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Themes in Help-seeking of Female Military Sexual Assault Survivors

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This Clinical Dissertation, written under the direction of the student's Clinical Dissertation Chair and Committee and approved by Members of the Committee, has been presented to and accepted by the faculty of the Clinical Psychology PsyD Program in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the student alone.

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Table of Contents

Introduction and Specific Aims 7
Brief Rationale and Alignment with Jesuit Mission of Social Justice 10
Literature Review 11
History of Military Sexual Assault in the Military 11
Mental Health Sequelae of MSA 13
Childhood sexual abuse in Military Sexual Assault Survivors 15
Barriers in Help-Seeking 16
Military Culture 17
Institutional Betrayal 18
Self-Blame, Shame, and Victim Blaming 19
Impact of MSA-related PTSD on Help-Seeking 21
Help-seeking Options Following Sexual Assault 23
Formal help-seeking 23
Treatment of MSA 25
Informal help-seeking 28
Facilitators in Help-seeking 29
Post-Traumatic Growth 30
Method 31
Participants 32
Procedures 34
Data Analysis 36
Results 39
Emerging Themes 43
Types of Help-Seeking 44
Subtheme: Formal Help-seeking 45
Subtheme: Informal Help-seeking 47
Barriers to Help-Seeking 48
Subtheme: Stigma 50
Subtheme: Fear 51
Subtheme: Culture 53
Subtheme: Self-blame 56
Subtheme: Limited Care 57
Facilitators to Help-seeking 58
Subtheme: Camaraderie 59
Coping 60
Subtheme: Maladaptive Coping 61
Subtheme: Adaptive Coping 64
Mental health impacts 65
Disclosure 66

Post-traumatic Growth....67
Clinical Implications....73
Study Limitations and Future Research....74
Conclusion....75
References....76
Appendix A. Recruitment Flyer....85
Appendix B. Participant Screener....86
Appendix C. Referral List....90
Appendix D. Consent Form....91
Appendix E. Interview Guide....94
Appendix F. Proof Quotes....98

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This dissertation is dedicated to the children of immigrants and first-generation college students– you can do it. This dissertation is also dedicated to all sexual assault survivors– I see you, I hear you, and I believe you.

Abstract

While large efforts have been made to address military sexual assault, there are still barriers in the help-seeking journey that need attention. This study aimed to examine barriers and facilitators to formal and informal help-seeking behaviors and to understand the role of stigma in survivors' help-seeking behaviors for female military sexual assault survivors. Through semi-structured interviews, the study explored the help-seeking experiences and mental health sequela of fourteen female military sexual assault survivors. This study focused on cis-gender women over the age of eighteen who experienced a military sexual assault, by another military service member, while on active-duty. Women shared their narratives, how their help-seeking experiences were impacted by cultural norms, facilitators, and barriers, and how these factors affected growth for some of the women. Thematic analysis (Braun & Clarke, 2006) produced seven themes in help-seeking: types of help-seeking, barriers to help-seeking, facilitators to help-seeking, coping, mental health impacts, disclosure, and post-traumatic growth. Findings from this study further inform the research community of facilitators and barriers to help-seeking and inform changes to decrease the mental health impact on survivors by increasing areas of support. The findings of this research highlighted that help-seeking was impacted by military culture, societal attitudes toward sexual assault, and self-perceptions of mental health. Further research is needed to minimize the widespread barriers to help-seeking, decrease the delay in receiving mental health services, and ultimately address and eliminate underlying factors that perpetuate military sexual assault.

Introduction and Specific Aims

The Department of Defense (DoD) has been actively conducting scientific surveys of active-duty armed forces and each military department since 2006. The rate of active-duty women who experienced military sexual assault (MSA) has increased from 4.3% in 2016 to 6.2% in 2017, while prevalence rates for active-duty men remained at 0.7% between 2016 and 2018 (Department of Defense, 2019). The increase in sexual assault prevalence between 2016 and 2018 from 14,900 to 20,500 service members, respectively, primarily among female service members aged 17 to 24 (Department of Defense, 2019), highlights a call to action. MSA still affects survivors even after the military, with a staggering 94% of the PTSD-related disability claims in the Veterans Affairs relating to MSA (United States Government Accountability Office, 2014).

Reported rates of MSA underrepresent the prevalence of the issue as MSA survivors underreport their experiences due to various reporting barriers and the survivors may choose to utilize informal help-seeking methods rather than formal help-seeking methods (Holland & Cipriano, 2019). This study explored themes in help-seeking barriers affecting the formal and informal help-seeking experiences of MSA survivors. The DoD found that only one in three survivors chose to report their sexual assault, and this rate has remained unchanged since 2016 (Department of Defense, 2019). Prior research on military sexual assault (MSA) has shown the negative impacts on the mental health (MH) of service members, which includes increased rates of depression, anxiety, PTSD and PTSD symptoms, and substance use disorders (Bell et al., 2014; Gilmore et al., 2016). The military has acknowledged sexual assault as an ongoing issue, and they have a goal to enhance support for MSA survivors by "provid[ing] all Service members reporting a sexual assault with a professional response that includes crisis intervention, reporting

options, and recovery services" (Department of Defense, 2019, p 15). Given the underreporting rates, we need to understand further the mental health impacts on MSA survivors and explore formal and informal help-seeking behaviors.

While there are many identified formal sources of support (e.g., psychotherapy, medical care, support groups) that help reduce adverse outcomes, more literature is needed to understand further how informal sources of support (e.g., disclosing to unit members, leaders, and significant others) can help reduce stigma and increase help-seeking behavior (Zinzow et al., 2015). Prior research has focused primarily on formal help-seeking behaviors and has identified barriers to formal help-seeking, including official reporting of MSA. Barriers to reporting MSA includes external factors (e.g., feeling unsafe and not belonging, hostile environments, rank hierarchy, in addition to many others), internal factors (e.g., shock, protection, internalized rape myths surrounding faults), interpersonal factors (e.g., betrayal from the system aimed at protecting survivors, invalidation), and fear of repercussions as a result of reporting and seeking help (Rasmussen, 2016).

To further expand upon current literature, this study explored the help-seeking behaviors of women who have survived MSA. It is imperative that we also better understand this highly prevalent problem through research on help-seeking behaviors as women are impacted disproportionately by MSA. One possible impact of this study includes expanding upon current sources of help-seeking and informing the development of additional interventions that will adequately meet our service members' help-seeking needs. This study employed qualitative methodology using a thematic analysis (Braun & Clarke, 2006) framework via in-depth individual interviews of female military sexual assault survivors to understand better the factors that impact informal and formal help-seeking behaviors. The specific aims of this project were:

1. To conduct in-depth interviews with female military sexual assault survivors to examine barriers and facilitators to formal and informal help-seeking behaviors.
2. To understand the role of stigma in survivors' help-seeking behaviors.

This study addressed the following research questions.

1. Explore how being an active-duty military member affected women's experience of sexual assault.
2. Identify help-seeking behaviors following military sexual assault and explore the impact on their mental health.
3. Understand how help-seeking, including reporting of the assault, affected the remainder of their time in the military.
4. Explore the role of stigma on women's help-seeking experiences.

Brief Rationale and Alignment with Jesuit Mission of Social Justice

In line with the University of San Francisco's Jesuit mission, this research confronted injustice and systemic violence and contributed to the just resolution of communal conflict. Specifically, this research project sheds further light on military sexual assault and themes surrounding help-seeking. Prior research has shown MSA survivors should be able to get justice through formal reporting to the military and prosecution of the perpetrator. However, barriers within military culture, including the dominance in numbers of male service members, power differentials, shame, and stigma in mental health are barriers to accessing care and healing. MSA is a form of both physical and psychological systemic violence, and the current formal and informal help-seeking methods available are not sufficient in resolving the aftermath of MSA. Exploring military culture, barriers to healing, and help-seeking behaviors can be a step in promoting and protecting human rights for all by meeting one of the most basic human needs—safety (Maslow, 1958). Findings from this project shed light on help-seeking behaviors following MSA, providing insight into barriers and facilitators of formal and informal help-seeking, and can aid in the expansion of trauma-focused intervention strategies to decrease the mental health impact on MSA survivors.

Literature Review

History of Military Sexual Assault in the Military

The Department of Defense (DoD) has actively conducted scientific surveys of active-duty forces and each of the military departments since 2006. Since 2006, the DoD has found an increase in the prevalence of sexual assault, primarily for female service members aged 17 to 24 (Department of Defense, 2019). Some researchers define sexual assault as any unwanted sexual experience, while research from others requires the assailant's use of force or threatened harm (Badgley et al., 1984; Russel, 1984, Jacobson, Koehler, & Jones-Brown, 1987; Koss & Gidycz, 1985; Koss, Gidycz, & Wisniewski, 1985, as cited in Skinner et al., 2000). In contrast to sexual assault in the civilian population, military sexual assault[1] can be defined as the use of force or the threat of force to have sexual relations with a person against their will while in the military (Holland & Cipriano, 2019). Within the civilian population, 17% of women in the United States will experience a sexual assault (SA) in their lifetime. The prevalence of sexual assault is two-fold in the military; 33% of women in the military experience sexual assault (Kelley et al., 2008). Despite higher incidences of sexual assault in the military, only a quarter of military sexual assaults against women are reported compared to the civilian population. In 2017, the military sexual assault (MSA) reporting rate for military personnel was approximately 6.2% for active-duty women, compared to a 24.9% reporting rate for civilian women (Department of Defense, 2019; Department of Justice, 2019). This difference in the sexual assault (SA) reporting rates can be attributed to the military culture around help-seeking and challenges to reporting. Help-seeking includes formal and informal help-seeking. Formal help-seeking encompasses the

[1] Military sexual assault and military sexual trauma have been used interchangeably in prior research. While both military sexual assault and military sexual trauma are similar, not all who experience military sexual assault may identify their experience as traumatic, thus the term military sexual assault will be used to encompass both terms.

utilization of established support, such as reporting or the use of a mental health provider. In contrast, informal seeking can include seeking support from friends, family, and the faith community.

Prior to 2005, each military branch had its own separate sexual assault prevention programming (U.S. DoD, 2016). The Sexual Assault Prevention and Response Office (SAPRO) was established by the Department of Defense in 2005 to address sexual assault across all military branches, focusing on prevention, surveillance, and reporting of sexual assault (Orchowski et al., 2018). In efforts to evaluate SA prevention programs in military settings, Orchowski et al. (2018) synthesized research literature and found five distinct SA prevention programs: "(1) bringing in the Bystander (BITB); (2) the Know Your Power social marketing campaign; (3) the Men's Program; (4) the Navy Sexual Assault Intervention Training Program (SAIT); and (5) the Sexual Assault Victim Intervention (SAVI)" (p. 423). Both SAIT and SAVI are the only two SA prevention programs explicitly developed for the military (Orchowski et al., 2018). The SAVI program was perceived to be more helpful in coping with sexual assault when compared to other SA prevention training (Orchowski et al., 2018). Further, SAVI program participants also reported a positive effect on the quality of life, readiness for duty, and retention plans (Kelley et al., 2005). Among men who participated in the Navy SAIT program, there was evidence of greater empathy with rape victims, a greater rate of knowledge of sexual assault, and less acceptance of rape myths (Rau et al., 2010). While these programs were developed and utilized, there is still a lack of knowledge of the mental health impacts and help-seeking options following MSA.

Mental Health Sequelae of MSA

While research on mental health in the military provides information about the types of mental health problems experienced in this population, as well as the types of help sought for mental health issues, further research is needed to understand the types of help-seeking for mental health issues that are specifically associated with military sexual assault (MSA). Nugent et al. (2020) assessed mental health treatment utilization in deployed (active-duty) soldiers (n = 2,412), and the research indicated that a quarter (n = 600) of all soldiers were classified as at-risk for a mental health problem, including moderate or severe stress, emotional, alcohol, or family problems. Further, half (12%) of the soldiers who were classified as at-risk for a mental health problem met the strict screening definition for Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder (MDD), or Generalized Anxiety Disorder (GAD). Although a quarter of soldiers were at risk for a mental health problem, only 19% (n = 458) of all soldiers reported receiving mental health help at least once during their current deployment. Three percent of all soldiers received help exclusively from a provider (i.e., mental health professional, combat stress professional, general medical doctor), 9% reported exclusively receiving help from a non-mental health provider (i.e., chaplain, medic, another unit member), and 7% reported receiving help from both non-providers and providers (Nugent et al., 2020).

The reported rates of active-duty women who experienced military sexual assault (MSA) increased from 4.3% in 2016 to 6.2% in 2017, while prevalence rates for active-duty men remained at 0.7% between 2016 and 2018 (Department of Defense, 2019). MSA reporting rates underrepresent the actual prevalence of the issue as MSA survivors underreport their experiences due to various reporting barriers (Orchowski & Gidycz, 2012), suggesting the prevalence and issue of MSA are more significant than the initial appraisal. Despite the high prevalence of

sexual assault, a majority of sexual assault survivors do not seek mental health treatment (Price et al., 2014). In addition to lower utilization rates, care is delayed when comparing civilian to military populations (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). In a sample of 266 civilian sexual assault survivor participants, 43.5%, 36.5%, and 31.4% utilized mental health care at 1.5-, 3-, and 6-month assessment periods, respectively. In comparison, in a study of women military personnel, only approximately 25% of MSA survivors sought help formally through mental health care (Washington, Bean-Mayberry, Riopelle, & Yano, 2011). Although not all survivors formally seek help, approximately two-thirds of all rape survivors disclose their assault to at least one person (Maguen et al., 2012) suggesting the use of informal support.

Despite a need and desire for mental health treatment, barriers to accessing help exist, including stigma, scheduling difficulties (e.g., difficulty getting time off and difficulty scheduling an appointment, and barriers specific to the military (Maguen et al., 2012)). Although much research has been done with MSA survivors, the unique symptoms and mental health barriers of military sexual assault survivors suggest a need for further exploration of mental health-seeking behaviors and the impact of the type of help-seeking on the individual.

Female MSA survivors are 4 to 9 times more likely to suffer from PTSD when compared to female Veterans without a history of sexual assault (Maguen et al., 2012; Turchik & Wilson, 2010). Further, both female and male MSA survivors with PTSD were found to have an increased prevalence of comorbid mental health disorders (Maguen et al., 2012). In the research sample of 74,493 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans with PTSD, men with both PTSD and MSA (n = 714) were more likely to receive comorbid substance use disorder diagnoses. In contrast, women with PTSD and MSA (n = 2,240) demonstrated higher rates of comorbid depression, anxiety, and eating disorder diagnoses

(Goldstein et al., 2017), as well as greater symptom severity (Maguen et al., 2012; Nugent et al., 2020). Moreover, research has the shown negative impacts of military sexual assault on a person's physical ability, ability to maintain employment, and quality of life due to psychological and emotional problems (Turchik & Wilson, 2010). Understanding comorbidities, symptoms, mental health service utilization, and perceived barriers in Veterans with MSA can help us better target evaluation, early intervention, and help-seeking options to prevent chronic mental illnesses (Holland et al., 2016).

Childhood sexual abuse in Military Sexual Assault Survivors

Experiences of childhood sexual assault are highly prevalent not only in the military population, but also in MST survivors, and are related to adverse health outcomes (Parnell et al., 2018). Military populations are more likely to have experienced adverse childhood events, including CSA, compared to civilian populations (Blosnich et al., 2014). Research has also found a relationship between childhood sexual abuse (CSA) and adult revictimization. In a study examining female Navy recruits, women with a history of CSA were five times as likely to be sexually re-victimized than women without a history of CSA (Mercado et al., 2015). Among women, CSA remains an independent predictor for a higher number of past-year medical healthcare visits, more severe depressive and PTSD symptoms, and increased risk for poorer outcomes in quality of life (Mercado et al., 2015; Williams et al., 2017); however, CSA was not a significant predictor of MH care visits or substance use disorder related visits (Mercado et al., 2015). This research suggests a prevalence of CSA history in MST survivors, as well as negative effects on mental health, but not an increase in formal help-seeking utilization through mental health visits. Because sexual violence is likely to happen throughout the lifespan, it is important to support and further research appropriate prevention, intervention, and treatment strategies, as

well as barriers to help-seeking after sexual assault in military personnel and Veterans (Schultz et al., 2006).

Barriers in Help-Seeking

Barriers to help-seeking have a clear impact on mental health, and it is important to expand upon current research and identify how to reduce these barriers. Research examining barriers and stigma in MSA survivors found that MSA survivors who perceived more significant help-seeking barriers endorsed more PTSD symptoms (Rasmussen, 2016). Prior interpretative phenomenological analysis (IPA) research with Veteran MSA survivors by Navy psychologist Dr. Rasmussen identified four emergent themes in barriers to help-seeking: external factors, internal processes, interpersonal experiences, and focus on the future (Rasmussen, 2018). In the qualitative interviews, the researcher found external barriers to help-seeking included environmental and cultural components that contributed to or detracted from safety and belonging, which included gender issues, hostile environment, and military-specific aspects (Rasmussen, 2016). Internal barriers included psychological and emotional processes such as shock, internalized rape myths, risk and benefit analysis, protection, breaking point, and meaning-making, which affected reporting the assaults and harassment (Rasmussen, 2016). Rasmussen (2016) found interpersonal barriers included experiences with others that invalidated beliefs, as well as betrayal. Betrayal occurred at both the individual and group levels. Participants reported feelings of betrayal by the perpetrators who were acquaintances or well-known peers. Additionally, participants felt betrayed when individuals, including family members, responded in invalidating ways. Further, betrayal was found to occur on the group and organizational levels where leadership did not follow the professed values of the branch and

peers responded with hostility and threats of retaliation. These forms of group and organizational betrayal decreased the likelihood of reporting (Holliday & Monteith, 2019; Conard et al., 2014).

