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Ecosystemic Effects of Military Sexual Trauma in Male Service Members and Veterans

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Acknowledgments and Dedication

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Abstract

Military sexual trauma (MST) represents a significant, endemic concern in the United States Armed Forces. Although approximately 50% of individuals who experience MST are male, few studies have been published examining the overall experience of males who survived MST, and no known project has recruited a sample unaffiliated with Veterans Health Administration (VHA). Therefore, this study investigated the immediate and enduring ecosystemic effects of MST on male service members and veterans recruited entirely outside the VHA system. To evaluate the depth and richness of human experience, 12 participants—10 veterans and two active duty service members (50% Euro-American, 58% partnered, 75% heterosexual, 50% Army, 100% enlisted rank, median age 48 years) who experienced MST were interviewed using narrative inquiry qualitative methodology. Data analysis was conducted through an eight-step process utilizing an ecosystemic framework. Thematic data analysis revealed 28 themes, 10 categories, and 4 concepts representing participants' experiences of MST. The concepts that emerged were (a) the MST events, (b) Intrapersonal effects attributed to MST, (c) Interpersonal effects attributed to MST, and (d) Contextual factors related to MST. Diversity in sexually violent MST events coupled with perpetrator demographics and relationships were identified to directly influence the systemic effects of MST. On the intrapersonal level, underlying categories of externalization, internalization, negative physical effects, and factors of recovery emerged from the data. Interpersonally, the three fundamental categories identified were interactions with perpetrators, family, and service members. The final concept of contextual factors relevant to MST demonstrates

that experiences of sexual violence were unique due to the military environment in which they occurred, especially in regard to the military command structure and protective factors. Study findings illuminate the far-reaching and recursive nature of MST and how sexual violence in a military setting uniquely impacts individuals' lives and interpersonal functioning. Although further research is needed to identify effective ways to increase education about MST, prevent MST, encourage disclosure, and provide treatment of MST for individual survivors, families, and military units, the findings of this study provide important evidence and insight into the diversity in MST experiences and the persistent ecosystemic effects of MST in males.

Keywords: MST, male, military, military sexual trauma, service member, sexual assault, sexual violence, systems, veteran

CHAPTER I

Introduction and Review of Literature

Purpose

The purpose of the present study is to report through narrative-based interviews the proximal and enduring ecosystemic experience of male service members and veterans of the United States (U.S.) Armed Forces who experienced military sexual trauma (MST). Sexual violence that occurs in the military system represents a significant social concern worthy of increased attention and research; the effects of MST on the individual are shown to be devastating with the potential to negatively impact all domains of human functioning. MST is associated with complex posttraumatic stress symptomatology, including severe psychological and physical health problems, increased high risk behaviors, and heightened rates of suicide (Allard, Nunnink, Gregory, Klest, & Platt, 2011; Kimerling, Gima, Smith, Street, & Frayne, 2007; Murdoch, Pryor, Polusny, & Gackstetter, 2007; Schry et al., 2015; Smith et al., 2011; Zinzow, Grubaugh, Frueh, & Magruder, 2008). The U.S. Department of Veterans Affairs (VA) defines MST as:

> psychological trauma, which in the judgment of a mental health professional employed by the Department [VA], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment [unsolicited verbal or physical contact of a sexual nature which is threatening in character] which occurred while the veteran was serving on active duty or active duty for training. (US Code, Title 38, §1720D; Veterans Health Care Act of 1992; Hoyt, Rielage, & Williams, 2012)

Although research examining sexual trauma is prevalent in the field of psychology, only recently have the psychological effects of sexual trauma in military populations been studied. However, MST research has primarily focused on females, which has resulted in a paucity of information concerning the experience of males affected by unwanted sexual encounters while serving in the military (Hoyt, Rielage, & Williams, 2011). The majority of existing literature pertaining to MST in males exists in the form of prevalence and correlative quantitative data obtained through mandatory U.S. Veterans Health Administration (VHA) screening. While this data provides initial information on intrapersonal outcomes and treatment utilization, the overall experience of MST in males and its effects on interpersonal functioning remains largely unknown, especially for those who have not reported MST within the military or VHA system. Therefore, to more completely understand the unique experience of male service members and veterans who survived MST, a narrative inquiry qualitative methodology was employed, which allowed the individual recruited outside the VHA to fully voice his story. Through analysis of the in-depth narrative interviews, the present study reports the ecosystemic experience of male service members and veterans who survived MST.

Sexual Violence

Sexual violence takes many forms, and numerous definitions pertaining to the broad experience of sexual trauma exist in the trauma literature. The National Center for Injury Prevention and Control offers a set of standardized terminology aimed toward promoting and improving consistency in the study and reporting of sexual violence. The most inclusive terminology is *sexual violence*, which is defined as "any sexual act that is committed or attempted by another person without freely given consent of the victim or

against someone who is unable to consent or refuse" (Basile, Smith, Breiding, Black, & Mahendra, 2014, p. 11). This terminology incorporates all forms of unwanted sexual encounters, including but not limited to verbal sexual harassment and noncontact advances, inappropriate sexual touch, sexual assault or battery, completed or attempted rape, and forced or coerced sexual contact with a third party. Another term commonly utilized in research is *sexual harassment*, which is defined as unwelcome sexual advances, requests for sexual favors, or other verbal persecution of a sexual nature (U.S. Equal Employment Opportunity Commission, 2014). The term most frequently used by researchers is *sexual assault*, which denotes causing another person to engage in an unwanted sexual act by force or threat. In the present study, language is standardized by using the terms *sexual violence* to refer inclusively to all unwelcome sexual encounters (verbal and physical), *sexual assault* to indicate sexual violence of a physical nature, and *military sexual trauma (MST)*, which includes all sexual violence in a military setting (see above definition). Because a proliferation of research demonstrates the long-term negative consequences associated with sexual violence, it is important to recognize how commonly it occurs in the general population.

