. M. (2001). Treatment effects of cognitive processing therapy on cognitive distortions of female child sexual abuse survivors. *Behavior Therapy, 32,* 413-424. doi:10.1016/s00005-7894(01)80028.9

Porter, M. (2010). *Research as a research tool.* In A. J. Mills. G. Durepos, & E. Wiebe (Eds.), Encyclopedia of case study research (p.809-811), Thousand Oaks, CA: Sage Publications.

Postmus, J. L. (2013). Qualitative interviewing. In A. E. Fortune, et al., (Eds.), *Qualitative Research in social work* (2nd ed.), New York, NY: Columbia University Press.

Probst, B. (2015). The *eye* regards itself: Benefits and challenges of reflexivity in qualitative social work research, *Social Work Research, 39* (1), 37-48. doi:10.1093/swr/svu028

Reinharz, S., & Chase, S. E., (2002). Interviewing women. In Gubrium, J. F., and Holstein, J. A., (Eds.), Handbook of interview research: Context and method. Thousand Oaks, CA: Sage Publications.

Resick, P. A. (2015). A randomized clinical trial of group cognitive processing therapy compared with group present-centered therapy for PTSD among active duty military personnel. *Journal of Consulting Clinical Psychology, 83*(6), 1058-1068. doi:10.1037/ccp00000/6

Resick, P.A., Monson, C.M., & Chard, K.M. (2017) Cognitive Processing Therapy for PTSD: A Comprehensive Manual. New York, New York: The Guilford Press.

Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feurer, C. A. (2002). A comparison of cognitive processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress in female rape victims. *Journal of Consulting and Clinical Psychology, 70,* 867-879. doi:10.1037/0022-006x.70

Resick, P. A., & Schnicke, M. K. (1996). Cognitive Processing Therapy for Rape Victims: A Treatment Manual. Thousand Oaks, CA: Sage Publications.

Resick, P.A., & Schnicke, M.K. (1992). Cognitive processing therapy for sexual assault victims, *Journal of Consulting and Clinical Psychology.60* (5), 748-756. doi:10.1037/0022-006x.60.5.748

Resick, P. A., & Schnicke, M. K. (1990). Treating symptoms in adult victims of sexual assault. *Journal of Interpersonal Violence, 60,* 748-756. doi:10.1177/08862609000 5004005

Richmond, K., Geiger, E., & Reed, C. (2013). The personal of political: A feminist and trauma-informed therapeutic approach to working with a survivor of sexual assault. *Clinical Case Studies, 12*(6), 443-456. doi:10.1177/1534650113500563

Robinson, O. C. (*2014*). Sampling in interviewing-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11,* 25-41. doi:10.1080/14780887.2013.801543

Ryan, K. M. (2011). The relationship between rape myths and sexual scripts: The social construction of rape. *Sex Roles, 65,* 774-782. doi:10.1007/s11199-011-0033-2

Schumm, J. A., Dickstein, B. D., Walter, K. H., Owens, G. P., & Chard, K. M. (2015). Changes in posttraumatic cognitions predict changes in posttraumatic stress disorder symptoms during cognitive processing therapy. *Journal of Consulting and Clinical Psychology, 83* (6), 1161-1166. doi:10.1037/ccp 0000040

Shields, N. M., Resick, P. A., & Hanneke, C. R. (1990). *Victims of marital rape*. In Ammerman, R. T. & Hersen, M. (Eds.), Treatment of family violence: A sourcebo*k*. New York, NY: John Wiley and Sons.

Shulz, P. M., Huber, L. C., & Resick, P. A. (2006). Practical adaptations of CPT with Bosnian refugees: Implications for adapting practice to a multicultural clientele. *Cognitive and Behavioral Practice, 13*(4), 310-321. doi: 10.1016/j.cbpra.2006.04.015

Skjelsback, I. (2001). Sexual violence and war: Mapping out a complex relationship. *European Journal of International Relations, 7* (2), 211-237. doi:10.1177/1354066.101007002003

Smith, C. P., & Freyd, J. J. (2013). Dangerous safe havens: Institutional betrayal exacerbates sexual trauma. *Journal of Traumatic Stress, 26,* 119-124. doi:10.1002/jts.21778

Sobel, A. A., Resick, P.A., & Rabalais, A. E. (2009). The effect of cognitive processing therapy on cognitions: Impact statements coding. *Journal of Traumatic Stress, 22,* 205-211. doi:10.1002/jts.20408