Individual barriers are also present and affect a servicewoman's likelihood of reporting. Consistent with approximately 75% of VA-enrolled Veterans (Sadler et al., 2003), embarrassment and impact on career were found to be among the reasons not to make a restricted report or to make an unrestricted report (Mengeling et al., 2014). Additionally, reasons for not reporting also included confidentiality concerns and thoughts that nothing would be done (Rock & Lipari, 2008, as cited in Mengeling et al., 2014) were also reasons for not reporting. Efforts have been made to de-stigmatize mental health, minimize negative career consequences, and ensure confidentiality, yet the lack of early intervention remains (Monteith et al., 2018). Help-seeking, such as types of reporting and barriers, were further explored in this literature review and study.

Military Culture

In addition to military culture contributing to the persistence of sexual assault, military culture is also a barrier to reporting and help-seeking (Rasmussen, 2018). Rasmussen (2018) found participants focused on the future of the cultural shift in military culture, which they felt needed to improve reporting rates or decrease assaults and harassment. Participants expressed the problem of sexual assault is rooted not only in military culture but also in civilian culture (Rasmussen, 2016). Through qualitative interviews, aspects of military culture were identified as contributing to an environment conducive to high MSA rates among women. Primarily identified factors included sexism, a low ratio of women to men, and men outranking women (Edwards et al., 2011). Participants suggested changes that are needed to address rape culture within the military, which included preventing assault and harassment by normalizing discussion about

sexual assaults (Rasmussen, 2018) and addressing stigma, including victim-blaming ideology and rape myths that permeate in our culture (Castro et al., 2015).

Military culture contributes to barriers in help-seeking due to problem resolution at a low level, team allegiance, and military resilience (Castro et al., 2015). The military has historically frowned upon bringing issues, such as MSA, to members higher in the chain of command; instead, it is preferred they try to resolve the issue themselves, allowing possible patterns to go undocumented (Castro et al., 2015; Firestone et al., 2012). Reporting a team member can be a form of betrayal and lead the reporter or victim to be blamed as the betrayer for violating military norms (Corrigan, 2004). The military's emphasis on resilience in stressful situations has the unintended consequence of labeling MSA survivors as "weak" if they cannot solve their own problems and seek help. These unintentional military barriers appear to have an impact on the likelihood of seeking help and are magnified by stigma (Andresen et al., 2019), and further complicated by the military institution.

Institutional Betrayal

Institutional betrayal is one social-ecological factor impacting the reluctance of MSA survivors to use Veterans Health Administration (VHA) services, which can be perceived as related to the Department of Defense -- although they are separate entities (Dempsey et al., 2016). Understanding the social-ecological factors and individual-level factors contributing to the underutilization of care is needed to better understand the likelihood of healthcare for MSA-related issues (Burgess et al., 2013). Military sexual assault is unique as it usually occurs in the work setting, and the perpetrator is often someone known (Dempsey et al., 2016). Betrayal trauma may occur when an individual experiences a traumatic violation of trust in a close

relationship in which the survivor depended on the perpetrator for survival or other important needs (Freyd, 2008) and has been described as the "enemy within" (Farris et al., 2013).

In institutions such as the military, military personnel exchange their sacrifice and service for many basic needs, including employment, social support, housing, and stability—and service members depend on the institution and its constituents for safety and survival, especially while deployed in a warzone (Monteith et al., 2016). In a small pilot study, 95.9% (n = 49) of participants endorsed some feeling of institutional betrayal (IB) related to reporting MSA which was assessed with the Institutional Betrayal Questionnaire, Version 2 (Kelly et al., 2008). The findings indicated that 73.5% (n = 36) of participants endorsed the perception that the military institution created an environment where they no longer felt like a valued member and 67.3% (n = 33) endorsed continued membership was difficult. Further, 79.6% (n = 39) reported the military institution created an environment that made it difficult to report the experience, and 77.6% (n = 38) reported the military had not been proactive in preventing MSA from occurring. MSA survivors who experienced their assault within the military encounter factors that increase the likelihood of victimization (Holliday et al., 2018). Factors included experiencing a power differential with the perpetrator (e.g., superior officer, supervisor), continued contact with the perpetrator, and a conflict between reporting trauma versus the potential adverse effects on their career (Oglesby-Taylor & Covington, 2015). In addition to institutional-level factors, interpersonal and intrapersonal factors also exist.

Self-Blame, Shame, and Victim Blaming

Self-blame and shame are internal factors that inhibit help-seeking and disclosure among MSA survivors, which can delay help-seeking and have a negative impact on the MH sequelae of MSA survivors (Holland et al., 2016). Self-stigma is one common inhibiting factor of

help-seeking (Corrigan, 2004) and is defined as the individual's negative attitudes regarding mental illness and its treatment (Manos et al., 2009). In a study of 209 females, 37 (17.7%) of the participants did not report their MSA in a prior screening; these participants did not endorse when questioned by a health or mental health provider about having experienced MSA (Andersen & Blais, 2019). Through bivariate analysis, the researcher found that female Veterans with higher self-stigma were less likely to disclose their MSA compared to participants who disclosed in a prior health screening (Andersen & Blais, 2019). Further, when comparing MSA survivors and non-victims[2], survivors reported greater stigma (e.g., "I would be seen as weak") and logistical barriers (e.g., adequate transportation to receive mental health care) than victims, as measured by the barriers to care and stigma subscales of the Perceived Stigma and Barriers to Care for Psychological Problems (PSBCPP; Watson Britt et al., 2008, as cited by Holland et al., 2016). Although self-blame and shame are separate terms, the impact of both these factors interact and influence help-seeking (Holland et al., 2016). Overall, both survivor and non-victim groups encountered stigma more frequently than logistical barriers, and the anticipation of public stigma (e.g., worry about being blamed for the assault) was one of the strongest predictors of PTSD and depression mental health outcomes (Resick, 1993). Although self-blame and shame may inhibit help-seeking and MSA disclosure, self-blame can be used as a means to cope among survivors of sexual assault as self-blame (i.e., accepting responsibility) may be used as a means to cope by maintaining control over the traumatic experience (Holliday et al., 2018).

In addition to self-blame, sexual assault survivors, including MSA survivors, also face victim-blaming when the onus is taken off the perpetrator, making the victim culpable for the

[2]Non-survivors were defined as those who did not endorse experience of sexual assault during their military employment. This study defined military sexual assault to include intentional sexual contacts that were against the participants will or occurred when the participant did not or could not consent. These behaviors include unwanted touching (e.g., sexual touching—intentional touching of genitalia, breasts, or buttocks) to attempted rape (e.g., “attempted to make you have sexual intercourse, but was not successful”) to completed rape (e.g., made participant perform or receive oral sex, anal sex, or penetration by a finger or object.”)

crime; victim-blaming is said to be a causal assumption that supports victimization (Ahrens, 2006). An example of victim-blaming is accusing survivors of putting themselves in vulnerable positions or saying that they should have known better (Koon-Magnin & Schulze, 2019). When reporting to formal help-seeking outlets, such as law enforcement, healthcare providers, and religious personnel, survivors reported higher victim-blaming incidences compared to informal help-seeking outlets (Ahrens, 2006). Exposure to victim-blaming behavior or attitudes has been described as feeling like a "second assault," "second rape," or "secondary victimization" (Campbell, 1998; Madigan & Gamble, 1991; Martin & Powell, 1994; Williams, 1984, as cited in Ahrens, 2006) and can lead survivors to believe there is no one they can turn to, feelings of self-blame, and internalized shame (Ahrens, 2006). Disclosure of sexual assault resulting in victim-blaming can render the survivor feeling powerless (Burns et al., 2014), thus calling for more information on help-seeking avenues, such as reporting.

Impact of MSA-related PTSD on Help-Seeking

Real-world conditions and effects of trauma limit the ability of a sexual assault survivor to speak about the MSA experience in life because discussing the impacts of MSA was seen as an invitation "to public humiliation, ridicule, and disbelief," (Herman, 2015, p. 28) also known as secondary victimization. Further, the fear and shame of speaking out silenced women, and this silence "gave license to every form of sexual exploitation" (Herman, 2015 p. 28). According to The Comprehensive Textbook of Psychiatry, the "common denominator of psychological trauma," such as sexual exploitation invokes feelings of "intense fear, helplessness, loss of control, and threat of annihilation" and cannot be quantified (Kaplan & Sadock, 2002, as cited in Herman, 2015). Although trauma cannot be measured in a single dimension, Herman (2015) suggests symptoms of post-traumatic stress disorder (PTSD) fall into three main categories:

hyperarousal, intrusion, and constriction. After a traumatic experience (American Psychiatric Association, 2013), such as military sexual assault, where the assault reconditioned the human nervous system, the body attempts to self-preserve by going into a state of permanent alertness, which may include startle reactions, poor sleep, hyperalertness, and irritability, resulting in symptoms of hyperarousal. Although the danger may have passed, the traumatic moment is encoded in the form of memory, and it can break through spontaneously or be triggered by seemingly insignificant reminders, resulting in repetitive intrusions that disable normal development and healing (Herman, 2015), as well as avoidance of the stimuli (American Psychiatric Association, 2013).

Between 2010 and 2013, post-traumatic stress disorder (PTSD) was the most frequently claimed disability, and 94% of the accounted claims were MSA-related claims to the Veterans Administration (United States Government Accountability Office, 2014). Research has shown that MSA impacts the survivor, the military, and society through increased unit tension (Farris, 2013; Klingensmith et al., 2014). Specifically, looking at the impacts on the survivors, Veterans who experienced MSA were more likely to have increased rates of depression, PTSD symptoms, and greater mental health and healthcare utilization in comparison to Veterans who did not experience MSA (Kessler, 1995). Additionally, research has shown that stress from traumatic experiences, like MSA, affects brain functions and exhausts the area of the brain in control of executive activities, which can "lead to problems with decision making, irritability, impulsivity, and apathy" (Manuck et al., 2014, as cited in van den Berk-Clark & Patterson Silver Wolf, 2015, p. 107). As trauma negatively impacts decision-making and the ability to seek help, it is imperative mental health providers also consider additional factors preventing help-seeking

behaviors, such as the interaction of military cultural values and the perception of trauma and its effects (Department of Defense, 2018).

Help-seeking Options Following Sexual Assault

Formal help-seeking

Prior research has shown that the availability of resources and help does not equate to help utilization (Nugent et al., 2020). The utilization of resources is impacted by barriers named above (e.g., stigma, military culture, and the impact of trauma), leading some MSA survivors to seek informal help rather than formal help. Within the military sexual assault survivor population who sought support, 87.6% of sexual assault victims in the military sought informal support compared to 59.3% who sought formal treatment (Zinzow et al., 2015). The most common form of formal help-seeking is reporting and formal treatment through individual therapy from military health providers (Zinzow et al., 2015).

MSA survivors may also choose to seek help by reporting the assault through the military Sexual Harassment/Assault Response and Prevention Program (SHARP) with restricted and unrestricted reports (Mengeling et al., 2014). Restricted reporting is a confidential report to designated military personnel that does not trigger an official investigation. In contrast, an unrestricted report is not confidential and does initiate a criminal investigation (Mengeling et al., 2014). Restricted reporting was first enacted in 2005 to encourage greater reporting of sexual assault through policy (Department of Defense, 2018). In the 2018 fiscal year, the military services received 5,805 unrestricted reports and 2,366 restricted reports, with 23% of the restricted reports later converted to unrestricted reports (Department of Defense, 2018). The reported number of military sexual has increased in sexual assault numbers between 2016 and 2018, from 14,900 to 20,500 service members, respectively (Department of Defense, 2019). Still,

the actual rate of MSA is drastically higher as less than 15% of MSA survivors report their assault to the military due to various barriers, such as institutional betrayal and stigma (DOD, 2013). Some research suggests approximately 80-90% of MSA experiences go unreported (Department of Defense, 2018). According to the 2018 Workplace and Gender Relations Survey of Active-Duty Members (WGRA), almost half of service members indicated they would not report the military sexual assault if restricted reporting were not an option, suggesting the impact of barriers in reporting (Mattocks et al., 2012).

Mengeling et al. (2014) conducted interviews with Active Component (AC), also known as Active Duty, and Reserve and National Guard (RNG) women who experienced sexual assault in the military (SAIM) to survey reporting perceptions and experiences and to identify factors associated with the two official reporting types: Restricted and Unrestricted Reporting. Factors associated with the two types of reporting will be discussed below. Although more AC than RNG servicewomen knew of at least one official reporting option (i.e., restricted reporting and unrestricted reporting), AC servicewomen were more likely to not officially report (29%) compared to RNG (19%). More unrestricted reports were made in both AC and RNG groups compared to restricted reports (40 vs. 15). Further, 79.6% (n = 39) reported the military institution created an environment that made it difficult to report the experience (Mengeling et al., 2014). In both the reporting and non-reporting groups, factors associated with reporting and reporting types involved concerns of lack of confidentiality, adverse treatment by peers, and beliefs that nothing would be done (Wadsworth et al., 2015). Additionally, concerns have been expressed around the confidentiality of reports where information shared with a sexual assault response coordinator may be used to inform legal staff, medical personnel, the chaplain, and senior leadership of the service member's installation (Castro et al., 2015). Active-duty status

decreases the likelihood of reporting due to barriers, as mentioned above, and reporting in and of itself can be a factor affecting help-seeking through treatment utilization (Koo & Maguen, 2014; Mcbratney, 2018).

Mengeling et al. (2014) examined factors contributing to the reporting of MSA and found no statistical differences in age, race, or marital status when comparing participants who reported and participants who did not report. Further, service type (Active component (AC) vs. Reserve National Guard (RNG)), branch (Army vs. Air Force), deployment experiences, military status (Active duty (AD) vs. Veterans), drug or alcohol use, pre-military SA, multiple sexual assault in military (SAIM), and completed (vs. attempted) SAIM were not found to be associated with reporting. However, factors correlated with reporting rates included the place of the assault, time of the assault, injury type, level of education, and enlisted/officer status. If the MSA occurred on base, while on duty, or resulted in a physical injury, the MSA was more likely to be reported. Additionally, comparing servicewomen with some college education with those with a high school education or less, women with some college education were less likely to report compared to those with a high school education or less (16% vs. 34%). Similarly, 28% of servicewomen reported compared to officers (10%). Reporting rates compared to the level of education and enlisted/officer status may be positively correlated because a college degree is required to be an officer ("U.S. Air Force - Officer Process," n.d.).

Treatment of MSA

Although documentation of the MSA experience is not required, MSA survivors may only receive MSA-related care within the DOD and VA if they disclose their MSA event to their provider, which can be complicated by the personal nature of the MSA experience (Koo & Maguen, 2014; McBratney, 2018). While treatment options are available, treatment utilization

rates for MSA may vary. Women MSA Veterans are less likely to receive treatment for MSA compared to their male counterparts (McBratney, 2018). However, the VA helps increase utilization through Women's Health Clinics and eases difficulties from insurance or lack of mental health services through its care (Koo & Maguen, 2014). Further, every VA facility has provided care for MSA since 1995 (Turchik et al., 2012 as cited in McBratney, 2018), and in 2012, 19.2% of outpatient and 44% of mental health visits were related to MSA (Turchik et al., 2012).

Formal help-seeking for MSA through the VA and DoD requires specific treatment following the VA/DoD PTSD Treatment Guidelines to address the trauma and can include Cognitive Processing Therapy (CPT), Cognitive Behavioral Therapy (CBT), DBT, STAIR, Seeking Safety, EMDR, and Prolonged Exposure Therapy paired with cognitive restructuring, as well as medications such as SSRIs, anxiolytics, and prazosin (Foa et al., 1999; Bryant et al., 2003; Karlin et al., 2010; Conard et al., 2014). Although MSA patients are overrepresented in specialty PTSD treatment settings within the VA and DoD, as well as other clinical settings, providers' training levels for MSA education and resources can vary (Valdez et al., 2011). While patients may have mixed perceptions of trauma disclosures to providers, providers need not be trauma specialists to broach topics of trauma with their patients (Tedeschi & Calhoun, 2004). While providers and staff at treatment facilities screen for MSA and are integral to the care of MSA survivors, clinicians in trauma treatment centers who possess specialized expertise in sexual trauma play a unique role in promoting and providing effective treatment for MSA, as the detection and treatment of sexual trauma have been defined by VHA's comprehensive policies (VHA, 2005, 2008, as cited in Valdez et al., 2011).