Prevalence of sexual violence. Prevalence studies indicate that sexual offending is universal, occurring across cultural, ethnic, socioeconomic, and sex/gender groups (Elliot, Mok, & Briere, 2004; Petrak, 2002). However, determining the frequency of sexual violence in any population proves challenging due to numerous barriers to reporting, as well as variability in research sampling, methodology, and definitions of sexual trauma (Davies, 2002; Peterson, Voller, Polusny, & Murdoch, 2011). Barriers to reporting are numerous, personal, and complex. Survivors have expressed worries that

others will judge or blame them for their abuse, concerns that they will not be believed, reservations about the legal process and the potential to encounter the perpetrator in court, and fears that they will experience further victimization (Rogers, 2002). Therefore, in any context sexual violence is underreported, and official databases are likely to underestimate its pervasiveness (Rogers, 2002). Research on sexual violence of females largely began following the feminist movement of the 1970s (Petrak, 2002) and suggests a general sexual violence (including noncontact unwanted sexual experiences) lifetime prevalence rate of up to 43.9% (Black et al., 2011), and a sexual assault lifetime prevalence rate of 13-25% for females (Elliott et al., 2004). Yet little attention was allocated to the prevalence and effects of sexual trauma on males until the late 1980s (Sorenson, Stein, Sidgal, Golding, & Stein, 1987).

Although the data of prevalence rates of sexual violence in males are limited and variable, a large national study found that 23.4% of males surveyed in the general population had experienced some form of sexual violence in their lifetime (Black et al., 2011). Similarly, Elliot et al. (2004) utilized a nationally representative sample to assess rates of sexual assault (i.e., not including noncontact unwanted sexual experiences) among males; findings revealed an incidence rate of sexual assault at 3.8%. Breiding et al. (2014) presented rates of lifetime male sexual violence from the National Intimate Partner and Sexual Violence Survey. Of the American male respondents (a) less than 1% reported experiencing attempted or completed rape, (b) 6.7% reported that they were forced to penetrate someone, (c) 5.8% reported sexual coercion, (d) 10.8% endorsed experiencing unwanted sexual contact, and (e) 13.3% reported experiencing some form of noncontact unwanted sexual experiences. Further demonstrating the variability in

prevalence rates, Peterson et al. (2011) conducted a meta-analysis of 79 studies that reported the prevalence of adult sexual assault among males. Prevalence varied between 0.2% to 73% of men, depending on operationalized definition of sexual assault and the population examined; additional reporting and prevalence discrepancies will be reviewed in the context of MST. The available prevalence rates of male sexual violence suggest significantly lower rates than those experienced by females; however, research has also demonstrated that males more than females underreport experiences of sexual violence (Elliot et al., 2004). In addition to previously identified barriers to reporting sexual violence, males must also contend with cultural stereotypes and misconceptions about masculinity and sexual trauma.

Sexual Violence in Males

Male sexual violence is an under-discussed and under-researched topic; "it happens but it is concealed by the victims who are too ashamed to speak out and by a society that is not prepared to listen" (Mezey & King, 2000, p. v).

Misconceptions surrounding male sexual violence. Historically females are generally considered to be the victims of sexual violence; it is less frequently appreciated that males may also be the victims of sexual offending. Researchers posit that cultural stereotypes and misconceptions about sexual assaults (i.e., male rape myths) stemming from traditional views of masculinity likely contribute to the tendency to overlook the vulnerability of males to the experience of sexual violence (Coxell & King, 2002; Davies, 2002; O'Brien, Keith, & Shoemaker, 2015; Polusny & Murdoch, 2005; Turchik & Edwards, 2012). Coxell and King (1996; 2002), O'Brien et al. (2015), and Turchik and Edwards (2012) identified commonly held beliefs that (a) men (or "real men") cannot be

sexually assaulted or raped, (b) sexual assault against males can only occur in a prison environment, (c) adult male victims of sexual violence must be homosexual, (d) heterosexual males do not sexually offend against other males, (e) a man cannot be raped by a woman, and (f) sexual violence is not as severe for males as it is for females. These stereotypes and myths serve to minimize the impact of sexual trauma on male survivors, resulting in victim blaming and a lack of attention to the problem, as well as inhibit survivors to disclose sexual violence (Polusny & Murdoch, 2005).

Further adding to ignorance surrounding male sexual violence are the Western cultural stereotypes of men that emphasize sexual dominance, as well as the ability to fend off unwanted advances with physical strength and assertiveness. In addition, sexual violence is commonly viewed as behavior motivated by sexual desire; however, sexual offending is typically aggressive and coercive in nature, not perpetrated based on attraction or desire (Mezey & King, 2000; Turchik & Edwards, 2012). Socio-biological research indicates sexual assaults perpetrated by males upon males are likely a manifestation of power relationships rather than sexual advances (Jones, 2000; Turchik & Edwards, 2012). Despite recent research highlighting the severe negative consequences associated with sexual trauma in males, male rape myths and stereotypes continue to maintain high prevalence in society, especially in male-dominated systems like the U.S. military (Hall, 2011; Turchik & Edwards, 2012).

Effects of sexual violence in males. Despite the ambiguity in prevalence rates of sexual trauma in men, recently researchers have recognized the need for increased attention into the effects of sexual violence of men. Data indicate that male survivors of sexual trauma share similar negative outcomes to those extensively recorded for females

(Davies, 2002; Peterson et al., 2011). Individuals who have incurred posttraumatic stress disorder (PTSD) from sexual trauma report higher levels of poor health behaviors (e.g., substance abuse, smoking, poor diet), double the number of physician visits, and increased symptoms across all body systems (Katz, Cojucar, Beheshti, Nakamura, & Murray, 2012). Male victims of sexual trauma experience adverse psychological, physical, interpersonal, and sexual consequences.