Stander, V. A. & Thomsen, C. J. (2016). Sexual harassment and assault in the U.S. military: A review of policy and research trends. *Military Medicine, 181,* 1-20. doi:10.7205/MILMED-D-15-00336

Suris, A., Lind, I., Kashner, T. M., & Borman, P. D. (2007). Mental health, quality of life, and health functioning in women veterans: Differential outcomes associated with military and civilian sexual assault. *Journal of Interpersonal Violence, 22,* 179-197. doi:10.1177/0886260506295347

Suris, A., Link-Malcolm, J., Chard, K.M., Ahn, C., & North, C. (2013). A randomized clinical trial of cognitive processing therapy for veterans with PTSD related to MST. *Journal of Traumatic Stress.* 26, 28-37. doi:10.1002/jts.21765

Suris, A. M. & Smith, J. C. (2013). *Sexual assault in the military.* In Moore, B. A. & Penk, W. E., Treating PTSD in military personnel: A clinical handbook. New York, NY: The Guilford Press.

Tashakkori, A. & Teddlie, C. (2003). Handbook of Mixed Methods in Social and Behavioral Research. Thousand Oaks, CA.: Sage Publications.

Toma, J. D. (2011). *Approaching rigor in applied qualitative research*. In C. F. Conrad & R.C. Serlin (Eds.) The SAGE handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry. (2nd ed., 332-336). Thousand Oaks, Sage Publications.

Turchik, J. A., Hebenstreit, C. L., & Judson, S. S. (2016). An examination of the gender inclusiveness of current theories of sexual violence in adulthood: Recognizing

male victims, female perpetrators, and same-sex violence. *Trauma, Violence & Abuse, 17,*2,133-148.

Turchik, J. & Wilson, S. (2010). Sexual assault in the U.S. military: A review of the literature and recommendations for the future. *Aggression and Violent Behavior, 15,* 267-277. doi:10.1016/ j.avb.2010.01.005

U.S. Department of Veterans' Affairs. (2015). National Center for PTSD: CPT. Washington DC: VA.

Valente, S. (2007). MST: Violence and sexual abuse. *Military Medicine, 172,*3, 250-265. doi:10.7205/MILMED.172.3.259

Vanburen, J. B. M. (2016). The military's dirty little secret: Military sexual trauma policies and implications for survivors, *Online theses and Dissertations,* 440.

Voelkel, E., Pukay-Martin, N.D., Walter, K.H., & Chard, K.M. (2015). Effectiveness of CPT for male and female U.S. veterans with and without military sexual trauma. *Journal of Traumatic Stress. 28*, 174-182. doi:10.1002/jts.22006

Wachen, J. S., Dondanville, K. A., Pruiksma, K. E., & Resick, P.A. (2016). Implementing cognitive processing therapy for posttraumatic stress disorder with active duty military personnel: Special considerations and case examples. *Cognitive and Behavioral Practice, 23* (2), 13147. doi: 10.1016/j.cbpra.2015.08.007

Webster, D. C. & Dunn, E. C. (2005). Feminist perspectives on trauma. *Women & Therapy, 28,* 111-142. doi:10.1300/J015v28n03_06

Williams, A.M., Galovski, T.E., Kattar, K.A., & Resick, P.A. (2011). Cognitive processing therapy. In Treating PTSD in Military Personnel: A Clinical Handbook. New York, NY.: The Guilford Press.

Willig, C. (2008). Discourse analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., 160-185). London, England: Sage.

Wilson, P. H. (2008). Defining military culture. *The Journal of Military History, 72,* 11-41. doi:10.1353/jmb.2008.0041

Zaleski, K. (2015). *Understanding and Treating Military Sexual Trauma.* Switzerland: Springer International Publishing.

Appendix: Interview Guide

1. Describe the experience of receiving CPT?
2. Describe what, if anything, has changed for you since receiving CPT.
3. Explain how CPT has had an impact (positive, negative, or neutral) in your life.
4. What components of CPT do you perceive as strengths?
5. What components of CPT do you perceive as ineffectual?
6. Are there any potentially damaging components of CPT? If so, what? Why?
7. Describe how your symptoms (PTSD, depression, etc.) have changed since receiving CPT.
8. Describe the way your view of the world has changed since receiving CPT.
9. Describe how your view of others has changed since receiving CPT.
10. Describe how your view of yourself has changed since receiving CPT.
11. If you had a close friend who was struggling due to MST and she asked you about CPT, what would you tell her?