MSA requires MSA-specific treatment as PTSD-specific therapies may not address the sequelae of MH consequences associated with MSA, which affects treatment outcomes. A meta-analysis of combat and assault trauma groups had more poor treatment outcomes when compared to the mixed trauma type group (Straud et al., 2019). However, a meta-analysis of the subsample of MSA-related traumas demonstrated large treatment effects (Straud et al., 2019). Further comparing Veterans with combat-related PTSD and MSA-related PTSD, the combat cohorts saw a greater reduction in PTSD symptoms over time relative to the MSA group (Zalta et al., 2018). In this study, 119 Veterans (19 cohorts: 12 combat-PTSD cohorts, 7 MSA-PTSD cohorts) completed a 3-week intensive outpatient program for PTSD, which comprised of daily group and individual Cognitive Processing Therapy, mindfulness, yoga, and psychoeducation, and outcomes were measured through PTSD score and depression symptoms scores (Zalta et al., 2018). Findings from research on inpatient VA PTSD specialty intensive treatment (i.e., individual cognitive processing therapy (CPT), group CPT, prolonged exposure therapy, and EMDR and reprocessing therapy) suggest a good response to treatment when comparing male and female Veterans with and without MSA, noting no differences in treatment outcomes between groups (Tiet et al., 2015). In a 3-week intensive treatment program for PTSD using CPT, treatment was less effective in survivors of MSA compared to the non-MSA trauma group (Lofgreen et al., 2020). However, modifications to treat PTSD secondary to MSA through skills-based groups in emotion regulation and interpersonal domains and training to clinical and non-clinical staff on the unique experiences and needs of MSA survivors resulted in comparable PTSD treatment outcomes for both survivors of MSA and combat trauma groups (Lofgreen et al., 2020).

While evidence suggests more than a third of Veterans prematurely drop out of PTSD psychotherapy treatment (Goetter et al., 2015; Kehle-Forbes et al., 2016, as cited in Farmer et al., 2020), women with a history of military sexual assault demonstrated higher psychotherapy retention rates when compared to women Veterans who faced other traumas (i.e., physical or sexual abuse as a child, combat exposure, and postmilitary interpersonal violence), possibly due to greater need for care (Farmer et al., 2020). Additionally, meta-analysis comparing military and civilian populations and types of traumas (i.e., combat vs. assault vs. mixed), military populations demonstrated poorer treatment outcomes compared to their civilian counterparts (Straud et al., 2019), suggesting a need to further research the impact of MH treatment and help-seeking for MSA.

Informal help-seeking

In both the US and the UK, military service members who sought help for a problem were more likely to seek help through informal channels than from a professional provider (Mulligan et al., 2010; Zinzow et al., 2015). In a sample of 927 soldiers, the majority of participants reported seeking informal support for stress, emotions, alcohol use, or family problems in the past 12 months (Zinzow et al., 2015). Informal help-seeking included seeking support from a romantic partner, friend or family member, unit member, unit leader, spiritual leader or chaplain, online resources, hotline, or self-help books (Zinzow et al., 2015). Prayer can also have positive mental health impacts, decrease PTSD and depressive symptomatology, and serve as an informal avenue of support (Tait et al., 2014). Sexual assault survivors were more likely to utilize informal support compared to non-sexual assault survivors (87.6% vs. 77.7%, respectively; Zinzow et al., 2015).

Research has attempted to better understand the use of informal support instead of formal support. There may be several reasons why a military member may choose to seek informal help. For example, military members may seek help through a pastoral counselor due to concerns regarding distrust of mental health care (Nieuwsma et al., 2014). Chaplains may also provide an opportunity to discuss mental health concerns without the perceived stigma of formally seeking help through mental health or medical professionals (Morgan et al., 2016). Although informal help can include friends and family members, some research has found female MSA survivors kept to themselves, instead of reaching out to friends and family, due to concerns that friends and family would not understand their military experiences (Rasmussen, 2016). Further research is needed to understand the help-seeking experiences of military sexual trauma survivors, and this research study explored themes in help-seeking behaviors, as well as barriers and facilitators to the utilization of help-seeking.

Facilitators in Help-seeking

Despite barriers and the consequential negative impacts of sexual assault on the survivors, survivors also demonstrated strength and resiliency after the assault by seeking well-being (Tedeschi & Calhoun, 2004). Resilience has been defined as a process characterized by the ability to return to pre-crisis status quickly (De Terte & Stephens, 2014) or the "ability to go on with life after hardship and adversity" and "to remain psychologically healthy despite very difficult circumstances" (Tedeschi & Calhoun, 2004). One indicator of resiliency in MSA survivors was reflecting on past negative experiences—through meaning-making-- and determining positive aspects (Christopher, 2004). In the study, meaning-making allowed the survivors to look back on their active-duty experiences and find what they could learn from the negative experiences (Ulloa et al., 2016).

Post-Traumatic Growth

Post-traumatic growth is characterized by resiliency, closer relationships with others, a greater willingness to accept and provide help, and an increased appreciation of life (Ulloa et al., 2016). Post-traumatic growth differs from resilience in that post-traumatic growth involves the gain of psychological benefits (Monteith et al., 2018). Christopher (2004) states all traumas leave a biological mark, and in the context of emotional sociocultural solidarity, post-traumatic growth can occur. Following the military sexual assault, some female service members described a process of empowerment in advocating for themselves and others (Rasmussen, 2016). Other research specifically cited disclosure as an important factor in survivors' healing from the assault, noting positive growth, increased coping, and greater attachment to others (Ahrens & Aldana, 2012; Borja et al., 2006; Frazier et al., 2004, Orchowski & Gidycz, 2012). The ability to advocate for others and choose disclosure can be an indication of one's control (real, perceived, or illusory), and control has been suggested to be important to growth after sexual assault (Ulloa et al., 2016). Overall, the literature on post-traumatic growth following a sexual assault—and military sexual assault—is limited compared to victims of other traumas (Ulloa et al., 2016). Further research to determine optimal ways to strengthen support for MSA survivors is essential (Monteith et al., 2018), and the results of this study provide suggestions.

The mental health sequelae and treatment of military sexual assault have been widely researched, yet there are still gaps in the literature. Qualitative research enables a better understanding of the experiences of military sexual assault survivors and their help-seeking experiences. This dissertation employed a thematic analysis framework (Braun & Clarke, 2006) via in-depth interviews to identify help-seeking behaviors for MSA survivors to address gaps in research on the themes of formal and informal help-seeking.

Method

This qualitative study examined the lived experiences of female Veterans (n = 14) who survived sexual assault in the military while on active duty. In this research, military sexual assault (MSA) was defined as sexual assault or repeated threatening sexual harassment that occurred during a Veteran's military service (Department of Veterans Affairs, 2020). Through this study, the researcher aimed to uncover themes of factors that may have played a role in formal and informal help-seeking behaviors for MSA survivors. The qualitative nature of this study allowed for an in-depth exploration through individual semi-structured interviews.

The present qualitative study employed thematic analysis (Braun & Clarke, 2006) to explore informal and formal help-seeking behaviors of military sexual assault survivors among a group of seven to twenty female Veterans. The qualitative methodology included semi-structured interviews, allowing women to share both the breadth and depth of their help-seeking experiences. In the interviews, sensitive topics, including the nature of the assault, were explored to understand the participants' contextual accounts, allowing them to share their feelings, beliefs, opinions, and experiences (Braun & Clarke, 2006). During the exploration of this topic, participants were encouraged to provide information about facilitators and barriers to help-seeking and the role of stigma in their help-seeking to address the research questions. Additionally, the interviews explored help-seeking behaviors to understand barriers to formal and informal help-seeking.

Participants

The population for this project was cis-gender women over the age of eighteen who experienced a military sexual assault after the age of eighteen while on active-duty[3] that was perpetrated by another military service member. Participants passed the screening questions as defined by the inclusion and exclusion criteria below to participate in this research study. To minimize the possibility of stress and harm during the interview, at least six months must have passed since the MSA experience. This duration was based on the diagnostic criteria for Acute Stress Diagnosis[4,5]—where a person with this diagnosis would have symptoms manifesting and lasting from three days to one month following exposure to trauma event--, Adjustment Diagnosis[6]—where a person with this diagnosis would develop symptoms within three months of the onset of the stressor--, Post Traumatic Stress Diagnosis[7] (PTSD)-- where a person with this diagnosis would likely have manifested diagnostic symptoms within three months after the trauma--, and Other Specified Trauma-and Stressor-Related Diagnosis[8]-- which includes a duration criteria of six months or more. Further inclusion criteria included being 1) cis-gender, 2) woman, 3) over the age of eighteen, 4) have experienced sexual assault while 5) on active duty 8) in the military (perpetrator is in the military), and 9) no longer active-duty status (i.e., a person can be reserve status, separated, retired, discharged). Exclusion criteria included being 1) not

[3] The term "active duty" means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such a term does not include full-time National Guard duty. For this study, active duty includes "active duty for a period of more than 30 days" which means active duty under a call or order that does not specify a period of 30 days or less.

Active duty excludes reserve components, including National Guard (i.e., Army National Guard, Air National Guard); 10 U.S. Code § 101 – definitions).

[4] "Diagnosis" is used in lieu of "disorder" as disorder suggests symptoms following the event are abnormal.
[5] DSM-5 terminology uses the term Acute Stress Disorder
[6] DSM-5 terminology used the term Adjustment Disorder
[7] DSM-5 terminology uses the term Post Traumatic Stress Disorder
[8] DSM-5 terminology uses the term Other Specified Trauma- and Stressor-Related Disorder

cis-gender (i.e., being transgender), 2) male, 3) under the age of eighteen, 4) not experiencing sexual assault while active duty in the military, 5) experiencing military sexual assault while on reserve status, and 6) experiencing sexual assault outside of the military (perpetrator is a non-military member). Potential participants who met the exclusion criteria may face significantly different experiences when compared to the potential participants who met the inclusion criteria. The inclusion and exclusion criteria allowed the researcher to uncover themes with the chosen sample population. The screening process is discussed in-depth in the Procedures section below.

A convenience sample was used to target the sample population. Given that this was a hard-to-reach population, participants were also recruited using purposive and snowball sampling (Patton, 2002). Through purposive sampling, this researcher conducted interviews with the purposively sampled group—meeting the specific inclusion criteria. With purposive sampling, a small number of carefully selected participants with information-rich cases allowed this researcher to foster insight and a more in-depth understanding of each participant's unique experience-- illuminating the questions under study (Patton, 2002). Variables for purposive sampling included being over the age of eighteen at the time of participation and prior United States service members of active-duty status. The sexual assault must have occurred in the military and have been perpetrated by another military member.

This project continued recruiting and interviewing participants until data saturation was indicated-- when the interviewer no longer heard new themes (Saunders et al., 2018). It was estimated that this project would recruit between 7 and 20 participants to meet data saturation; this study reached data saturation with 13 participants and the 14th participant was interviewed and included in the study to ensure data saturation. In qualitative research, saturation has been

widely accepted as a methodological principle, where based on the data that has been collected or analyzed, further data collection and/or analysis are unnecessary because new data tends to be redundant to the data already collected (Braun & Clarke, 2006; Saunders et al., 2018).

Procedures

Targeted venue recruitment was used in this study. A flyer (Appendix A) was circulated through social media platforms (e.g., Facebook and Instagram), hospitals for Veterans (e.g., San Francisco Veterans Association, Veterans Association Northern California, Palo Alto Veterans Association), and community Veteran organizations (e.g., San Francisco Vet Center, Oakland Veteran Center, Swords to Plowshares, San Jose Veteran Center). The researcher sought permission and obtained a memorandum of understanding (MOU) from the organizations and locations, as needed, where the flyers were circulated. MOUs included information about the study population, IRB number, and contact information to access screening for the study. Participants completed a screening via phone with the researcher. The screening questionnaire (Appendix B) addressed inclusion and exclusion criteria and inquired where participants learned about the study. After screening participants, those who did not qualify for this study were offered information about mental health services in their community (Appendix C).

Once eligible for the study, all potential participants were informed about the study and received consent procedures consistent with the University of San Francisco's (USF) Institutional Review Board (IRB) prior to voluntarily deciding to participate. Prior to the interview date, prospective participants were emailed the IRB-approved Informed Consent form (Appendix D) as a PDF document to read, sign, and email back to the researcher. Prior to scheduling the interview, participants were informed that the interview length would be approximately 60-90 minutes over Zoom, or in-person, if appropriate-- in a confidential location,

such as a private study room in the USF library. All interviews were conducted virtually. A Zoom link with a unique password was emailed to each participant. Participants were informed that the confidential interview would be audio-recorded, and they may choose to use a pseudonym for the purposes of participation. Prior to the interview, demographic information was briefly collected using a participant demographic sheet (Table 2), which included age, religious or spiritual affiliation, service history, rank, and branch. Information about household income, and current occupation was intended to be gathered, however did not occur during the study. Additionally, participants were asked about their prior trauma history and use of help-seeking services. On the day of the interview, the researcher identified and greeted the participant via Zoom. The researcher reviewed the informed consent, explained the purpose of the study, and informed each participant that they could withdraw from the study without penalty at any time.

The semi-structured interview (Appendix E) consisted of open-ended questions that focused on understanding the participants' formal and informal help-seeking experiences following the sexual assault, including formal and informal help-seeking. Example questions included, "How did you seek help after your assault? Where did you seek help? With whom did you seek help? What were the challenges or barriers to help-seeking?" Following the completion of the interview, participants were given the opportunity to ask any questions or provide additional information. After each interview, there was a 15 to 20-minute debriefing session, if needed. This debriefing session included discussing how this interview was for the participant and a grounding exercise (e.g., breathing, progressive muscle relaxation) if needed. At the end of the interview, participants were given a list of community referrals for additional support. All participants who participated in the interview received a $25 e-gift card to Target or Walmart,

depending on their preference; participants who withdrew at any point of the interview or did not complete the interview received a gift card as well. Interviewer field notes were taken during and after the interview to highlight the participants' statements, document personal reflections, and note follow-up questions to statements made during the interview. Additionally, after each interview, the researcher made notes of observations and preliminary themes from each interview. Identifying information was removed from the interviews and all the data was presented in aggregate form using pseudonyms.

Data Analysis

Braun & Clarke (2006) and DeLoveh & Cattaneo (2017) suggested a future direction in qualitative research and analysis in the realm of help-seeking behaviors, which would allow for exploration of covert help-seeking beyond the ones identified in the research on help-seeking in college sexual assault survivors. A qualitative design such as thematic analysis is often chosen and ideal for in-depth face-to-face interviews exploring sensitive topics (Elmir et al. 2011, Liamputtong, 2007; Taylor et al., 2011). Thematic analysis (Braun & Clarke, 2006) is a flexible research tool and was used in this project to analyze participant data. Through thematic analysis, this researcher was able to describe patterns across the qualitative data, enabling the researcher to find themes in help-seeking behaviors among MSA survivors.

This study employed a thematic analysis framework to help organize the data by identifying, analyzing, and reporting patterns within the data collected from the interviews (Braun & Clarke, 2006). Their six steps in thematic analysis included:

1. All the audiotaped interviews were transcribed verbatim by Otter.ai to preserve the accuracy of the information. This researcher read and reread the interviews' transcription

for accuracy and familiarized themself with data by noting initial ideas that emerged from reading the data.

2. Interviewer field notes were taken during and after the interview, noting observations and preliminary themes from each interview. The researcher reviewed the data again to uncover themes and use these themes for initial codes for the data (Braun & Clarke, 2006).
3. These codes were collated into potential themes to identify overarching themes and possible subthemes. Themes were assessed for their relation to the coded data, and this researcher generated a thematic map (Braun & Clarke, 2006).
4. Further analysis was conducted to provide theme names and establish definitions to depict the underlying ideas that create a unified picture of the data collected. As part of the iterative process in thematic analysis, this researcher conducted a more in-depth examination of the identified themes and determined whether to combine, refine, separate, or discard initial themes. This researcher examined the relationship between all codes, subthemes, and themes. Thus, this researcher conducted an ongoing analysis to identify each theme's specifics through clear definition and naming, which was used to tell the overall story of the data (Braun & Clarke, 2006).
5. The final step in the analysis was to extract examples from the transcript that illustrate the themes (Braun & Clarke, 2006).
6. A scholarly report was produced with compelling abstract examples that related back to the research question and literature (Braun & Clarke, 2006).

Reflexivity Statement

The researcher conducted all aspects of the study. The author shares identities with the participants as she identifies as a cis-gender woman and an officer in the United States Air Force. She is a subject matter expert in the areas of sexual assault and trauma in the military. In addition to mentorship on qualitative research, the dissertation chair's formal training in thematic analysis allowed for the fidelity of this research, as well as ongoing consultation. Reflexivity, documentation, and consultation with the researcher's dissertation chair were used to monitor and reflect on potential biases related to the researcher's shared identities with the participants, as well as other identities. Through discussion of generated themes following the coding, there was a system of checks and balances to check the coding. Frequent check-ins ensured themes and codes were generated to be reflective of the collected data. It was critical to the researcher to take account of the sensitive experiences that were discussed in the study. As this researcher guided the semi-structured interviews, the participants had agency to share what they were willing to share, and their experience of their sexual assault and their help-seeking were honored as their experience.

Results

This section presents the findings of semi-structured interviews with fourteen participants using a thematic analysis framework (Braun & Clarke, 2006). A total of fourteen female Veterans who were sexual trauma survivors completed the interview that explored their help-seeking process. The interview guide consisted of seventeen questions to understand how the perceptions of military culture may have influenced the utilization of formal and informal help-seeking options after their military sexual assault. Further, this study identified barriers and facilitators for help-seeking and helped to better understand the role of stigma in the survivors' help-seeking behaviors. There were a total of 7 themes that emerged from the semi-structured interviews based on the research questions. The themes include: 1) Types of help-seeking, 2) Barriers to help-seeking, 3) Facilitators to help-seeking, 4) Coping, 5) Mental health impacts, 6) Disclosure, and 7) Post-traumatic growth (Table 1).