Much research into the psychological effects of male sexual violence exists in the form of gender comparison studies between males and females. Findings are disparate in their conclusions with some studies finding less severe consequences for males, more severe effects, and no significant differences between genders (Peterson et al., 2011). Males express similar initial reactions as females following sexual assault, including disbelief, humiliation, fear, and rage; males also experience similar rates of posttraumatic symptomatology (Mezey & King, 2000). A recent meta-analysis conducted by Peterson et al. (2011) indicated there is ample evidence to support that males who have experienced sexual violence present with higher rates of psychological disturbance than those who have not been sexually mistreated. Several recent empirical studies highlight shared symptoms among males and females. As in females, experiences of adult sexual trauma in males are associated with high rates of general psychiatric symptoms. However, following sexual assault males are more likely to maintain increased incidence of self-harm and alcohol abuse/dependence and have a longer history of psychiatric hospitalizations (Coxell, King, Mezey, & Gordon, 1999; Kimerling, Rellini, & Kelly, 2002). In a general, non-treatment-seeking sample, Elliot et al. (2004) found that male survivors of sexual assault reported significantly higher levels of distress than females on

8 out of 10 measures of posttraumatic symptoms (e.g., depression, anxiety, re-experiencing). Long-term problems of male sexual assault victims include relationship difficulties, sexual dysfunction, and fear or paranoia about being sexually assaulted again (Anderson, 1982; Turchik, Pavao, Nazarian, Iqbal, McLean, & Kimerling, 2012). Findings of Elliot et al. (2004) and other studies suggest that sexual violence may be especially traumatizing for males. Recent research has also demonstrated that sexual trauma may especially impact males in closed systems, or isolative environments, such as prisons or the U.S. military (Lapp et al., 2005).

The Military System as Related to MST

Lebowitz and Roth (1994) emphasize the immeasurable impact of the context in which an individual experiences sexual trauma; in the mind of the survivor, the traumatic event is fused with the system in which it occurred, "…We are a part of our environment. One cannot separate… experience of, or recovery from, sexual trauma from the sociocultural environment in which it is experienced" (p. 389). Therefore, although any experience of sexual violence is traumatic, sexual trauma that occurs in a closed system—like the military—involves the additional complexity of an insulated, cultural context. Although the military is comprised of American citizens with ethnic, cultural, and religious diversity, it is uniquely different from civilian society in its homogeneity of focus on camaraderie and esprit de corps. The military system represents a career, a legal commitment, a home, a lifestyle, and a culture in which the individual is embedded. The unique culture and worldview of the military is all-encompassing, affecting the service member's life at all levels. Membership in the military includes mandatory participation in a hierarchical structure with spoken—and unspoken—rules, boundaries, regulations,

and habits (Hall, 2011; O'Brien et al., 2015).

Reasons for enlisting. Wertsch (1991) identified four main reasons why individuals join the military, voluntarily surrendering certain freedoms in the service of their country: (a) benefits, (b) family traditions, (c) identification with a warrior mentality, and (d) escape (as cited in Hall, 2011). Benefits of enlisting include steady financial income and education or training opportunities that might be otherwise unattainable. Many service members endorsed enlisting because of family ties to the military and a previous understanding of the institutional culture, making an easy and comfortable transition. In addition, many individuals enlist with the spirit of patriotism and the desire to serve others and defend their country.

Of particular importance when considering male MST is the identification with the warrior that drives individuals to enlist. In this case, "the structure, the expectations, the rules, even the penalties and overriding identity as a 'warrior' are reassuring while, at the same time, providing service members with security, identity, and a sense of purpose" (Hall, 2011, p. 7). Service members may find meaning in merging their identity with that of a warrior, or member of the Armed Forces. In this way military membership and participation in combat may be considered a test of manhood or a rite of initiation (Hall, 2011; Nash, 2007); it provides a source of power and honor. Equally important to consider is the escape that military life may provide. Individuals may enlist in order to leave painful life experiences behind and to start anew. Military units may become like an extended family and support system that was not experienced previously (Hall, 2011). However, in the occurrence of MST a male service member may experience both perceived loss of manhood or power, and betrayal by a "family" member.

Characteristics of military culture relevant to MST. In order to better understand the environment in which MST occurs it is prudent to consider the unique characteristics of the military institution. First, the military maintains an authoritarian internal structure with standards, regimentation, and mandated conformity (Hall, 2011; Wilson, 2008). This authoritarian environment can provide a comforting atmosphere to those who appreciate structure and the security of a system; however, it can also be overwhelming and isolative in the event of abuse or mistreatment. Hall (2011) notes that the military "becomes a culture that is very inward focused with a consistent hierarchical" make up (p. 9). The hierarchical system is omnipresent in the military and is represented by two distinct subcultures: the life of enlisted service members and the life of officers. Inherent in a hierarchical structure is a lack of power or control (i.e., over monetary compensation, stationing, unit assignment, etc.) for subordinates, as well as the social effects of living in ranked system. Although imperative to the functioning of the military system, this rigid hierarchy is exclusively based on dominance and subordination, which establishes distance within the service member ranks. Further, the hierarchy functions to establish and foster camaraderie within ranks, and may promote a sense of safety and belonging.