Table 1

Themes of Help-seeking from Thematic Analysis

Themes	Subtheme(s)	Code	Definition
Types of Help-seeking		Therapist, help, support, listening, acknowledgment	The various forms of help and assistance women sought/utilized when dealing with the issues that arose after a sexual assault
	Formal Help-Seeking	Healthcare provider, command, reporting, military chaplain	Structured help women obtained through various formal mechanisms
	Informal Help-Seeking	A romantic partner, friend or family member, unit member, unit leader, spiritual leader	Women obtained informal support, social support, and emotional support from various individuals outside of formal venues

Barriers to Help-seeking		Feeling a lack of control; higher ranking or well-liked perpetrator	Women encountered obstacles, thoughts, or behaviors that prevented or delayed seeking help
	Stigma	Perceived or actual negative/discriminatory treatment; attention; weak	Women worried about blame or shame. They also held negative beliefs about the assault.
	Fear	Fear of being killed by the perpetrator; lack of safety (feeling threatened, physical safety, institutional betrayal, no place safe for women (in healthcare); fear they would not be believed; fear of reprisal; fear of the consequences of the perpetrator	Women feared for their safety and the possible outcomes if they were to report or seek help.
	Culture	Military culture; suck it up; dismissing past sexual assaults; Personal culture; ignore, hide, minimize	An environment that contributed to norms about help-seeking, including upbringing (ethnicity/religion), norms of the workplace or military culture, and culture of silence
	Self-Blame	Allowing it to happen, sending cues to the perpetrator, I let it happen, I drank	Assigning fault to self, including blaming self for assault, regretting actions that preceded assault, rationalizing why it happened
	Limited Care	No medical care; no information about sexual assault happening to others, no military sexual assault organizations; lack of resources	Women's experiences with insufficient access or information about care for sexual assault.
Facilitators to Help-seeking		Camaraderie; normalization; women-only treatment	Aspects that helped or encouraged help-seeking, feeling safe with other women; sisterhood, not alone, trusted military member
Coping		Spending time with others, activities to pass time, drinking, self-harm	Actions or thoughts in an attempt to decrease the stress of the experience, adaptive/maladaptive

	Maladaptive Coping	Avoidance, minimizing impact, blame, isolation from others, self-harm	Behaviors or thoughts that can help short-term benefit to coping but have long-term consequences.
	Adaptive Coping	Therapy/counseling, prayer, caring for others, forgiveness, hobbies	Helpful behaviors or thoughts to cope/survive the assault which included seeking therapy or a formal service, as well as receiving support from others.
Mental Health Impacts		Mood changes; impact on relationships or others, worry about safety; difficulty with trust (others/military/healthcare); suicidal ideation; burden on others; depression	Changes in mood, behavior, feelings, and functioning following the sexual assault, including secondary impacts.
Disclosure		Difficulty finding the words, disclosure at work, wanting to be heard	Who they told, what it looked like, expectations, when they disclosed
Post Traumatic Growth		Sense of freedom or positive outlook on life, helping another woman, increase in spirituality or sense of community	Positive change as a result of the trauma, including strength, helping others, and decreasing blame on the self

Participants

A total of fourteen participants completed the semi-structured Zoom interview in private settings (e.g., respective homes, workplaces). The interviews were conducted from August 2022 through November 2022. Twenty-eight potential participants across the United States of America contacted the researcher to express interest in this study. Twenty-three women were screened, and fourteen were eligible and invited to participate in the study; five people were unable to be contacted after their initial interest, four women of the twenty-three screened did not meet the MSA criteria, two women did not meet the military/Veteran criteria, two women experienced

assault while in the military however the perpetrator was not active-duty military, and one woman declined to participate as the interview was too long in duration. Women were eligible to participate if they identified as cis-gender female Veterans over the age of 18 who experienced a sexual trauma by another military member while on active duty (e.g., Veteran, current guard, or reserve). The women also needed to consent to the study to be considered eligible to participate. After the initial screening process, a total of fourteen women were excluded from the study (e.g., never served in the military, perpetrator who was not on active duty, did not experience military sexual trauma, attrition). A list of nationally available resources was provided to participants who were not eligible to participate.

Interviewed participants (Table 2) resided across the continental United States. Women were between the ages of 20 and 66 (M= 47 years, SD= 12.7), all but one participant reported a religious affiliation, eight participants (57%) identified as Caucasian, two women (14%) identified as African American, one woman (7%) identified as Alaskan Native, and three women (21%) identified as multi-ethnic/multi-racial. Women were invited during the semi-structured interview to create a pseudonym for themselves.

Table 2

Participant Demographics (n= 14)

	Pseudonym	Age (years)	Ethnicity/Race	Religion/ Spirituality	Branch of Service	Rank at time of assault[1]
1	Rose	20	Caucasian	Christian	Army	E-3
2	Natalie	39	Mexican American and Native American	Christian/Native American	Navy	E-1
3	Cornelia	49	Caucasian	Atheist	Navy	E-3
4	Licorice	56	Caucasian	Christian	Army	E-4

5	Smooth	38	African American and Hispanic	Christian (Baptist)	Air Force and Army	E-4
6	Carol	66	African American	Christian (Methodist)	Army	E-4
7	Bessie	39	Alaskan Native	Christian	Air Force	E-3
8	Susie	66	Caucasian	Christian (Lutheran)	Army	E-4
9	Mary	59	Caucasian	Christian (Roman Catholic)	Army	E-4
10	Jess	38	Caucasian	Agnostic	Army	O-3E
11	Jill	49	African American	Non-denominational Christian	Army	E-1
12	Susanne	60	Caucasian	Christian	Navy	E-3
13	Nicole	37	Caucasian	Non-denominational Christian	Marine Corps	E-3
14	Amy	43	Multi-ethnic	Indigenous	Army	E-2

[1] E-1 to E-4 indicates junior enlisted members who are usually in their first enlistment period (less than four years in the military). O-3E indicates an officer who was previously enlisted. Differences in rank between a survivor and the perpetrator may contribute to power differences and help-seeking behaviors.

Emerging Themes

Seven themes emerged from the semi-structured interviews, which included: Types of help-seeking, Barriers to help-seeking, Facilitators to help-seeking, Coping, Mental health impacts, Disclosure, and Post-traumatic growth (Table 1). The themes were organized into proof (Appendix F) and power quotes (Pratt, 2009), and the power quotes are detailed below.

Types of Help-Seeking

Types of help-seeking referred to the help that the Veteran sought and if the help was a trained or official avenue of support, or support of a peer, family member, significant other, or stranger. Help-seeking arose primarily in two ways and was coded between formal and informal help-seeking. Help can be unintentionally sought, and it can also be difficult to define what is needed for support. Jill made an unplanned disclosure to her boyfriend and received his support through active listening. However, she was unable to convey her specific needs for help, and he was not aware of what she needed at that time, leaving her wanting more support from him besides just listening:

"I know one day, I just went, and I sat in [my boyfriend's] lap, and I cried. And he didn't... he didn't do anything like he listened to me. But I expected him, as my boyfriend, to do something. And I don't know what I expected him to do. But I expected him to do something. And he didn't." *(Jill)*

For others, it took more time to realize that the assault was wrong and that their trauma response is not necessarily the norm or what should happen. Susanna did not seek healthcare at the VA until forty years after her separation from the military. Susanne reflected that everything felt "normal" for all that time and that she did not know she needed help:

"It was only forty years after the military that I started counseling for [the assault], particularly when I joined the VA about, you know, five years ago, so it was a, it was a long time before I…I actually addressed that, all of that and realized that, that was not normal." *(Susanne)*

Many women noted their help and support often included both formal and informal help. Amy noted relying on her friends, boyfriends, and some family members as she began therapy to address the sequelae from the sexual assault:

"When I started the first attempts at therapy, and I was super triggered. And I was just a mess of a human being, I heavily relied on friends and family. Not a lot of my family, because of family dynamics, but mostly, you know, friends, boyfriends, which, you know, those relationships were pretty rough." *(Amy)*

Many women identified some attempts at using formal resources as one of their ways of seeking help.

Subtheme: Formal Help-seeking

The subtheme of formal help-seeking encapsulated each of the women's specific types of help they sought which was often more structured such as healthcare providers, command, or military chaplains. Natalie, and other women, sought help through formal avenues including medical care after their assault, and also disclosed her assault:

"I didn't want to say anything to anybody. I didn't. But [the doctor] kept like-- they kept bringing me into the room to talk to him. And he, you know, he kept asking me over and over, like, 'Why are you here? Why did you do this?' Till I eventually broke down and told him." *(Natalie)*

Natalie only intended to seek medical support following the assault, however, the doctor continued to query her about the assault again and again—trying to find Natalie's role and responsibility in the assault. She was unable to hold in the truth—that she was sexually assaulted. Natalie reported that this disclosure to the doctor eventually led her to need to go to court for the sexual assault, which caused further stress, and she felt that she lacked adequate legal support.

Women also sought multiple avenues of support, including the use of professional mental health and military chaplain services to cope with the emotions after the assault. Although she identified as an Atheist, Natalie sought emotional support from a chaplain as her issues were identified as somatic by a psychologist. However, she did not find the support helpful in her experience:

"So, I went to the [mental health] doctor about [my stomach issue]. And she said it was like a somatic. So, it was like, but then nothing, no follow-up. No, no, talking to a therapist, no counseling or anything. So, I think by that point, I'd realized that, or at least in my head, there was no counselor, no, no psychologist. I could go talk to so the next closest thing, person career-thing I could go speak with would be the chaplain. Yeah. And I guess at that point, I was starting to explore a little bit of spirituality. I was raised in the household, my mom was like, ... 'Don't... religion is personal. You don't... We don't.' It doesn't matter what one you pick, just

looking at them all and decide what you want. And so, at that point, I was like, 'Okay, well, I'm gonna go check out some religions, because they're starting to do that, because being an atheist is hard... And, you know, there's… still, science is still explaining so many things, even psychologically, so, you know, there's the possibility … of maybe finding some answers and how to ease some of my psychological issues through spirituality, which I now know, doesn't work." *(Natalie)*

In addition to support from military-trained chaplains, women also sought formal help through therapy, or help from a counselor, to address mental health and well-being, including processing, trauma treatment, having a witness, and learning about trauma or the experience. Women found benefits to the use of trauma-specific treatment. Nicole praised cognitive processing therapy (CPT) and noted wanting to review the content and skills again now as she found it helpful—so helpful that she would want CPT, processing, and identifications of facts and feelings to be foundational as the treatment for women who are healing from MSA:

"I did the cognitive processing therapy, this CPT that was, I think that should be a foundation. Like, force the person to do the homework like force, you know, don't for– obviously, don't force but like highly, highly encourage them to stick with it. You know, and then do it. The two parts where you have homework and then you also talk about it, and then you also read your homework, you read it to them, because just writing it is not enough like you have to read it out loud. Like we had to write our story what happened with it and like, include our senses, like what happened, like what …. describe the room, describe any smells, that were there any kind of feelings you felt, and then read it out loud to yourself, read it out loud to someone, and then they had me for a week they had me rewrite it every day and reread it to myself out loud every day. And then just like going through that process, just that was the biggest thing. And then there was another like ABC [Action Behavior Consequence] chart, which I should probably do again with other areas. But this is what happened or this is what I see that happened. This is my thoughts about it that are incorrect, but this is, and then C was like what really, I think C was what really happened like stepping back and be like, 'Your thoughts are not .... your feelings are not fact. This is the facts and your… you don't need to blame yourself' like because I was… the feelings were blaming myself mostly. So, I would definitely like have CPT be the basis." *(Nicole)*

While there is often stigma for seeking help, therapy can offer skills and assistance in social well-being for patients and clients. Bessie increased her use of therapy over time and has her medication managed by a prescriber, leading to notable benefits in her support system, as well as her understanding of her behaviors:

"Current day, these days, I definitely am resourceful and seeking out support, I have not only a psychologist, but a psychiatrist. And I am on anti-anxiety meds, I, I know how to like self-care and self-soothe. I've learned all of those techniques through groups, group therapies. I have a very good support system with my church. And so those are ways I seek help. Now, now back when it happened, seeking mental health help, was frowned upon. And so, I never talked to a counselor or therapist about what happened until years later… Understanding how [the assault] has affected my life and my relationships and hesitancies and-- then kind of psychoanalyzing my marriage, like, reasons why I had jumped into that so quickly. And… nothing like I'm not judging myself. There's like, nothing wrong." *(Bessie)*

Subtheme: Informal Help-seeking

Informal help-seeking encapsulated each of the women's specific types of help used, which was often less structured. Informal help included support from a romantic partner, friend, family member, unit member/peer, spiritual leader, non-military chaplain, or online peer groups. Because some formal avenues of help-seeking had barriers, women utilized informal help-seeking. Nicole's friend offered support due to Nicole's divorce, and this provided the opportunity for Nicole to borrow her friend's ear to talk in general and she was also able to talk about her assault:

"I had some friends that were just helping me talk, you know, when you're going through divorce, you just talk all the time trying to process and figure out like what reality is, and I brought up one of my friends, she was in Okinawa with me, and she knew she was just a couple rooms down for me. And I mentioned like, what happened and she's like, she, she felt bad. She didn't know that that happened to me, but she just let me talk about it. And then I also mentioned it to my mom. And but I don't remember, if I went to the Vet Center First, I think I probably talked to my friend, my friend Aaron, and then my mom." *(Nicole)*

Informal support was also utilized due to the ease of access to support. The informal help and support were offered to women by people who cared about them and were in contact with these women. Cornelia's boyfriend was concerned about her and inquired if she was raped. While she attempted to cope in various ways, her boyfriend supported her by cooking:

"[My boyfriend] asked me again later if I'd been raped, and I was I told him 'No' because I didn't remember it at the time. But I was still with him when I started remembering. And then we broke up and then I sent him a message a while back that said, 'Yes, you're right. Your instincts are

right' …. [drugs] and [driving] was a coping mechanism. Music. Sex. … food— cooking [was] not good. I didn't cook very often but definitely I ... my boyfriend cooked, and I ate." *(Cornelia)*

For other women, the support of family and friends was helpful—even if they did not understand. Natalie noted difficulty connecting with friends and family as they did not go through the same experience— that they had neither experienced sexual assault and they were not in the military. Despite the differences in experiences and identities, she still noted some benefits of informal help-seeking. Natalie also praised the help of advocates from the internet who were both familiar with and passionate about addressing military sexual assault, and Natalie advised others to follow suit:

"Well, I ... like friends that I grew up with, and my family there, they tried to be there for me as much as they can. But they'll only … they just don't …. really understand. So, they keep, they keep themselves like at a distance. My friends too, they try to.. they would try to understand but… they just don't understand. So, they… I… but… I think they're… even just them trying helped me along the way... Just go to… go to somebody they trust and if it's military sexual assault, there's like, advocates online. I would definitely, you know, send them to Jen, like, Jen [last name]. She's… she's been around for…. I mean, fighting against military sexual assault for such a long time." *(Natalie)*

For some women, despite attempting to seek help and support from formal avenues of help, this was not always what they needed, or may not have been helpful. Women benefited from using both formal and informal support to address their mental health. However, actual and perceived barriers made it more difficult for these women to find adequate help.

Barriers to Help-Seeking

Participants endorsed actual and perceived barriers to seeking help or reporting. Subthemes of barriers to help-seeking included stigma, fear, impacts of cultural norms, blame, and limited knowledge of resources. The chain of command is often conveyed as a reliable avenue for addressing issues, however, some women disclosed their assault to their chain of command, but were not always believed, and this led to not disclosing to anyone else or delayed

help-seeking. For Smooth, her negative experience in seeking help invalidated her feelings and sense of trust:

"I was in a really toxic environment. But when I threat--- I, I, I told him I would cut him up into little pieces and throw him overboard if he ever touched me again. And he told the commander that and the commander called me in his office asked me why I threatened him. And I told him, "Because, he assaulted me." And the command team didn't believe me. So, because they didn't believe me, I didn't tell anybody else for a long time… I didn't want to get in trouble because I felt like my threat was valid. And they basically invalidated my feelings and invalidated everything for me." *(Smooth)*

Smooth felt she needed to be strong and take care of herself, and that she could not rely on anyone else. Her sense of a non-supportive environment was confirmed when her assault was not believed, which felt invalidating. This invalidation, from her trusted command team, dissuaded Smooth from seeking help again until much later. Similarly, there is no ideal time to seek help or be vulnerable, as life is busy. But there were continued attempts to resolve issues and heal without relying on others:

"It's just that… I felt like, when, I felt like I, I needed or wanted someone to help me or fix me, they're… not available. So, it falls back on me. And I can't rely on other people. So, I have to rely on me. And it's either I'm going to do it or not. My, my daughter graduated from college in May. And then two weeks ago, I had to help move her. My son came home two weeks ago. And so, I'm trying to get him situated. And so, it's really like, I have to fix me because I don't have time right now to break down. There's no time for a breakdown. I have things to do. So, I have to-- you know-- I have to fix me and keep moving." *(Jill)*

Women also faced military-related barriers to reporting their assault. They were expected to utilize their chain of command, and for women like Susie, the perpetrator was in her command, and going outside of the command structure could have resulted in other consequences, including a court-martial:

"I had to go through the CQ (military charge of quarters) on duty and I just thought 'I need to talk to the first sergeant now.' And so, you have to go through your chain of command. And [the perpetrator] was part of my chain of command. So, like, what … there is no way in hell, I'm just I'm like, 'It is what it is.' So, you know, I could have been court-martialed for going outside my chain of command… I would have had to have told [two supervisors] the story and then get permission from [the perpetrator/supervisor] to go see the first sergeant and the captain." *(Susie)*

The steps in reporting through the chain of command would have required Susie to disclose her very recent assault to numerous people before being able to seek support from her commander. Further, help-seeking was not always a clear process for military sexual assault survivors, and the worry about opening up and the possible emotional toll can be dissuading, even when it was clear the participant was sexually assaulted:

"And she tried to convince me to open-report. Because I knew the guy's name. I knew, you know, everything about them. It would have been, I assume, an easy case I don't know. But I didn't want to… go through all of that. I didn't want… I didn't want anyone to know… I didn't want to have to go through, you know, telling people what happened. And court and I don't know what else that entails." *(Bessie)*

Bessie sought support, however the unknown chaos of court and unrestricted reporting posed as one of the many barriers to seeking help and impacted her choices to do so. The barriers of help-seeking can be difficult to overcome and can lead a woman to feel that she is only able to rely on herself as past attempts of seeking help have failed. Although women wanted support, another barrier to help-seeking was stigma.