A third characteristic of the military is a possible experience of isolation and alienation from extended family members and civilian life (Wilson, 2008). Service members often become enmeshed in the military culture; service members' language changes (e.g., acronyms and idiosyncratic terms), relocations are frequent (e.g., average tour of duty is three years), and they are often stationed abroad. Thus, a detachment from civilian life is deliberately created. Any isolation from external support networks may be

compounded for individuals who have experienced a personal traumatic event, such as MST. Two additional characteristics common in military culture are the "mission first mentality" and constant disaster preparedness (Hall, 2011; Wilson, 2008). The importance of the mission is perhaps the most vital component of military membership and unit cohesion; the mission provides the military institution with a common purpose that validates its very existence and function (Wilson, 2008). In order to achieve the high standards accompanying the mission and to be successful, service members are taught to trust and depend on their "battle buddies" over all civilians (Hall, 2011; Houppert, 2005). The mission and the unit come before the individual; service members are trained and willing to sacrifice in order to support their unit, which fosters community and selflessness in service of the greater good. At the same time, the importance and care for one's fellow service member may contribute to the desire to hide weakness from fellow enlisted personnel or officers; individuals may aim to present as strong, prepared, and able. This sense of loyalty to the greater system may result in ecosystemic difficulties for service members who experience violence as individuals within the context of the larger system. Finally, the military institution is in a state of constant readiness for disaster or deployment. On an individual level this incessant state of preparedness creates a great deal of stress and pressure, which may inhibit an individual's capacity to function post-trauma (Allard et al., 2011).

Traits of enlisted service members relevant to MST. Although not a comprehensive view of military traits, Wertsch (1991), in her seminal research, identified three common traits that emerge from life embedded in the military culture, and that may contribute to negative effects of MST. First is the prominence of secrecy in military life.

Service members adhere to a strict obligation to keep information separate from different life domains (e.g., work, family). The privacy of information is essential for the often classified nature of military operations, but the culture of secrecy can also prove detrimental for service members. For example, service members may be personally uncomfortable or dissuaded by others to disclose private experiences, like MST, to other service members or health care workers. Furthermore, the secrecy may lead to challenges in fostering interpersonal relationships outside of the unit (Hall, 2001).

Second, Werth's (1991) research indicated that service members commonly endorse stoicism, the maintenance of an outward appearance of stability and preparedness. Therefore, many service members may deny any experience of stress or psychological turmoil in order to maintain the status as a capable and battle-ready warrior. The third trait—denial—is related to stoicism. Werth's definition of denial in the military context refers to a service member's attempt to hide or repudiate all personal stress responses (e.g., fears, negative emotions, work-related concerns; Hall, 2011). Historically, the military has discouraged the expression of psychological issues, which may be viewed as weakness or emasculation (Belkin, 2008).

Military culture and sexual violence. The organization and culture of the military system contributes to both the high prevalence of MST in women and men, as well as the lasting effects of the trauma (Hall, 2011; O'Brien et al., 2015; Wilson, 2008). The military is a hierarchical structure developed out of values and qualities that favor men in positions of power; therefore, the military is a male-dominated culture that emphasizes strength, power, obedience, and stoicism. Historically, within this environment exists a tolerance of sexualization and harassment that impacts the nature of

interactions between service members and leads to greater risk for sexual violence (O'Brien et al., 2015; Turchik & Wilson, 2010). Researchers have suggested that sexual violence in the military is bred out of a culture of misogyny and homophobia (e.g., using insult talk such as "pussy" or "sissy," which equates women, sexual minorities, and effeminate men with degradation). Furthermore, the importance of power and dominance within the military fosters a tension, which may lead some individuals to abuse their role of power.

Additional factors unique to sexual violence in the military setting include the proximity and roles of survivors to their perpetrators. After experiencing MST survivors may feel a lack of unit cohesion, which has been shown to be essential for maintaining solidarity and trust among service members; survivors report feeling stripped of their unit's support, a loss of safety, and a lack of competence (Allard et al., 2011). In the military environment, survivors are more likely to be required to continue to interact with their perpetrators, which virtually renders survivors captive (Katz et al., 2012; Kimerling et al., 2007). Survivors may be forced to depend on their perpetrator (or friends of their perpetrator) in myriad situations—in combat, in daily occupational tasks, for health care, or to receive promotions. However, survivors may not only work around their perpetrators, but may also live in the same building with their perpetrator, which is especially common in male MST and further contributes to feeling powerless and vulnerable in all environments. Additionally, survivors of MST may be under the command of their perpetrators, forced to not only interact with the abuser, but also to obey the perpetrator's orders without question.

Within dominant Western culture and the military culture, survivors of MST are

frequently viewed as weak or unable to protect themselves, or guilty of inviting the sexual assault (Katz et al., 2012). Turchik and Edwards (2012) noted that historically, a victim of male sexual violence was believed to "lose his manhood," which resulted in an inability to be a true service member or warrior (p. 218). Survivors may experience stigmatization, scrutiny, marginalization, and harassment by peers and military leadership if they report MST. An ad hoc and correlational study conducted by O'Brien et al. (2015) found that male rape myths and related military cultural beliefs may prohibit the recovery of male MST survivors. Overall, the researchers summarized, "Male rape myths and related beliefs that arise from cultural norms and are further amplified and modified by military culture impact male MST survivors and delay or obstruct their recovery."

Military Sexual Trauma

As mentioned previously, MST is defined as threatening noncontact harassment or physical assault of a sexual nature that took place while the individual was in the military (Veteran's Benefits U.S. Code, Section 1720D, 1992; Allard et al., 2011). Males who survive sexual violence within the military system undergo a unique experience with exceptional consequences over and above those endured by male survivors in the general population and female survivors of MST.

MST in females. As previously discussed, the majority of research regarding MST has focused on the prevalence rates and experience of female veterans. National MST Screening and Treatment data collected across all VHA medical centers revealed that approximately 25% of female veterans reported experiencing MST in the VHA system during the fiscal year 2014. Although exact rates remain unknown, recent

empirical literature has shown that MST in females is pervasive, ranging from 22% to 72.8% (Kimerling et al., 2007; Murdoch, Polusny, Hodges, & O'Brien, 2004; Pavao et al., 2013; Street, Gradus, Stafford, & Kelly, 2007; Street, Stafford, Mahan, & Hendricks, 2008). A review of 25 studies by Suris and Lind (2008) found that between 20-43% of female veterans have experienced MST. Furthermore, MST in females has been correlated with detrimental psychological symptoms, including increased rates of PTSD, depression, and substance use as compared to female veterans who did not experience MST (Suris & Lind, 2008; Suris, Lind, Kashner, & Borman, 2007). Specifically, females who survived MST endorsed higher rates of PTSD and alcohol abuse than women with other types of military trauma and females who experienced sexual assault in the general population (Suris et al., 2007). Consistent with previous research, Luterek, Bittinger, and Simpson (2011) found that female veterans who endorsed MST reported increased symptoms of PTSD and disorders of extreme stress not otherwise specified (DESNOS) compared to matched female veterans with no history of MST. Specific symptoms endorsed by participants included emotion dysregulation, dissociation, interpersonal problems, somatization, negative self-perception, and hopelessness.

MST in males. Like sexual trauma research in the general public, the majority of research regarding sexual trauma in the military has centered on incidence and prevalence rates, focusing largely on the population of female veterans. However, also like sexual violence outside of the military system, the true prevalence of male MST is unknown and reporting of rates varies dramatically, ranging from less than 1% to 42% (Katz et al., 2012; Kimerling et al., 2007; Murdoch et al., 2004; Pavao et al., 2013; Street et al., 2007; Street et al., 2008). From their research Hoyt et al. (2011) assert that the majority of

MST incidents involving male victims are not reported, much like the lack of reporting in the civilian world. In addition to reasons previously discussed for underreporting male sexual violence in the general population, male MST survivors experience added complications in reporting due to the nature of the military system.

The cultural features of the military and its systemic response to MST create inherent challenges in reporting sexual violence. Although recent national policy changes regarding MST aim to protect service members who report MST, the longstanding culture of stigma and silence is slow to change. As recently as 2005, military policies created barriers to reporting MST. Nelson (2002) describes some difficulties in reporting MST in the military system that often functionally exist today: (a) MST is addressed internally as a personnel issue and not reported as a crime, (b) within the last decade there were no victim protection statutes in the military, (c) there are great inconsistencies in how MST is handled, (d) service members are largely unaware of policy, (e) victims often fear retribution, and (f) victims often fear damaging their career. The value of silence and secrecy is also prominent among males who experienced MST. Specifically, male survivors may decide to remain silent about their sexual violence, or they may even be encouraged to stay silent in order to "maintain unit cohesion" (Kimerling et al., 2007).

Systemic homonegativity or homophobia in the military further contributes to the problems of reporting MST. For example, like in the civilian population, many male service members consider rape and sexual assault to be desire-motivated instead of an implementation of power, which discourages reporting of male MST due to fears of being considered homosexual (Turchik & Edwards, 2012). Furthermore, complaints of

encounters of MST may simply be ignored by officers. One researcher posits that military command tends to minimize instances of male MST out of fear that the military's reputation as an organization of strong, masculine, heterosexual men would be at risk, which could cause decline in enrollment (Belkin, 2008).

In addition to underreporting by service members, there are numerous barriers to achieving accurate reporting of MST in research. Largely contributing to disparate rates of MST in the empirical literature is a lack of standardization in the definition of MST; for example, some studies exclude threatening verbal sexual harassment, while other researchers utilize a broad definition of MST that includes noncontact sexual violence (e.g., sexually suggestive gestures, words, and innuendos). Also adding to the variable rates is the methodology and, in particular, the manner in which survey questions are phrased; vague questions (e.g., "Have you experienced military sexual trauma?") force the participant to interpret their experience as "sexual trauma," while more specific or operationalized questions may lead to more positive responses (e.g., "Have you experienced unwanted sexual advances that were either verbal or physical in approach?").

While mandatory screening data of the VHA provides rough estimates, the institution's "gold standard" assessment procedures of MST were normed on university-educated females and likely do not reliably represent the experience of MST in males or in military members who do not have a college education (Murdoch et al., 2011). Furthermore, initial VHA screenings are typically conducted by medical support staff not trained in research methods, and the screening itself is completed early in a service member's relationship with his VHA clinic when he may be uncomfortable disclosing sensitive information. Contributing more to limited disclosures in clinics and variability

in prevalence rates is the fact that disclosure of MST will often be permanently documented in the service member's records, which is undesirable for many individuals (Kimerling et al., 2010).

Therefore, the estimated prevalence and incidence rates for MST in males are highly variable with a significant degree of unreliability in the data (Allard et al., 2011). Most recently, the National MST Screening and Treatment data indicated that 1.3% of male veterans within the VHA system endorsed experiencing MST during the fiscal year 2014. In 2004, Murdoch et al. found that 1.3% of male veterans applying for VA disability benefits for PTSD reported experiencing MST. Hoyt et al. (2011) conducted a meta-analysis examining prevalence rates from 29 studies completed over the past 30 years and found a range of MST in 0.02% to 6% of males.

Prevalence rates also vary significantly across era of wartime service and combat exposure. Polusny and Murdoch (2005) summarized findings that 1.7% of male World War II veterans reported MST versus 13.3% of male Gulf War veterans, and that noncombatant males experienced significantly more MST (12.6%) than male combat veterans (approximately 4%). Katz et al. (2012) examined prevalence rates of different types of sexual violence occurring in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. Results indicated that 12.5% of male veterans surveyed had experienced MST in general, with 11% experiencing verbal sexual harassment, 8% reporting unwanted physical advances, and 4% experiencing sexual assault or rape. In 2013 the VHA reported similar rates through universal screening of veterans receiving treatment at VHAs; 57,800 (1.3%) of male veterans endorsed MST (VA national screening and treatment data, 2013). Of note, although female veterans report MST in

higher proportions than males, in terms of actual numbers, there are an almost equal number of males (43%) who disclose MST as females (Kimerling et al., 2007; Street et al., 2008; Turchik et al., 2013; VA national screening and treatment data, 2013). Thus, despite a significant amount of research into prevalence rates of MST in males, the literature is inconsistent and unclear in the number of male service members affected by sexual violence in the military. However, it is clear that MST poses a significant threat to the health and wellbeing of military members, both female and male.