Subtheme: Stigma

Stigma is a form of judgment related to the assault, as well as coping. Participants described how stigma impacted their willingness to seek help. The women disclosed stigma about sexual assault and help-seeking from others, themselves, and their culture. Women felt internally dissuaded from seeking help due to fear of being perceived as "dirty" or "bad". They were also worried about the perception of appearing weak because of their military identity and feeling like they had something to prove to others about their capabilities. Women, including Natalie, often tried to find fault in their actions that may have led to the assault or self-blame:

"They told me that, 'I was too young'. Like, I was in way over my head when I joined and I kind of wanted to prove everybody wrong. So the shame was, like, 'Oh, you know, they were right',

this, like, ‘I couldn't handle it’’. And then the shame of being … being raped was… I was just so… for me, I felt like it was soul-crushing. And I felt so dirty and like a bad person. And put, I put all the blame on myself-- nothing on him.” *(Natalie)*

The sense of stigma not only impacted the survivors of the assault, it was also perceived to have an impact on other women, specifically military women. Jess shared not wanting to be perceived as weak, and also not wanting the weakness to be generalized to other women as he worried this could negatively impact their time in the military:

“I think that [stigma] impacted [help-seeking] in the way that it discourages you-- the way that women are treated in the military, it just there's already this feeling that's very well reinforced by everything you experience-- that women shouldn't be there in the first place. And there's also this feeling of that ‘We’re, we're weak.’ And so, I think that that also impacts the decision to seek help and report, because you don't want to reinforce that attitude and harm other women behind you by reinforcing that, we are weak and we don't belong there, and that were a detriment to the unit.” (Jess)

For these women, being sexually assaulted was accompanied by the stigma of being perceived as weak, and seeking help to address the sexual assault was felt to be additional proof that women were weak and did not belong in the military. By not seeking help, women felt they were dispelling the negative sentiment of women in the military and minimizing stigma from others.

Subtheme: Fear

The subtheme of fear encapsulated women’s worries about consequences, safety, and judgment; this showed up in two main ways: fear of repercussions and lack of safety. The fear of repercussions included fear of what others would think, as well as fear of career consequences. Lack of safety included feeling threatened, either emotionally or physically, as well as fear they would not be believed. This sense of lack of safety was also noted for some women to be in part due to the institutional betrayal felt. Mary shared that her trust in the military and trust in her

comrades was violated by the assault. She also feared that she would not be believed and worried about her career:

"I think because it's different in the military because we're supposed to watch out for each other… got each other's back. And, you know, that's the ultimate betrayal of that code. Um, well. I had to see this person every day. It was somebody I thought I trusted. Somebody I thought I could trust... somebody that I look toward as a mentor. You know, and when it happened the first time, it was like, you know, the trust was gone. It was, it was hard as hell to go to work, you know, every day, and, you know, pretend like nothing happened back then. And I was in the command group, and I knew enough that you don't report this. Um, well, it could have made my life more hell than it was. You know, they could try to get rid of me. You know, when, when he is, you know, playing softball with the boys in the unit. You know, he couldn't have done something like that. You know, I didn't, I knew I knew what could happen. A lot of times, 'It's the female's fault'. Or that's what they say, you know, I knew things that could happen. So, I just didn't want to deal with any of that." *(Mary)*

Women were often hesitant to take further action for fear of reprisal. Sometimes the fear was perceived based on past exposures to similar incidents or hearing about the negative experiences from other women. Some participants did report receiving threats if they were to seek help or report. The perpetrator instilled a sense of fear and threatened Licorice's safety and her daughter's safety if she were to disclose it to anyone. Her fear was amplified further as she needed to continue working with the perpetrator. While she debated seeking help, she recounted that women die for speaking up, and she dissuaded herself from seeking help to keep herself and her daughter safe:

"'If you go… if you tell anyone… I'm gonna come back and do this to your daughter too' said the perpetrator. And all I could do is just… just lay there. And I... after he left, I just laid there, I couldn't do anything. And I blacked out… I had so much fear put in me in those two months that I had to work next to him that I was grateful to be transferred to another unit because I knew I wasn't going to die. Because I'm still afraid that sergeant finding out where I live. And what what … I'm doing that... I- I'm afraid period, that he's gonna find me again one day. That's what I'm afraid of… I felt like if I reported and something happened to him, I felt like if people were going to come after me. I didn't know if I would, I would get attacked verbally or physically or I just, I wasn't really willing to risk. Women are killed for telling, for speaking up. Women die for doing what I'm doing right now. It's terrifying that they… that it's so intimidating for us to speak out. Because women die, and they really do. I mean, people don't understand. There, there... are people out there that just don't understand that poor, these poor women die." *(Licorice)*

The fear following the assault manifested as worry, hypervigilance, and doubt that they would not be believed. Although fear was reportedly a large deterrent in help-seeking, other factors served as deterrents in a woman's help-seeking behavior, including culture.

Subtheme: Culture

Women noted aspects of culture from their environments that informed their help-seeking behaviors. Culture included religion, ethnicity, and norms from upbringing or also as an adult. Jill identified the tendency for Black people to not share with others outside of the home, and also that seeing a mental health provider was not something that Black people did:

"It deterred me. Because as Black people, our thing is, you know, for the longest... one, you don't talk about what goes on inside the home. You don't let the world into your business. And then, two-- as Black people, we definitely don't see psychologists, that's for white people. Like, that was the overall idea. And my, my daughter, she's a psychology major. And that was, that's her platform, and she ran for homecoming or whatever. And so, she's so big on that... that is… the stigma in the black community of seeking of … you know, mental health help." *(Jill)*

Women of other ethnicities also shared similar cultural norms that influenced their help-seeking behavior. Natalie, a Mexican American woman, noted the importance of pride and perseverance during adversity, especially when she felt her problems were not as severe in comparison to the problems that her grandparents overcame. In comparing her trauma to the experiences and perseverance of her family, Natalie silenced her issues, just as she was taught to do while growing up:

"Because I'm Mexican American, so they will, you don't talk about like, stuff that have bad stuff that happens to you, because you, you know, you don't talk about stuff like, like bad stuff that happened to you. You have your pride. Like they're like, 'You have your pride, just swallow it and suck it up and keep going', like, you know, my, my grandfathers and stuff. You know, that was always the thing with my culture, like, 'Look at everything grandma went through, look at everything Papi went through. And they never complained.' So that was another reason why I kind of just dealt … with it on my own. Like, who am I to complain about anything when my when I look at everything that my grandparents, my great-grandparents went through." *(Natalie)*

For other women, their ethnic and religious backgrounds posed barriers to help-seeking based on past experiences or hearing about how other issues were handled. Jess specifically cited issues that were covered up, as well as the protection of perpetrators:

"My family is a large Irish Catholic family. And so, they, they don't talk about stuff, right? If some, they don't, they just ignore or hide or minimize, they expect you to just get over it and move on, right? So, that was definitely a barrier to seeking help or reporting. There's also this sense that, right. There's weakness, right, in getting help. Because you should just be able to deal with your own problems, and that therapists are just like, after your money, or something. And that's not unique to my family. I know there are other families that feel that way too and communities that feel that way. And then I ... we saw how they handled the sex scandal within the Catholic Church of child abuse; they covered it up. There's this sense of 'Oh, hush-hush, let's just move him to a different parish.' And it's very much a protection of, of reputation, I think, that that somehow talking about the bad things will reflect badly on our whole family. And so, we're just not going to talk about that shhh shh kind of thing." *(Jess)*

In addition to religious or ethnic cultural impacts on help-seeking, women specifically cited military culture as a barrier to their help-seeking. Participants described how military norms, beliefs, ideals, and military-specific aspects impacted their sexual assault experience. The women described thoughts and structures that civilian survivors of sexual assault may not face. For example, Jess cited the small community and institutional betrayal from her assault that eroded trust:

"I thought of this person as a friend … a colleague and I didn't expect that person to be somebody who would hurt me, especially intentionally… I flew [aircraft] where every time you fly, it's a danger to your life, like, we lose a lot of people just doing normal training flights and normal cross-country flights. And so, you're, there's really a trust built up there. Because you're, you're keeping each other alive. He and I never actually flew together. But we still were in the same unit, that same kind of mentality, that same kind of trust for each other, because we could have flown together. Um, and then there was also the betrayal that I've come to understand now is institutional betrayal. Because I didn't feel comfortable reporting or going to my leadership or getting resources while I was actually in because I had the sense based on some experiences within that unit, that I wouldn't be believed-- that the unit would pick sides. And that it would it would be a fracture within the unit. And so, I didn't feel comfortable coming forward." *(Jess)*

Survivors also described the military's need to protect the military image, but this minimized the sexual assaults that occurred. Licorice explained the US military's distinguishment from other countries:

"I don't think they wanted to believe that [sexual assault] happens in their military. You know, 'We're the good ol' USA, we're the strong the brave' and, and umm ... 'Look at us ... look how good we are. We free people, we free the other countries and stuff,' they don't want to look bad in... in the papers, they don't want to look bad. You know, '[sexual assault] doesn't happen in OUR military. That happens in other countries' military', you know, not the good ol' USA." *(Licorice)*

The lack of diversity of women in the military also impacted women's ability to seek help or report due to the possible lack of anonymity and fear of repercussions in the work environment. Smooth noted that the members of the military and members in her unit were predominantly men, and fear arose that she could be easily identified due to the small unit size and that the small number of women would have made her easily identifiable if she were to report:

"I felt like if I reported and something happened to him, I felt like … people were going to come after me. I didn't know if I would … get attacked verbally or physically or I just, I wasn't really willing to risk. Because the career field that I was in is so small and when I say small like engineers, watercraft engineers in the Army, the field is probably 500 people. In it, 500 people, maybe 20 of them are women. So, to be in a field that's so dominated by men, and for it to be such a small unit of people, if I report, I guarantee you, everybody's going to know it was me. So, then you get black-balled. You're automatically going to be black-balled because nobody's gonna want to work with you." *(Smooth)*

Survivors also felt the need to be strong during and after their assault as this would better align with the stereotype of military members being strong. Nicole noted feeling like she should have been stronger to fight off the assault, as well as feeling pressured to endure the physical impacts after the assault:

"I just felt like, the whole like, 'you're a Marine, you can do anything, but you can't like protect your own body'. Like, 'How are you supposed to protect the country?' Or, you know, be a part of that? Like, 'Am I really even a Marine?' … Because I was overpowered, and then froze … I don't know, it's just like, I guess I felt ashamed that it's something that I felt like I allowed myself

to happen, even though that's not reality. But I just felt like, I should have done something … But I think the source was shame. …And there's just like a stigma like if you .... like you're weak if you go to medical, so you don't go to medical because it's like you get like .... if you go to medical too much to get checked out for whatever issues you're having. 'You're like not a good Marine' … So, I think part of that was also part of my subconscious maybe when I was like, 'Oh, you're raped? Don't go to medical' because like, you do everything you can not to go to medical, like, you don't want to be seen as a weak body or, you know, 'You're like you're screwing over everyone else that is working hard.' If you're not there with the team doing work every day, like you're screwing, you don't want to, they call you Blue Falcon, like, which is like that the non-profane word of saying buddy fucker, like, like you're screwing over people, like you're your BF… you're buddy fucking. So, it's just like, culture too. And I know, like, if you're in a combat situation, you don't back down, like if you are just like, if you get shot, or whatever, and you can still keep going, you don't want to just like lay there and say 'medic' or whatever. Unless if you're like, really, really bad, you want to keep moving and get safe and get with your other people, you know, you kill the bad guy first, and then you deal with your injuries later … Like this is a situation where you tell people in this situation … when you're in combat like you deal with it later." *(Nicole)*

Military culture served not only as a barrier to help-seeking; it also served as a guide—though unhelpful in the long-term—helpful for coping through the present. Women also blamed themselves as a way to make sense of the situation, and this also presented as a barrier.

Subtheme: Self-blame

Participants assigned fault to themselves, which included blaming themselves for the assault, regretting actions that preceded the assault, and rationalizing why the assault happened. Women attempted to make sense of the assault to have some closure. Rose felt she was unable to understand how someone could assault someone else as this was an egregious act against humanity. Being unable to believe that another person could act this way and assault another person, she was left finding blame in herself:

"I'm all just really looking for any explanation as to why something of that degree would happen to me. You know, and it was like, I want to blame him. Because it was his fault. I didn't deserve what happened to me, but I couldn't understand why someone could do something so selfish and so wrong. So, I guess I had too much faith in humanity to believe something like that could ever actually happen so I blamed myself instead." *(Rose)*

In addition to questioning what happened and blaming themselves, women also assigned blame to their actions as they felt it had caused the assault. Jess questioned her actions that preceded the assault and wondered if she had done things differently, if the assault may not have happened:

"So, there was a lot of questioning myself about .... blaming myself and questioning myself—like, 'If I had done X, Y or Z differently, maybe this wouldn't have happened. If I hadn't been drinking, this maybe wouldn't have happened. If I had been more forceful in like pushing him or saying 'no', this wouldn't have happened the way that it did.'" *(Jess)*

At some point, most women found blame in themselves. However, despite noting the need to seek care, there were limitations in the availability of care that served as a barrier to help-seeking.

Subtheme: Limited Care

Women shared wanting to seek help but encountered issues, including not knowing the options, a lack of availability to care, or a perceived lack of quality options. For some women who served many years ago, there was a lack of sexual assault-specific resources. Amy shared wanting help, but noted there were not any options for her:

"This was before… there was no there was no SHARP [Sexual Harassment/Assault Response and Prevention] there was no SARC [Sexual Assault Response Coordinator] and there was nothing for us. So, at that time, that was it, the equal opportunity officer." *(Amy)*

Amy also noted a barrier to access of care at the VA. Although services were available for sexual assault, she did not qualify as a Veteran due to not meeting the time in service requirement as she left the military before the end of her contract due to the assault:

"When I got out, I tried going to VA hospitals. But at that time, I was not considered a Veteran because I had not served two years. So, they turned me away. It was not until I… there were some other Veterans who helped me apply for disability. And I took six years and an attorney from the American Legion, and I actually gave up, but the … the attorney from the American Legion didn't. And after six years, I was awarded 20% service connection, which then I was considered a Veteran, and then I could go seek care at the VA. So, in that span of time, I was not

able to receive care, and the… the PTSD, depression, and all of those outcomes of the violence were raging in my life." *(Amy)*

Other women, may have known about help-seeking resources but felt they would not be useful, so they were dissuaded from utilizing them. Jess was aware of the confidentiality of chaplains and mental health providers but felt she could not trust these options based on poor interactions and the lack of belief in women:

"Our chaplain actually gave a speech about how you should be careful around women because they might falsely accuse you of rape. So, I was not going to my chaplain. In front of 500 people, he did that. And yeah, so I was like 'No, there's no way.'" *(Jess)*

Although there are a large number of barriers that interfered with these women's abilities to seek help for their assault, there were also facilitating factors that aided their help-seeking process.

Facilitators to Help-seeking

Participants shared aspects that helped them to seek help, including feeling safe, finding the right fit, and others inquiring. Women reflected on their help-seeking experiences and identified factors that assisted in their help-seeking. For Natalie, she felt unsafe around men after the assault, but having a women's clinic and services for women allowed her to feel safe and seek the help she wanted:

"Like now at the VA here in my city, they have an actual women's clinic that they opened this year. So, I feel like that's a safe place. Because we always had to be seen with the men for everything. But it was all I mean, you go into the VA, back when I lived in Texas, and it was nothing but men. There was really nowhere we can go to... we can have maybe just group, but our groups were also with men." *(Natalie)*

Once women sought help, they were able to continue with the help when they felt it was a good fit. Nicole appreciated hearing group members' shared life struggles, which also included issues besides their assaults. Additionally, feeling normalized was a key factor in beneficial help:

"And then really getting into like a 12-step program. And then I wasn't even like sharing at that point. But just hearing other people share their struggles with life. It wasn't necessarily about rape, but it would be about just other things. But it would be like, 'Oh, these other people have… their life isn't perfect either.' Like they had messes in their life, and they've healed from that. And it's just, other people have hurts and it's okay– it's okay to share your hurts." *(Nicole)*

In addition to these facilitators of help-seeking, the availability of resources played a key role in women's help-seeking, specifically the availability of formal resources for military sexual assault including Sexual Assault Prevention and Response (SAPR), Sexual Harassment/Assault Response and Prevention (SHARP), Service Women's Action Network (SWAN), military healthcare, and VA care. Women found the benefit of having resources that are versed and trained in a variety of issues. Susanne sought care for a physical issue but also received assistance with her sexual assault and disability claim:

"And then when I had a neck fusion, and couldn't work anymore, I don't… I have two discs in my neck that are fused and started going to the VA. And their MST program, you know, is really ramped up for detecting that. And so, when I gone to a nurse practitioner, and some of the things she asked me because I was going .... and seeking help for depression, for major depression disorder. And she was the one who said, you know, asking me questions, or talking about things. When I was in, the military said, 'Well, yeah, this is all military sexual trauma and even, which is unusual' … But for whatever reason, Susan, who was a nurse practitioner, referred me over to the disability part of the Navy. They contacted me for an interview, and then made me 50% disabled with a pension that I never sought... you know that somebody did for me, and it's hard for a lot of people to believe that that's how it happened. It's like, nope I never applied." *(Susanne)*

Subtheme: Camaraderie

Participants noted aspects of camaraderie and understanding that assisted with help-seeking and support, including feeling safe with other women, a sense of sisterhood, feeling not alone, and having a trusted military member. Women sought spaces where they felt safe and had a similar purpose. Jill joined a sorority with mental health initiatives, and she was able to build a network of supportive peers:

“Everybody's pushing mental health I, you know, I personally push it. And one of the reasons I joined the sorority [was] because one of their initiatives is mental health and suicide awareness. So, I'm a Zumba instructor as well. I've been a Zumba instructor for 15 years. Up until COVID, we had a big Zumba event every year, with this guy named Rob, who's a former Marine, and it was called The Hero, The Heroes, The Zumba for Heroes. So basically, it was suicide– suicide awareness among, among … the military. And so, that was something that we pushed all the time. So, I think that we are better with it. But like, you can go on Facebook now. I'll have 30 of my friends who are who are talking about self-care, mental health, mental health. And these are, these are Black friends. So, I do think that we're getting better. I'm not saying everybody's gonna follow it. You know, my, my way of thinking is slowly changing.” *(Jill)*

The camaraderie was also found within a military unit. Amy felt it was beneficial to have support from members of the unit immediately after an assault, even though she did not ask for help:

“So, there was that when the guy came to kick my ass. I didn't have to seek help. I was pleasantly surprised that my platoonmates actually surrounded me to protect ... surrounded him to detain him. And that one of my drill sergeants, two of my drill sergeants, backed me up and escorted him away and pursued him being removed from the base– that was a good example [of help] even though I didn't consciously ask for their help it was offered.” *(Amy)*

Coping

Coping included actions or thoughts that occurred in an attempt to decrease the stress of the assault experience. This included maladaptive and adaptive coping strategies. Cornelia ignored and buried her military sexual assault as this was what she was used to doing, and also what she did to cope with her emotional abuse as a child:

“I didn't process it., I didn't think about it again. I don't… it happened and it was over. And, you know, I didn't even talk about what happened within my childhood, until 2008. So, I had, you know, I did have to have a history of, of just letting it go. There's, I mean, I was, I was sexually abused. Growing up, I was emotionally abused. I was mentally abused. It wasn't like I could do anything. I never had the opportunity to tell anyone any of it. And I think that part of that is from that whole ‘adoptees have to be grateful.’ And so, there's no opportunity to say, ‘Hey, this bad thing is happening to me’. And that's just a learned behavior. So, after it happened, there was no comprehension that I could talk to anybody about it. So, it just went immediately to my subconscious because I didn't have the knowledge and I didn't have the skill or knowledge. I guess skill, I think is more appropriate… to have the skill of talking about the abuse.” *(Cornelia)*

For other women, leaving the military felt like the only solution to cope at the time. Licorice was desperate to decrease the stress from the assault—she purposely became pregnant, with plans to have an abortion, to leave the military. However, she kept the baby, and her love for her child and her grandchildren became a coping factor:

"I went to chaplain and I told the chaplain that, 'I'm going to kill myself.' And they sent me to a mental health unit. And I had to get help from the mental health unit there. And I didn't know what to do. So, they wouldn't let me out [of the military]. So, I got pregnant on purpose to get out…My idea was to get pregnant on purpose, and get out on pregnancy, and then have an abortion and move on with my life. But when I got out, I couldn't get an abortion. I figured it's not this baby's fault that this happened. So, I had the baby and I raised the baby. Now I have a son, and he's got a wife and they have four children. And I love them. It's not his fault that [the sexual assault] happened to me. It's not the baby's fault. So, I kept the baby." *(Licorice)*

Although coping can be helpful, not all coping may be considered healthy.

Subtheme: Maladaptive Coping

Maladaptive coping includes behaviors or thoughts that can help in the short-term but may have long-term consequences. This included acts to mitigate the physical and emotional impacts of the assault and included the use of substances, suicide attempts, and ideation, avoidance of others or isolation, as well as avoidance of emotional pain. Jess shared about self-medicating to cope, and how she also worried about the repercussions on her abilities to parents, as well as worry about her baby's well-being:

"I was self-medicating. I was drinking very heavily, and I had a baby and so I was getting scared to the point where I was worried that I was going to neglect or hurt my baby, and so I sought help for the drinking-- not realizing that that would then open the door to figuring out 'Well, why are you drinking'. So then ... then it came down to... I started the therapy, started digging into the reasons for the self-medicating, and then got put on some medication." *(Jess)*

Women also engaged in maladaptive behavior as it felt relaxing or created a feeling that was the opposite of the assault. Licorice endorsed gambling and not caring about the consequences:

"I gambled. I gambled. It just relaxed me, you know, I don't have to think about anything. Just push the button. I just push the button. And sometimes I just sit there numbingly and just push the button. And I didn't-- I didn't care about the consequences of running out of money or anything. But now I have that under control." *(Licorice)*

Avoidance came up in women's experience when describing maladaptive coping and included engaging in other activities, pushing thoughts away, avoiding opportunities where they may be hurt again, and avoiding people or places. For some women avoiding the thoughts and not processing the sexual assault helped them to cope with the experience. Smooth noted her pattern of avoiding and suppressing memories:

"I think isolation has always been my coping mechanism, shutting things down, mentally, not processing and not dealing completely... just completely, maybe trying not to, I guess the memory is formed but trying to compartmentalize that memory so deep in the back of my mind that it just ... if you asked me it didn't happen." *(Smooth)*

Other women's negative experiences of the trauma were at the forefront of their minds, and they coped by avoiding the possibility of being hurt again. Nicole is rarely able to go out alone. She feels she avoided the risk of harm by changing her lifestyle and behavior, and she needs to have someone with her at all times so she can feel safe:

"I think I'm still scared of going out places if I don't know someone that's going to be with me like a person that's a security blanket like, I can go to the grocery store for my-- by myself. I don't that often. I usually … my grandma's blind, so she needs groceries too. So that's kind of like, it's a weird protection like, but I guess it's hard for me to go to a grocery store by myself– I just realized that. Yes, I can still hold onto a cart. It's like, run [the cart] into someone-- if they start to assault me or something. I don't know, what the -what my, you know, rationale is there. But I don't think I could go to a restaurant by myself. You know, like, I'd have to have someone go with me to be that security blanket." *(Nicole)*

Minimizing was also a code in maladaptive coping. The women minimized the sexual assault by blaming themselves to have closure, rationalizing the assault, accepting all or elements of blame, or denying the impact of the assault. Women attempted to understand why the assault happened or what they could have done differently. Licorice used to blame and guilt herself—feeling as though she should have known better:

"So, I don't blame myself anymore. But I used to blame myself for opening the door. And I should, I should have known better that he was drunk. He was out there and he was wearing a white t-shirt. And I knew something was off, and I shouldn't have opened that door. I guilted myself for a long time, but not anymore." *(Licorice)*

Similarly, Mary was able to identify why it was difficult to tell her perpetrator to stop. However, she also blamed herself and accepted part of the responsibility as she "allowed it to happen," or felt that she could have tried harder to stop the assault:

"[I felt] a lot of guilt and shame. You know about what happened. Um, you know, I didn't really fight--, you know, you can't really fight. I couldn't --it was my supervisor. You know, you can't really say no. And you know, even though I wanted to, you just can't do that… the shame because I let it happen. I felt like I let it happen since I didn't say no or then fight you know." *(Mary)*

Blaming oneself can be a way of decreasing stress from cognitive dissonance, in an attempt to make sense of unexplainable actions. In this instance, maladaptive coping for sexual assault was a form of coping that helped in beginning the journey of healing. Coping behaviors were also informed by cultural norms. Nicole noted the cultural norm of drinking, and how this also became a normal coping behavior for her:

"I mean, we drank. It was definitely part of the culture that I got into with… in Okinawa, like, you're thousands of miles from your home. So, hang out with your friends, your friends or your family now, as part of what was like, 'Hey, we got money. Let's buy some drinks'… Fortunately, I didn't get addicted to that with my like, self-medicating with alcohol which I have alcoholics on both sides of my family, both of my parents' side of the family. So that's just another silver lining. I think I've self-medicated by just never wanting to be alone trying to make plans and be with people." *(Nicole)*

Women were also able to notice their self-medication and coping patterns and acted on seeking professional help to address their concerns. Amy's therapist assisted her with medication management and treatment by switching to prescribed cannabis to address her mental health:

"There were times that I did try to self-medicate with alcohol. With support from a VA therapist—I, for maybe like five or six years, used cannabis to help with the nightmares, the mood, also eating disorder. So that helped me for a time it's no longer like my medicine. Because I realized like, actually don't feel like I need that now." *(Amy)*

Women also utilized strategies of coping that were more helpful in the longer term as well.

Subtheme: Adaptive Coping

Adaptive coping was used by women to survive and heal from the assault. Helpful behaviors or thoughts to cope or survive the assault that provided immediate and long-term benefits. Mindset can be helpful with living in the present moment, forgiveness, and valuing protective factors that one has. Susie adapted by living one day at a time and she utilized a variety of behaviors, including spending time with family and other hobbies:

"I just tried to live each day. You, know, that's like... are there times I snap at the kids? Yeah, it's like, okay, you know? It's not always intentional. But I'm probably... so, what have I done to survive? Reading, music, planning different adventures, family is very important to me. Our house in Minnesota was you know, there was a lot more family around up there. And here, we're like two and a half hours away, but having fun get-togethers and big holidays." *(Susie)*

Another adaptive mentality used by women was forgiveness. Mary was able to decrease her anger by forgiving the perpetrator, but she still remembered the actions. Over time, she felt the assault had had less of a hold on her:

"I'm trying to learn the saying because... you get… you forgive the person but not the deed. That's something I'm trying to work on. I think-- just like a lot of things, when distance-- once distance has happened, it doesn't have quite the grip. But it still-- certain times of the year I have trouble-- anniversary type things is worse. There's a lot of ways that I'm better than I used to be. I don't have quite the anger. Yeah, I don't. I used to be angry more often and, and more angry. Now, it's not as often-- it's not as … pronounced I guess, then it used to be. But there's still things I've got to work-- work out-- work on." *(Mary)*

Participants had both immediate and delayed impacts on their mental health due to their military sexual assault.

Mental health impacts

Participants reported impacts on their mental health, which was defined as changes in their mood, thoughts, and behaviors. Jill noted a change in her sexual behavior, which, for some, can provide a sense of control after losing control during a sexual assault:

"I will say I was somewhat promiscuous. Um, because I felt ... almost purposely wanted to hurt guys. I wanted to see them weak. And then the minute I saw like them being weak, I would drop them but I would feel somewhat satisfied." *(Jill)*

After the assault, women also noted feeling the impacts of mental health before knowing they needed help. For Bessie, she also engaged in risky behavior and her appraisal and view of her life did not accurately match the situation; this disconnect led her to seek therapeutic help and she has been under the same provider's care for over 10 years:

"I was just a downward spiral. And I knew my mental health was not good. Like, I was hurting myself. I was doing risky things on purpose. Like I … I was not coping. And I thought I was like, I had this amazing position at work. I had a house I had two cars like on paper. My life looked amazing. But inside my head and my heart, I was so shattered. And I didn't know I needed help. But I knew something was wrong." *(Bessie)*

The mental health impacts following an assault can sometimes be so severe that one questions their overall ability to cope. Rose had an adverse childhood and grew resilient, but she was confused about the severity of the impact of the sexual assault:

"I turned a lot to drugs and alcohol I was dropping Percs (Percocet) a lot. Drinking a lot. Partying, partying in Nashville a lot. I messed around with Blue Lotus and acid. I was trying to ... I didn't want to think because every time I think, I thought about what had happened every day, flashbacks every night I had nightmares. It mentally took a very big toll on me. And I hated myself because I know I'm a resilient person. I had been through literal Hell and back I'd been in you know, an abusive household. I've been homeless for portions of my childhood. It's like, 'Why is this getting me so much?' And I was just not in good place mentally at all." *(Rose)*

Women also had a change in mood, including an impact on relationships with others, worry about safety, difficulty with trust (of others, military, health care), suicidal ideation, worry about burden on others, and depressed mood. For some women, their change in mood was

significant and led to a potential of harm or suicide to stop their pain, but this was also a sign to seek help. Jill had intense suicidal ideation and wanted to cut herself, which led to her trying to phone a friend:

"I don't want to be here. I thought ... I want to slit my wrists, get in, get in the bathtub, slit my wrists, and just die. Like, that was what I felt. And I didn't understand that. Like, I was just so it was like this cloud that was over me that I just didn't want to be here. And I tried calling... the one day I … I tried calling, like three or four people. Course nobody answered the phone. And everybody's always like, oh, you know, 'If you need me call me.'" *(Jill)*

Impacts on mood can be enduring, and it can also impact one's career. Jess's mood fluctuated and she needed medication to manage her symptoms. However, the state of her mental health and the use of medication for her mood negatively impacted her military career; the choice to fly in the military again was stripped from her—leaving her angry and depressed in response:

"I have I guess you could call like a relapse. I have relapses where I'll be very functional and doing well and then something will happen or I'll just have a bad day in or it'll all come crashing down again, I have to get intensive treatment again. It's like a… there's dips-- there's ups and downs. So, almost a roller coaster so like, I can be fine-- level-level-level and then all of a sudden, I super get angry or I super get depressed. It's up and down. And it's … it depends on a lot of factors. So, like something that could kick it off as —I tried to join the Reserves and fly again, different airframe. And I cannot do it because of my mental health background now and the medications I was on. And that really put me in a bad spot for a while super angry, super depressed because I was so angry-- that I wanted to serve again. And because of what someone else did to me, I could no longer do that. And so, it took away a choice for me, that should have been my choice." *(Jess)*

Disclosure

The theme disclosure included who the women told, what the disclosure looked like, and when the disclosure was made. For some women, the disclosure was not intentional—others inquired about a situation and this led to a disclosure. Susie was at the VA for her appointments and she was asked routine questions, and this time it included a question about military sexual trauma:

"Well, I've never had anybody reached out to me, or, you know, until about five years ago, when I'm in the VA, and for an appointment, and all of a sudden, it comes out, and they're asking me about any sexual trauma while I was active duty. And I'm like, you know, 'After 40 years, what the hell is wrong with you guys? Why are you asking me this now?' And I was very, very angry. And upset. 'Oh, it's like a little too little. A little too late. Too little, too late.' You know what I mean? So that's probably where it started. And I probably started becoming more vocal about it because of, but more out of anger." *(Susie)*

In a similar vein, Amy's friend noticed bruising on Amy's arm and asked about it:

"But the bruise it was covered my entire tricep area. It was really dark. And he bit me through my uniform. So, he bit hard. And it was a fellow soldier who saw it while we were doing our physical training and the sleeve of my t-shirt rode up. And she saw it and right away, she was like, 'Who bit you?' And she basically made me tell she said, 'If you don't, I will, whoever did this like needs to be held accountable.'" *(Amy)*

Although disclosures can help facilitate seeking help and the healing process, the disclosure itself did not always pan out in the intended way. Women may have sought help for a separate issue, or were engaging in regular activities, and were queried about their assault. To whom disclosures were made, was also impacted by the culture and the structure of the military; this structure can impact a woman's autonomy following an experience where they lacked control.