Overall, there currently exists limited data about the experience of MST in males. While recent studies demonstrate a similar initial stress response in male veterans as their female counterparts, in the little research available there are some unique psychological and physical effects that appear more likely to be experienced by males. Researchers have found correlations between male MST and symptoms of PTSD and anxiety disorders, challenges in interpersonal relationships, emotion dysregulation, dissociation, somatization, high levels of pain-related health conditions, increased substance abuse, and heightened rates of suicide (Allard et al., 2011; Kimerling et al., 2007; Luterek et al., 2011; Magley, Waldo, Drasgow, & Fitzgerald, 1999; Murdoch et al., 2007; O'Brien & Sher, 2013; Schry et al., 2015; Smith et al., 2011; Zinzow et al., 2008).

Psychological factors associated with male MST. In regard to mental health-related conditions and suicidality, Schry et al. (2015) conducted a study providing preliminary data presenting functional correlates of MST in male OEF/OIF veterans. They found that MST was affiliated with higher incidence of suicidality, greater PTSD severity, higher depression severity, and higher outpatient psychological treatment than a non-MST sample. Another 2015 study examined correlates of MST in male OEF/OIF

veterans. Those who reported MST were more likely to be diagnosed with a mood disorder and more likely to perceive emotional mistreatment following deployment (Mondragon, Wang, Pritchett, Graham, & Plasencia, 2015). Godfrey et al. (2015) found that male veterans with combat exposure and MST were linked to significantly higher depression, PTSD, and somatic symptoms and to lower mental health functioning. A study by Magley et al. (1999) found that sexual harassment of males in the military is associated with greater decreases in work productivity and increased emotional problems when compared to females who reported sexual harassment. Furthermore, males were found to be less likely to seek treatment for MST in the VHA system than females. Kimerling et al. (2007) analyzed VHA administrative data of a nationally representative sample of veterans receiving outpatient care in VA medical centers to determine whether those who endorsed MST experienced increased rates of mental illness and physical health complaints, and if this varied by gender. Findings indicated that veterans with a positive MST screen were 2 to 3 times more likely to be diagnosed with a mental health disorder, with a stronger association for females compared to males. However, for males the association between MST and Adjustment Disorder was significantly stronger than among females. Anxiety disorders, bipolar disorders, psychosis and schizophrenia were stronger for males as compared to females. Overall, Kimerling et al.'s research suggested that prevalent psychological conditions demonstrated similar associations among females and males who reported MST. Although no causal effects may be determined, the results of these studies reveal that psychological symptoms are significantly higher in veterans who endorse MST.

Physical factors associated with male MST. Kimerling et al.'s (2007) investigation further analyzed physical health correlates of MST. Findings indicated that chronic pulmonary disease and liver disease were moderately associated with MST in both males and females. In males with MST incidence of HIV/AIDS was significantly more common than in females with MST. Another study examined gender-specific associations between sexual harassment and sexual assault and negative psychological and physical factors in a sample of veteran reservists (Street et al., 2008). The researchers created measures to assess for medical conditions and somatic symptoms. Results relevant to male MST suggested that those who reported only noncontact sexual harassment experienced an increased risk of psychoneurological, gastrointestinal, and sexual dysfunction symptoms, as well as medical conditions, including arthritis, hypothyroidism, and diabetes. Furthermore, for male veterans who experienced sexual assault as well as noncontact harassment, there was a stronger association with somatic symptoms when compared to veterans who denied experiencing any forms of MST. Turchik, Pavao, Hyun, Mark, & Kimerling (2012) conducted analyses exploring the utilization of health care in the VHA system as related to MST experiences in OEF/OIF male and female veterans. Of those receiving MST-related care, the following percentages of veterans were reported to experience these main physical health diagnoses: undefined medical conditions or symptoms (29.6% males; 40.5% females); connective tissue or musculoskeletal diseases (10.2% males; 13.7% females); nervous system conditions (6.9% males; 8.2% females); injuries and poisonings (4.6% males; 7.9% females); residual symptoms and *E* codes (5.4% males; 5.2% females); genitourinary diseases (1.1% males; 6.3% females); digestive system conditions (3.8%

males; 4.9% females); respiratory diseases (1.7% males; 3.9% females); and metabolic, endocrine, or immunity disorders (1.7% males; 2.6% females). Further, males were less likely to engage in MST-related health care as compared to female veterans. Finally, a meta-analysis conducted by O'Brien and Sher (2013) that included a search of behavioral science databases between 1990 and 2012 summarized the relationship of male and female MST to psychological and physical illness. Overall, researchers found that MST across genders is related to increases in mental health and medical conditions. Specifically, higher rates of PTSD, substance use disorders, generalized anxiety, depression, eating disorders, and suicidal behaviors were found, as well as heightened pain-related complaints involving neurological, gastrointestinal, musculoskeletal, and genitourinary symptoms.