Post-traumatic Growth

Post-traumatic growth was a positive change as a result of the trauma, including helping others and decreasing blame on self. Survivors shared positive changes from healing from their trauma, including increased strength. Women found benefit and purpose in helping other military sexual assault survivors. Licorice wanted her story to benefit others:

"I just want people to know, this is happening. And if my story gets out, and it saves one woman, soldier, from getting raped then then then I did I put out something that is worth some good. You know? I did something good." *(Licorice)*

Following her assault, Bessie has been dedicated to helping others who have experienced similar experiences:

"I am a survivor, and I try to help other people who have gone through other situations, whether it's physical or sexual violence. I am on the board of a domestic violence shelter here… Before my son was born, I would say it was just me being this tough overcomer and choosing the word survivor over victim that, you know, sometimes bad things happen, and I can still be my normal, joyous, cheerful self, even if something bad happens. That resiliency and, and now that my son exists, I want to be a role model for him to know that, you know, bad things are gonna happen, and it's how you deal with them, and how you get through it, and the support you get from it. That, you know, like, builds who you are and builds your character and yeah, I very easily could have a completely different life right now if I made different choices, and I'm so glad I am where I am today." *(Bessie)*

The trauma can also lead to resilience, growth, and adaptability. Jill noted a stronger personality and preparedness for anything:

"It made me… I think that's where my personality developed too. Don't get me wrong. I was already like a fighter because I grew up in a house of boys. But it became something different. Like, to this day, I'm still known as the one... as I say, "Stay on go". Like I'm always ready for a fight. And I don't care for if it's man because I have to show you just because you're a man. You can't beat me. You can't outmaneuver me, you can't out-think me." *(Jill)*

Women grew from their sexual assault and were able to acknowledge what happened to them. The trauma of military sexual assault became a reason to help others through trauma by raising awareness of sexual assault, promoting strength, and remembering the fight and personality that they have always had.

Discussion

This qualitative study used a thematic analysis framework (Braun & Clarke, 2006) to examine how female Veterans (n = 14) sought help after they experienced military sexual trauma and the factors that impacted their help-seeking. This study sought to explore three specific areas: to examine their formal and informal help-seeking behaviors, identify barriers and facilitators to help-seeking for females who are survivors of military sexual assault, and understand the role of stigma in survivors' help-seeking behaviors. Additionally, women were asked to describe the impacts of the trauma after surviving a military sexual assault, as well as their experiences with help-seeking. Although there is a significant amount of literature on military sexual assault, the mental health sequelae, and the treatment of military sexual assault (Rasmussen, 2016; Holliday & Monteith, 2019; Conard et al., 2014; Nugent et al., 2020; Tedeschi & Calhoun, 2004; De Terte & Stephens, 2014; Tedeschi & Calhoun, 2004; Christopher, 2004), there are still gaps in understanding the barriers and facilitators to formal and informal help-seeking behaviors of female military sexual assault survivors. Qualitative research employing a thematic analysis framework (Braun & Clarke, 2006) helped provide a safe space for women to share their help-seeking experiences. This research study found seven data-rich themes which included: 1) Types of help-seeking, 2) Barriers to help-seeking, 3) Facilitators to help-seeking, 4) Coping, 5) Mental health impacts, 6) Disclosure, and 7) Post-traumatic growth.

The qualitative method of this study allowed the collection of authentic narratives and experiences for these women (Dempsey et al., 2016; Kelle, 2006) that would have been difficult to capture in quantitative research. The findings of this study shed light on barriers to healing and illustrated the importance of identifying barriers to aid help-seeking and healing among female sexual assault survivors. Whether through formal or informal help-seeking, women sought help

at various points in their lives and faced multiple barriers in seeking support. Despite possible benefits from seeking help, women encountered actual – and perceived – barriers to seeking, including stigma, fear, impacts of cultural norms, blame, limited knowledge of resources, or perception that help would not be useful. Women sought informal help (Zinzow et al., 2015) following their sexual assault and this included friends and family, even though they felt their support systems did not fully understand. However, speaking to someone who had military experience or was formally trained to help with mental health or sexual assault was also an important factor in formal help-seeking, as some women reported that informal support, especially friends and family, may not understand the military nuances related to the assault (Rasmussen, 2016). Although all women sought informal and formal sources of support, some barriers made it more difficult to seek help.

Barriers to help-seeking included stigma, fear, military culture, self-blame, and limited care. Consistent with prior research (Castro et al., 2015), women were internally dissuaded and also dissuaded by the military due to perceived and actual messages that they were weak because the sexual assault happened. These women blamed themselves for the assault and criticized their behaviors that preceded the assault (Holland et al., 2016). Although self-blame is a barrier in help-seeking (Coleman et al., 2017), this study found that self-blame was used as a means to cope in the short-term among survivors of sexual assault as self-blame (i.e., accepting responsibility) was a form of maintaining control over the traumatic experience (Holliday et al., 2018).

Many participants also identified a sense of betrayal from the sexual trauma as the perpetrator was an acquaintance or a military member whom they felt could be trusted (Rasmussen, 2016). The institutional betrayal and violation of professed values created a barrier

to reporting (Holliday & Monteith, 2019; Conard et al., 2014). This violation of trust left lasting imprints on the women and affected their relationships with their families and support systems. The women endorsed difficulty trusting others, and a continued journey to repair and strengthen relationships following their military sexual assault.

Although the betrayal may be perceived as severe and difficult to overcome, these women found a way to cope with their trauma in an attempt to keep themselves moving forward. For many of these women, there was some form of coping that was helpful in the short-term, but possibly harmful in the longer term. This included minimizing or avoiding the problem, coping with substances to numb the pain, or mood and behavior changes, which included isolation and building barriers to prevent potential harm or another assault (Archer, 2019). Although women often do not intend to cope in an unhealthy way, maladaptive coping (Mattocks et al., 2012) is informed by cultural norms (Dworkin & Weaver, 2021; Gobin & Gómez, 2020) and a lack of access or support to more appropriate or healthy coping were common barriers. For example, drinking culture in the military was often seen as an acceptable method of coping (Jones & Fear, 2011). Cultural norms or styles of upbringing in women of color and norms within religion also impacted and fostered a culture of silence where it was more appropriate to avoid discussing issues to avoid shame for the self or others.

Women were able to seek help and heal with the presence of camaraderie. Members of the unit offered support following the assault and fostered a sense of safety through camaraderie (Weitz, 2015), which was a strength for some women. Women were also able to cope with the sexual assault both adaptively and maladaptively. Blaming themselves was a form of closure that helped to move through the experience. However, maladaptive coping often was not helpful for extended periods and is a strong predictor of PTSD and depression mental health outcomes (Dell

et al., 2023; Resick, 1993). This study found that forgiving the perpetrator and a shift in mindset was a factor of adaptive coping that helped in healing for some women (De Souza Ferreira, 2024; Ha, Bae, and Hyun, 2019).

Therapy and formal treatment were common avenues used to aid healing and reduce the mental health impacts (Zinzow et al., 2015). However, the availability of resources did not equate to utilization due to barriers (e.g., lack of knowledge of resources, fear) and led women to utilize informal avenues of help-seeking initially (Nugent et al., 2020). Women in this study sought help to address their mental health symptoms, including symptoms of depression, avoidance, hyperarousal, and a lack of trust that impacted their functioning. Symptoms from the assault also included difficulties with decision-making and apathy, which can impact the ability to seek help after an assault (Kessler, 1995; Manuck et al., 2014, as cited in van den Berk-Clark & Patterson Silver Wolf, 2015, p. 107; Washington, Bean-Mayberry, Riopelle, & Yano, 2011).

Healing often did not occur immediately following the assault. Consistent with prior research, women who disclosed their assault had post-traumatic growth (Ahrens & Aldana, 2012; Borja et al., 2006; Frazier et al., 2004, Orchowski & Gidycz, 2012) – resiliency, closer relationships with others, a greater willingness to accept and provide help, and an increased appreciation of life (Ulloa et al., 2016). The women also shared increased adaptive coping behaviors and greater attachment to others, and improvement in relationships with others (Ahrens & Aldana, 2012; Borja et al., 2006; Frazier et al., 2004, Orchowski & Gidycz, 2012). All of the women in this study who received help and support from other female military sexual assault survivors reported that the camaraderie and community were largely beneficial; the survivors also expressed willingness to support other military sexual assault survivors. Empowering others to heal was also a part of post-traumatic growth (Rasmussen, 2016).

Clinical Implications

While this study evaluated themes in help-seeking and informs the research community of areas to address in help-seeking, there are areas of military sexual assault research to further address that can strengthen research in this area. This study contributes to the knowledge of the help-seeking process and barriers for female military sexual assault survivors. The participants noted a need to address barriers, as well as the large mental health impact of the assault; these women also reported benefit from the inquiry of others, which acted as a catalyst for their help-seeking and post-traumatic growth. These findings call for more action for healthcare providers and the military to work with supervisors, members, and the support systems of the members to increase check-ins on well-being and increase knowledge of what assault is, as well as the signs of assault or changes in mental health. Military members, including commanders, may benefit from briefings on the specific barriers and facilitators detailed in this research to inform needed changes to enable help-seeking among survivors of military sexual trauma.

Many women sought care after the military and reported that if someone had inquired, they likely would have disclosed. Earlier assessment in healthcare visits may be key in timely intervention and care to reduce mental health impacts. Approximately one-third of women wait at least six months after the trauma before seeking help (Price et al., 2014). Training for healthcare providers and assessment protocols in military treatment facilities may need to be adapted to integrate protocols and norms in trauma assessment; the training may include interviewing skills and empathy for all healthcare providers, rather than only mental health providers, as survivors may be seeking medical help following their assault. Additionally, explicit and empathetic queries during medical intakes about the member's history of sexual assault may catalyze further help-seeking.

Through the interviews in this qualitative research, participants were able to provide The data further highlighted important clinical recommendations for all healthcare providers. Beyond assessing trauma, the participants in this study also identified areas of improvement and training that may decrease barriers to care, increase the remission of mental health symptoms, and decrease the impact on functioning. Women identified the need for individualization and culturally sensitive adaptations to evidence-based interventions. Additionally, empathy and understanding of military culture were also a commonality in ideal care. Further, clarifying expectations, including the possible risks of treatment, time commitment, and emotional vulnerability, may improve treatment adherence.

Study Limitations and Future Research

Despite the strengths of this study, there are limitations that can inform future research. Purposive and convenience sampling may limit the generalizability to other populations due to the specific inclusion criteria for this study. Additionally, although this study had some range in demographics that added to the depth and applicability of the findings, it is possible that the small sample size (n = 14) may also limit generalizability.

Future research should identify the healing and post-traumatic growth gained from informal help-seeking avenues. Specifically, research should explore the impacts of peer-led groups, events, or retreats with female Veterans, and the benefits of community and sisterhood, specifically with other female Veterans who have a history of trauma. Additionally, this study can be replicated with military sexual assault survivors of all gender identities, to understand similarities and differences in help-seeking behaviors.

Conclusion

This study highlighted the help-seeking experiences and mental health sequela of female military sexual assault survivors. The goal was to contribute to the depth of literature on how female military members sought help for their assault and identify the factors that impacted their help-seeking process. Fourteen women who served across a span of over forty years shared their experiences and how their experiences were impacted by cultural norms, facilitators, and barriers, and how they achieved growth. Although these women served at different times and different locations, there were similarities in how they sought help for their military sexual assault. Through further research and application of findings, a goal may be to minimize the widespread barriers to help-seeking, decrease the delay in receiving help, and ultimately address and eliminate underlying factors that persist in military sexual assault.

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Appendix A. Recruitment Flyer

Appendix B. Participant Screener

Participant Screening Form

About the Study:

- This study will help us understand military sexual assault survivors' access to services for mental health.
- Women will participate in a one-time individual interview and will receive **$25** for their time.
- This study is interested in understanding the services you sought out or received and your perception of those services.

ALL OF THE INFORMATION YOU TELL ME IS CONFIDENTIAL

Would you like to see if you are eligible to participate?
If Yes □ Ask eligibility questions
If No □ Thank them for their time and end the interaction

A. Eligibility Questions
Today's Date: _____ Screener's Initials: ___ Recruitment Location: _____

1. How old are you? _____ [If under 18 years old: INELIGIBLE]

2. How would you identify your sex?
If needed to clarify: What is your sex assigned at birth? If I were to ask you (choices), which would you choose? [If male or intersex: INELIGIBLE] _____ (Response here)

□ Male
□ Female
□ Intersex

3. How would you identify your gender?
If needed to clarify: What is your gender identity? Does your current gender match the gender you were assigned at birth? [If not cis-gender woman: INELIGIBLE]

□ Cis-gender man
□ **Cis-gender woman**
□ Transgender
□ Nonbinary
□ Gender fluid
□ Agender
□ Other: _____

4. Have you ever served in the military? [If no: INELIGIBLE]

□ Yes
□ No

4a. Which U.S. military branch did you serve?

□ Air Force
□ Army
□ Coast Guard
□ Navy
□ Marine Corps
□ Military outside of the U.S. [If Military outside of US: Ineligible]
□ Other branch: _____

4b. Are you currently active-duty in the military?
□ Yes; Active-duty [If active-duty: INELIGIBLE]
□ No; not active duty (ask follow-up question)

4c. What is your current military status? (Check all that apply)
□ Active-duty [If active-duty: INELIGIBLE]
□ National Guard
□ Active-Reserves
□ Inactive or Individual Ready Reserve
□ Honorable discharge
□ Retired
□ Dishonorable discharge
□ Discharge other than dishonorable
□ Medically separated
□ Other: _____

5. Did you experience sexual assault while serving in the military?
□ Yes
□ No [If No: INELIGIBLE]

5b. How long ago did the assault occur? (If you were assaulted more than once, how long ago did the most recent occur?)
□ less than 6 months ago [INELIGIBLE]
□ 6 months to 1 year
□ one year to 5 years
□ five to ten years ago
□ ten to thirty years ago

5c. What was your military status when you were sexually assaulted?
□ Active-duty
□ National Guard [INELIGIBLE]
□ Active-Reserves [INELIGIBLE]
□ Inactive or Individual Ready Reserve [INELIGIBLE]

5d. If you answered yes to question 5, what was the military affiliation of the perpetrator(s) or person(s) who sexually assaulted you? Was the person who assaulted you also an active duty member? Yes or No.
□ Yes (eligible)
□ No

□ **Eligible** □ **Ineligible**

If ELIGIBLE

 You are eligible to participate in this study. Your participation in this study is very important to us.

1. Obtain further screening information
2. Obtain contact information for the interview phase
3. *Schedule with her* at the end of the screener. The interview will take place at the University, at a location near you, or via Zoom.

If INELIGIBLE

 Thank you for your time. Unfortunately, you are not eligible to participate in this study.
 Offer mental health referral packet.

B. Next, I will ask you some QUESTIONS ABOUT YOURSELF.

6. What is your race/ethnicity?

□ Latina/Hispanic
□ White
□ African American
□ Asian/Pacific Islander
□ Native American
□ Other _____

7. What is your spiritual or religious affiliation?

□ Christianity
□ Islam
□ Hinduism
□ Buddhism
□ Sikhism
□ Taoism
□ Judaism
□ Confucianism
□ Taoism
□ Aspiritual
□ Agnostic
□ Atheist
□ Other: _____

C. Next, I will ask you for your CONTACT INFORMATION. All of your information is kept confidential.

1. Name: (First)_____ (Last) _____

2. Telephone number: ( ) _____ - _____

3. Is it ok for us to leave a message/text for you at this number? Yes / No

4. E-mail address: _____

5. When we call, how should we identify ourselves?
□ University of San Francisco (plus our true name)
□ Women Wellbeing Research (Study Name)
□ Code Name (Julia)

6. Here are some times that I am available _____ Would _____ work for you?

7 We have the option to meet in person (if it is safe and convenient), or meeting via Zoom. Which would be your preference?
□ Zoom
□ In-person
□ Able to do both; no preference

Appendix C. Referral List

Community Resources

- SFWA
  - 24-hour Crisis hotline at 415-647-RAPE
  - Resources, advocacy, education
- RAINN
  - National Sexual Assault Hotline at 800-656-HOPE
- Ujima
  - Get connected with culturally specific services and resources at 1-884-77-UJIMA (1 -884-7785462)
- The Network/La Red
  - 24-hour hotline at 1-800-832-1901
  - Confidential emotional support, information, referrals, safety planning, and more for LGBTQ folx.
- DoD Safe Helpline
  - 24-hour hotline at 877-995-5247 or chat at safehelpline.org
  - Secure, confidential, and anonymous crisis support service designed for members of the Department of Defense community affected by sexual assault.
- Psychology Today
  - Find detailed professional listings for treatment centers in the United States and Canada.
- StrongHearts
  - 24-hour helpline at 1-844-762-8483 or chat at strongheartshelpline.org
  - Confidential and anonymous culturally-appropriate domestic, dating, and sexual violence helpline for Native Americans.

Appendix D. Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Below is a description of the research procedures and an explanation of your rights as a research participant. You should read this information carefully. If you agree to participate, you will sign in the space provided to indicate that you have read and understand the information on this consent form. You are entitled to and will receive a copy of this form.

You have been asked to participate in a research study conducted by Priscilla Phan, a graduate student in the Clinical Psychology PsyD Program within the School of Nursing and Health Professions at the University of San Francisco. The faculty supervisor for this study is Dr. Dellanira Garcia, PhD, a professor in the Clinical Psychology PsyD Program.

WHAT THE STUDY IS ABOUT:
The purpose of this research study is to learn about the experiences of female military sexual assault (MSA) survivors. Specifically, this study aims to explore the way MSA survivors sought support after the assault.

WHAT WE WILL ASK YOU TO DO:
During this study, the following will happen: we will arrange a time to meet online using video teleconferencing software. At this meeting, I will ask you questions about your experiences after the assault. I will ask you to change your name on Zoom to protect your privacy. Our meeting will be audio-recorded, password-protected, and transcribed.

DURATION AND LOCATION OF THE STUDY:
Your participation in this study will involve one individual interview session that will last approximately one and a half hours. The study will take place over Zoom, a virtual communication platform, with audio and video enabled.