Interpersonal factors associated with male MST. Although sparse, there is research illuminating the impact of male MST on intrapersonal physical and mental health. However, to date, only two studies were found to examine the potential impact of MST on interpersonal functioning. The first, authored by Katz et al. (2012), explored the correlative relationship between male MST and readjustment, finding that MST was significantly related to PTSD symptoms and readjustment, most strongly correlating with intimacy problems. Second, Mondragon et al. (2015) found that experience of male MST during deployment was negatively associated with post-deployment social support, but was not associated with loss of romantic relationship. A conceptual paper written by Goodcase, Love, and Ladson (2015) highlighted the dearth of available research on the impact of MST on interpersonal functioning, noting inability to find a single empirical article for male or female MST related to couples' health. And overall, the dearth of

available research on MST in male veterans and service members was made clear in a meta-analysis of MST research by Allard et al. (2011). The researchers found that there are no studies specifically examining the health care utilization correlates of male veterans or the interpersonal effects associated with MST in males apart from females.

Systems Perspective

Based on the available literature examining male MST it is evident that the experience of MST affects the male service member on an intrapersonal level through myriad psychological and physical symptoms. Preliminary findings suggest that males may be affected interpersonally in the relationships with fellow service members and significant others, and contextually through the characteristics present within the military environment. Therefore, to fully explore the effects of MST across levels of functioning, the present study utilized an ecosystemic framework in conceptualizing and organizing this research on male MST.

Previous research on sexual trauma has utilized ecological theory to inform research, prevention, and treatment (Campbell, Dwarkin, & Cabral, 2009; Stanton, 2009). Neville and Heppner (1999) utilized an ecological framework to explain how sexual assault affects the well-being and recovery processes of females; the researchers emphasized that the survivors of sexual assault are influenced by numerous systemic factors, not just individual characteristics and the assault itself. Similarly, recent research employed an ecological model of rape recovery to assess how mental health systems and medical institutions respond to survivors' needs and, reciprocally, how those systemic experiences influence survivors' sexual health and psychological outcomes (Campbell, Sefl, & Ahrens 2004; Campbell et al., 2009).

Bronfenbrenner's ecological approach. Grounded in a developmental approach, Bronfenbrenner's (1979) ecological theory posits that "human development occurs through constantly evolving interactions between individuals and their multiple, interconnected environmental contexts" (Campbell et al., 2009, p. 227). Bronfenbrenner's model is organized into the (a) individual level—idiographic biopsychosocial factors of the person; (b) microsystem level—interpersonal interactions with members of immediate environments; (c) mesosystem level—links and connections between the individual and systems; (d) exosystem level—the individual's organizations and systems; (e) macrosystem level—cultural norms, values, and expectations that comprise the overarching social environment; and (f) chronosystem level—the changes that occur over time across all levels. The environmental influences are subdivided into multiple levels that indicate the degree of formality of the contextual setting, the immediacy of the particular interaction, and the size (Bronfenbrenner, 1979; Campbell et al., 2009).

Based in Brofenbrenner's (1979) ecological model, a systems psychology theoretical foundation emerges as a holistic view with no emphasis on one level greater than another (Stanton, 2009). Each system—individual, micro, meso, exo, macro—is seen to impact and be impacted by the others. A systems approach reflects the convergence of the interpersonal and contextual environments in which the individual service member is embedded (i.e., military unit, branch of military, armed forces, etc.), each one affecting and being affected by the others (Stanton, 2009).

Because quantitative methodology has been employed almost exclusively in MST literature, there exists virtually no data on the complex ecological interplay between the

individual male who experienced MST and his interpersonal relationships within the context of his military environment. In other words, there is little available data regarding the ecosystemic ramifications of a male who has experienced sexual violence within the military system. In fact, no known studies have examined in-depth the ecosystemic functioning associated with male MST, including information about how these traumatic events occur, who perpetrates, and detailed information about the consequences and their pathways. However, available literature is clear that MST in male veterans is associated on an intrapersonal level with complex posttraumatic stress symptomatology. While quantitative data is descriptive of broad, generalized statistics, qualitative data drills down to the complex interplay of intrapersonal, interpersonal, and contextual elements of MST and its aftermath (Gilgun, 2009; Stanton, 2009). Consequently, the present study utilized a narrative inquiry methodology grounded in an ecosystemic theory to allow for a rich account of a male individual's ecosystemic experience of surviving MST and to illuminate themes associated with interpersonal functioning.

CHAPTER II

Method

Research Design Rationale

As previously discussed, military sexual trauma (MST) in male service members represents an important area of human trauma experience that has not been sufficiently researched, especially outside of the VHA system. As such, there exists a dearth of knowledge concerning males affected by sexual violence while employed in the military (Hoyt et al., 2011). The available literature indicates a great need for in-depth information about psychosocial functioning associated with male MST, the systemic prevention of MST, increased access to mental health services, and evidence-based interventions to help mitigate the negative psychological and interpersonal effects of MST in males and their relationships.

The contemporary field of psychology is largely dominated by nomothetic, quantitative methodologies useful for collecting data in order to develop and further test overarching theories. Thus, psychological researchers commonly employ quantitative methodology to assess phenomena related to sexual trauma, including MST. However, qualitative research allows for an exploratory and subjective approach to procuring an in-depth understanding of phenomena (Haverkamp & Young, 2007; Morrow, 2007; Reissman, 1993). More specifically, an idiographic, qualitative approach to studying MST in men permits researchers to gather detailed and vivid descriptions of an individual participant and his experience, yielding new questions to be asked at a quantitative level of inquiry (Flick, 1998; Haverkamp & Young, 2007). Therefore, a qualitative research methodology is most useful in providing a deep, comprehensive understanding of the

overall experience of sexual violence in male service members. Specifically, a narrative inquiry approach was utilized to obtain a complexity of data for analysis (Gilgun, 2009). The variables unique to the male experience of MST are immersed within the participants' stories, and common themes must be extracted from the complex and rich narrative of human experience provided by the male service members in order to truly understand the ecosystemic factors associated with MST in males.