POTENTIAL RISKS AND DISCOMFORTS:
The research procedures described above may involve the following risks and/or discomforts: you will be asked questions about your sexual assault, the support you sought, and your relationships with your peers. These questions may feel personal and may cause uncomfortable memories. While it is your choice what you share over the course of the interview, you may experience negative feelings or memories as a result of the interview process. If that occurs, this researcher will assess for safety risks to you or others, provide grounding exercises, and respond accordingly. Additionally, support resources will be available to you (see below). Serious risks

are unlikely over the course of this study. If you wish, you may choose to withdraw your consent and discontinue your participation at any time during the study without penalty.

In addition to a debrief at the end of the interview, community resources are also available in case you need additional support. Please See the end of this consent form for a list of resources. Recordings that are kept online, while password-protected, will be transcribed. There is minimal risk of this data being accessed by unauthorized individuals, and your real name will not be associated with your recording.

BENEFITS:
There are no immediate benefits to participants. This study may provide possible benefits to others in the MSA community, which includes access to the collective wisdom of study participants.

PRIVACY/CONFIDENTIALITY:

Any data you provide in this study will be kept confidential unless disclosure is required by law. In any report we publish, we will not include information that will make it possible to identify you or any individual participant. Specifically, we will change your name prior to beginning recording, so research assistants will not have access to your real name. Records linking your real name to your pseudonym will be kept only as a hard copy, separate from your recording, in a password-protected file. We will delete these records following completion of data analysis and successful defense of the dissertation.

COMPENSATION/PAYMENT FOR PARTICIPATION:

You will receive one (1) virtual gift card totaling $25 for your participation in this study. If the prospective participant qualifies for the study, and the study is terminated by the researcher, or if the participant withdraws from the study at any time, said participant will receive the $25 gift card.

VOLUNTARY NATURE OF THE STUDY:

Your participation is voluntary and you may refuse to participate without penalty or loss of benefits. Furthermore, you may skip any questions or tasks that make you uncomfortable and may discontinue your participation at any time without penalty. In addition, the researcher has the right to withdraw you from participation in the study at any time.

OFFER TO ANSWER QUESTIONS:

Please ask any questions you have now. If you have questions later, you should contact the principal investigator: Priscilla Phan at WomenWellbeingResearch@gmail.com. You may also contact the faculty supervisor, Dr. Dellanira Garcia, PhD, at dgarcia12@usfca.edu. If you have questions or concerns about your rights as a participant in this study, you may contact the University of San Francisco Institutional Review Board at IRBPHS@usfca.edu.

I HAVE READ THE ABOVE INFORMATION. ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED. I AGREE TO PARTICIPATE IN THIS RESEARCH PROJECT AND I WILL RECEIVE A COPY OF THIS CONSENT FORM.

PARTICIPANT'S SIGNATURE *DATE*

Appendix E. Interview Guide

Well-being in Women Servicemembers and Veterans

Themes in Help-seeking of Female Military Sexual Assault Survivors

Pseudonym_____ Start time_____ End Time_____ Date_____

Interview Guide

Script:

Thank you for participating in this research study. The interview will take one to two hours. This interview is confidential and I will use a pseudonym to help protect confidentiality. Are you in a quiet and private space? What name should we use for our interview today?

I am going to ask you a few questions about yourself first. There are no right or wrong answers.

Thank you for your participation so far. The questions I have now will ask you to think about some of your experiences and the way you have coped with them. I am interested in hearing about ways you have recovered from sexual trauma, so sometimes I will ask for more details that will relate to your thoughts or feelings. I will not ask you about the details of what happened to you, but instead about how you understood some of your experiences and what you did. There are no right or wrong answers to my questions, I want to hear about your experiences. If there are any questions you do not want to talk about, please let me know and we can move to the next questions. I will be sure to leave time at the end of our interview in case you have any questions for me. Do you have any questions before we begin?

1. What made you decide to participate in this study?

2. To get started, I'm going to briefly ask some questions about your service.
    - I would like to know how old you were when you joined the military
    - What were some of the main reasons you joined?
    - What branch did you serve in (info from screener)
    - What rank were you when you left active duty military?
    - How many years did you serve?
    - If you had to summarize your experience in the military, what would you say about it?

3. From the survey questionnaire, I understand you unfortunately experienced a sexual assault in the military, is this accurate? I acknowledge that assault and what happens after can look different for different people.

As you know this study focuses on women Veterans who have experienced sexual assault (SA) in the military. While I'm not going to ask you in-depth about your experiences, I do want to get a better understanding of what happened, so I can understand how you sought help.

- Can you tell me briefly what happened to you? Definitions differ, what do you define as sexual assault?
- Tell me about your relationship to the person that did this to you.
- How long were you in the military when this happened to you?
- What rank were you when you were assaulted?
- In what ways did this experience affect you over time?

4. There are many different ways that people seek or do not seek help, I'm going to ask about the ways you sought help. When you think about help-seeking, what comes to mind?
    - Tell me more about that.
    - How would you define help-seeking?

[I will use the term help-seeking, this can include (reporting, psychology services, seeing a medical provider (for health-related consequences), chaplain, seeking support from a friend, colleague, family member)]

I'm going to ask about what happened after your assault.

5. Think about after your assault and before you sought help.

    Tell me about your decision to not seek help at the time.
    - (probe) What do you think would have assisted you in seeking help?
    - (probe) What hindered your ability to support/help-seek?

(interviewer note: ask about self-blame, stigma, discrimination for being female (or other identities), fear of retribution, informal formal seeking, reporting)

And when you did seek help, how soon after did you seek help?

- (probe) Who did you turn to for help after your assault/Who did you tell about the assault?
- (probe: what words did you say?)
- When you did seek help… (probe)
- (probe) Tell me about the experience of the help you received. How soon did you seek help?
- (probe) When you reached out for help, what were you hoping for?

Did you get what you were hoping for?

- (probe) What helped you make the decision to seek help?
- (probe) Who did you tell you were seeking help?
- (probe) What changes, if any, would you make about the help you received?

What more would you have wished for?
- Did that experience increase your wish to get more help or discourage you?
- (probe) What helped you to seek support/help-seek?

6. Did you report your assault? Or think about it?
   - If yes
     - When did you report it?
     - Tell me about your decision to report, what did you think was going to happen?
       (probe: fears, concerns)

   - If no
     - Tell me about your decision not to report
     - What do you think was going to happen if you reported?
       (probe: fears, concerns)

7. When you did seek help, what hindered your ability to support/help-seek? (int note: ask about Self-blame, stigma, discrimination for being female (or other identities), fear of retribution, informal formal seeking, reporting)
   - What other types of help-seeking did you use?

8. Tell me about how the assault and how your help-seeking experience affected your mental health at the time.

9. How has your help-seeking experience affected your mental health then?
   Over time?
   Now?

10. In what ways did you cope with this experience? (positive or negative) (examples of this can include drinking, spending more time with friends, going to the gym, spending more time alone, etc.).
    - (probe) Specifically, how did you survive this experience
    - (probe) What helped/ didn't help?

Thank you for sharing your experiences about your help-seeking, now I would like to ask you about your experience as a woman in the military.

11. How do you think being a woman in the military impacted your help-seeking for the assault? Probe: do you think it is different for men?

12. What aspects of your culture assisted in your help-seeking process? What aspects of your culture posed obstacles or prevented you from your help-seeking process?
    - (Interviewer note: probe here for culturally specific content. Military culture)
    - (probe) If only religion stated: Besides religion, can you describe other ways your culture has helped you cope with sexual trauma/these experiences?

- (probe) What helped/didn't help?

13. Was the help you received sensitive to your identity as a female servicemember? Probe: In what ways were your expectations met? In what ways were they not met?
    - Your identity as a female?
    - As a service-member or Branch identity (Marine/soldier, etc.)?

Thank you for sharing your experiences about your culture and identities, now I would like to ask you about seeking help.

14. What do you wish mental health providers would know about female service members who have survived sexual assault?

15. If you had a magic wand and you could develop a treatment for other female servicewomen who have had similar experiences, what would it look like?

As we come to the end of this interview, tell me about your healing process.

16. What does this look like for you?
    - (probe) When did that start?
    - (probe) Tell me about when you felt best or healthiest during your period of recovery.
    - (probe) Where do you feel such strength came from?
    - (probe) What personal strengths/characteristics did you draw upon?

17. Lastly, what advice would you give to other female service members recovering from sexual trauma?

Thank you for taking the time to come and meet with me today and share your experiences.

Do you have any questions for me?

Is there anything else that you would like to add about what we have discussed today?

In the next fifteen minutes, we will debrief and reflect on the interview.

Appendix F. Proof Quotes

Table 3

Proof Quotes

Themes	Subtheme	Proof Quotes
Types of Help-seeking		I have not only a psychologist but a psychiatrist. And I am on anti-anxiety meds, I know how to self-care and self-soothe. I've learned all those techniques through groups, group therapies, I have a very good support system with my church. (Bessie) From my husband, I wouldn't necessarily call it support. Okay. It was simply acknowledgment if that's what it was. (Susanne)
	Formal Help-Seeking	I needed medical help. And so, I did I called the SARC-- sexual assault response coordinator. And she came and picked me up and took me to a civilian ER and they took care of me and, but I did it restricted because I felt like it was my fault. And they set me up with someone to talk to at that time. (Bessie) I just went straight [and said], “I want to talk to a First Sergeant, I want to talk to him now”. And so, the First Sergeant was very gracious. And so, I told him what happened. And he's like, he went in and told the captain and so, you know, they both sat with me, while I told the whole story to [the] captain. (Susie)
	Informal Help-Seeking	I had one friend who's actually Air Force and I was Army, but we did the same job. And I talked to her and told her not all the details, but enough, so she knew what was going on. (Mary) I have a Veteran support group, basically just a group of friends that we've been maintaining a chat for like, two, three years now. (Amy)

Barriers to Help-seeking		Because the power dynamics that existed-- I wish I could have had a higher rank-- not that that would have mattered as much. But maybe that would have given me a little bit more to work with. If I had been ranked higher than the… that perpetrator, maybe then he wouldn't have assaulted me. (Amy) He was well known. And he was their person; I was this new girl. And he was their supervisor. They knew him and his family. To them, he was like this great guy. And they are and there's a word mostly the military men will say, "I vouch for him," they vouch for each other. So that's a higher-ranking person. They vouch ... and a higher ranking person high ranking respected person vouches for you. That like makes your credibility even better. That's like to make him look good. He had a whole bunch of people on his side vouching for him. (Natalie)
	Stigma	You keep your mouth shut because the men are gonna defend each other. If it didn't have that atmosphere, I probably would have reported sooner, but I watched someone report their assault and all of the men talk absolute crap about her saying like, "Oh, she's just a whore, she's just doing this for attention," when that wasn't the case. I think that there was that atmosphere and that negativity and stigmatism towards you know, people who've been assaulted. [If it] wasn't there, I probably would have reported a lot sooner. (Rose) I definitely didn't want anyone at work to know because I thought I had done something wrong. I didn't I didn't want the reputation of a victim-- that I let something happen to me, like I'm vulnerable or weak or something along those lines. (Bessie)
	Fear	I had so much fear putting me in those two months that I had to work next to him that I was grateful to be transferred to another unit because I knew I wasn't going to die. Because I'm still afraid of that [perpetrator] finding out where I live. And what I'm doing. I'm afraid, period, that he's gonna find me again one day. (Licorice) Scared to come up dead if I tried to report. I was scared he would attempt to do it again. I was scared that male protecting males, my leadership would come for me. I was scared no one would believe me. (Rose)

	Culture	The biggest thing in the Black community is we pray everything away. You pray, pray, pray, pray, go seek, God, pray. But it's okay to pray... and see a professional. (Jill) Military rape culture is part of military society. Because at the time that I was enlisting, there was still a lot of resistance to women being in the military. And so right away, the misogynist, violence was present. And as we can also observe from so-called "civil society", sexual violence is just like woven into misogynist violence. (Amy) I could have told the head of the department or other people, but I didn't because drinking was involved, and other kind of stuff was involved. Somehow, I was able to get away. So, I just didn't want to cause waves, I just wanted to be a good soldier, so to speak. So, I just kind of swept it under the rug. And that's just kind of how you did things back then. (Susanne)
	Self-Blame	It's okay to acknowledge that it did happen, because I would lie to myself all the time and say, "No, it didn't happen. No, maybe I did something to make him think that that was okay". (Nicole) I think about what happened. Because I feel like it was my fault. It was partly my fault wasn't completely my fault. He committed the act, but I do feel like it was my fault and I still feel like that, and I don't know that I will ever change. I'm feeling like it was my fault, especially knowing that he picked someone from every cycle. And so, I feel there had to be something that maybe I was projecting ... for him to think, "Okay. Um, I'm going to pick her". But then not only that, and that I didn't... I didn't report it. Like officially report it-- maybe if I had told the first sergeant, I feel like that may have changed things. (Jill)

	Limited Care	After I got out of the hospital, they put me into a police interrogation room on base. And I was by myself-- I had no representation, nothing. I had to give my statement by myself to a man in a small room. And he was asking me -- I feel like they're trick questions, like setting me up to make it not sound so bad. (Natalie) There's no procedure that says, "When you get out, you go do this, you go do that." It's kind of just figure it out. I didn't have medical care. I didn't have any anything. And I don't even remember who told me to go to the VA. (Smooth) It was not like it is now. There was no specific person you reported to --whatever acronym it is--the SHARP or whatever it is. We didn't have anything like that. (Mary)
Facilitators to Help-seeking		The VA here in my city, they have an actual women's clinic that they opened this year. So, I feel like that's a safe place. (Natalie) I found the Vet Center. And it's like they knew me. And I didn't even have to tell them who I was. And they respected me. And they understood the things that went with being a Veteran that we struggle with. And we don't even know that we struggle with it until we started getting into counseling and things come up. And they're just like, "Yep, this is normal. You're normal, it's okay." (Nicole)
Coping		Alcohol was definitely a problem after [the assault]. And I didn't get close to people, even my husband, my ex-husband. I never really let down that wall. But maybe if I had sought help, sooner, we might still be together. I wasn't ever suicidal, but I did self-harm. And I did finally seek help for that. My self-harm started kind of getting out of control. And I finally … I knew something was wrong. (Bessie) I blocked it all out. I don't think about it at all. I acted like it didn't happen. But it was always there with me, I guess. And that's why I would drink. I could, I could pretend it didn't happen. (Natalie)

	Maladaptive Coping	I never really addressed it-- just kind of buried it. It was all inappropriate a lot of what happened to me over and over and over again. And so probably my drinking had increased. (Susanne) I was realizing that I wasn't going outside. I wasn't really engaging with people. I wasn't doing anything really. I was just kind of to myself all the time. I was angry, I was hitting things, I was violent, breaking just whatever. (Smooth)
	Adaptive Coping	I poured myself in my family. I walked places with my kids-- took them to the park. I took a lot of trips; I drive long distances. Music. (Cornelia) Anytime I didn't have my son, I would try to make plans with my mom or my friends or something around here, like volunteer at church or something. (Nicole)
Mental Health Impacts		I'm 100% Disabled Veteran, because of the MST issue. I break down-- I can't work because I break down too much. And I get paranoid at work that my boss is out to get me all the time. I'm too angry. (Licorice) There were times that I did try to self-medicate with alcohol. With support from a VA therapist, for maybe like five or six years, I used cannabis to help with the nightmares, the mood, also eating disorder. (Amy) I didn't trust people as much anymore and I started getting in fights and discipline -- like not fights per se --not like fist fights, but like, I wouldn't back down. (Cornelia) My life was just unraveling. I try to work –I just couldn't focus. I was angry. I just wasn't "Carol." They called the police on me because I was out there ranting and raving. I was a mess kinda for no reason. I was just all over [the place]. I'm single, I don't have any kids or husband. (Carol) If I'm in depressed mood, kind of depends, I really don't want to talk. You got to kind of pull it out of me a little bit. When I'm angry, I don't want to say or do anything to make somebody else even though I'm angry… [I] drank more. And spent time alone. (Mary)

Disclosure		And I know one day, I just went, and I sat in [my boyfriend's] lap, and I cried. And he didn't... he didn't do anything like he listened to me. But I expected him as my boyfriend to do something. And I don't know what I expected him to do. But I expected him to do something. And he didn't. (Jill) My boss pulled me in because she could tell that I was upset. And I ended up breaking down in her office and kind of explained to her what was going on. (Jess)
Post Traumatic Growth		I volunteer for Veterans' treatment. I have a guy I mentor. I do stuff at the church with the homeless. I just tried to keep busy and give back. I stretch too thin sometimes; I try to keep as busy as I can. (Carol) I think that therapy caused me to heal. It caused me to process, and it put me in a better place mentally, because now I'm capable of helping other people…I'm a part of two different organizations. I'm a peer leader, peer support group leader. So, I host groups, and it's an eight-week process…But because of the fact that I've been able to heal myself, I've been able to help other women process different things go through different things I've been able to tell not necessarily my story, but to open up enough for other women to be able to feel comfortable to come to me, whether it's during group or after group, help guide them into different programs, if they need it, whatever resources I can find that will help facilitate their mental health, and just integrating them into a community of women. (Smooth) I do feel like I am more in charge versus me. Before feeling like okay, I have to be in charge. I actually feel like I'm in charge. (Jill)