Qualitative Methodology

Qualitative research approaches are of particular utility for identifying and understanding the meanings that people attribute to events in their lives, and can assist in learning about cultural themes and practices in the lives of individuals (Gephart, 2004; Gilgun, 2009). A qualitative approach allows researchers to measure the richness, depth, and intricacies of human experience, and further probes identification of underlying mechanisms that drive an individual's personal experience (Creswell, Hanson, Plano Clark, & Morales, 2007; Morrow, 2007). Qualitative research is used to examine diverse topics that cannot be easily understood from a nomothetic approach, and serves myriad functions in research (Gilgun, 2009). In particular, a qualitative design may be utilized to construct and test theories, to delineate human social processes, to guide paradigms, to identify and develop assessment, and to better understand lived human experiences and psychological processes (Gilgun, 2009; Morrow, 2007). As described by Gilgun (2009), qualitative methodologies "can provide the model to be tested, the hypotheses that compose the model, and the items of instruments that represent the hypotheses" (p.85). Importantly, in contrast to quantitative approaches, qualitative designs may humanize empirical research by providing an opportunity to learn about and understand the

meaning that human beings attribute to their lives and experiences (Gephart, 2004). When examining complex issues in a unique population—such as MST in male service members and veterans—a qualitative approach is the appropriate methodology to uncover and describe a foundation in emerging areas of research.

Social constructivism. A major philosophical foundation of qualitative research is social constructivism (Denzin & Lincoln, 2005; Ponterotto, 2005). Social constructivism holds that multiple realities are each affected by an individual's subjective interaction with and perception of his or her environment (Ponterotto, 2005). Researchers employing qualitative methodology study how reality and meaning are constructed socially, both between participant and researcher and between the individual and the cultural system. Based in this social constructivist view that reality is subjective, there is flexibility in the implementation of qualitative research (Denzin & Lincoln, 2005). This methodological flexibility gives researchers the ability to design studies in a manner that is expected to effectively draw out the meaning of experiences being examined.

Different approaches to qualitative research include case study, participatory action, grounded theory, ethnography, phenomenology, and narrative inquiry (Creswell et al., 2007). When conducting case studies, researchers complete a thorough investigation using multiple sources of information centered on a single unique individual. Similarly, the experiences of human beings in relation to a singular phenomenon represent a phenomenological approach to qualitative research while the aim of studies framed in grounded theory methodology is to identify a theory that does not yet exist on the topic of interest (Creswell et al., 2007; Morrow, 2005). Finally, researchers employ narrative

inquiry procedures in order to obtain an in-depth personal account of an individual's experience in chronological order (Lieblich, Tuval-Mashiach, & Zilber, 1998). For the present study, narrative inquiry may elucidate service members' psychosocial functioning associated with MST by providing a detailed and context-specific account of their overall experience of MST.

Narrative inquiry methodology. The latest data on the prevalence of male MST suggest that it is of sufficient magnitude to warrant research beyond the phenomena of a single case. Further, quantitative data points to an extant theoretical formulation grounded in ecological elements that are intrapersonal, interpersonal, and contextual. Therefore, a narrative inquiry methodology is most appropriate to analyze male MST.

Narrative methodology has been utilized in research since the early 1970s and has been conducted in psychological research for over a century (Reissman, 1993). Narrative inquiry represents the most effective qualitative approach in allowing participants to communicate complex, detailed stories that facilitate researchers' understanding of the topic of interest (Creswell et al., 2007; Lieblich et al., 2008). Furthermore, the chronological focus of narrative inquiry provides a linear framework that lends itself to thorough, coherent analysis that can validate or invalidate existing theory. Therefore, in the present study, males who experienced MST communicated their personal experiences in chronological narrative form; then, through systematic analysis the raw and thematic data were extrapolated and combined in order to generalize and better understand the overall experience of male service members and veterans who survived MST.

Psychologists using qualitative methodology aim to analyze and understand the motivations of behavior and the inner processes of individuals. Narrative interviews

allow for the exploration of an individual's inner processes of external events—such as MST—or phenomena. Through the narrative process the researcher is able access rich, detailed data that cannot be obtained only through questionnaires, measures, and quantitative research (Creswell et al., 2007; Gilgun, 2009). A narrative inquiry design provides increased insight and detailed understanding into the overall experience of male MST, which may help guide future research in the area of male sexual trauma and elucidate areas for development of prevention and intervention (Kimerling et al., 2007; Lieblich et al., 1998).

Order and meaning. Narrative inquiry research and analysis boasts a rich history grounded in the humanities and social science disciplines (Creswell et al., 2007; Hoshmand, 2005). Because isolated events do not hold inherent meaning, human beings use stories to make sense of and ascribe meaning to life events and changes; through narratives people bring order to lives that are seemingly chaotic (Reissman, 1993). Narrative inquiry is conceptualized as a two-part qualitative method of (1) data collection in which the participant orates or writes their personal account of an event, action, or experience that is temporally connected, and (2) analysis in which the researcher identifies themes and concepts.

The narrative provides a depiction of cause and effect instances or connections that direct toward a specific, greater outcome (Hiles & Cermak, 2008). In other words, narrative inquiry consists of researchers conducting detailed interviews that are intended to reveal individuals' life experiences and how those experiences progress over time. The process provides a richness of data that illuminates the meaning and order that a person assigns to their experiences (Creswell et al., 2007; Morrow, 2005), and enables

researchers to study ecosystemically how a person's identity, cognitive patterns, and behaviors change throughout different life experiences and in unique life contexts. Researchers' capacity to conduct trustworthy coding and analysis largely depends on the structure, organization, and quality of the narratives, or interview data.

Psychometric properties. Researchers employing narrative inquiry methodology must interview individual participants, gather and extract data from the interview narratives, sequence the experiences, and analyze or interpret the meanings assigned by the participant (Creswell et al., 2007). Throughout this process, researchers must attend to the qualitative psychometric properties of trustworthiness and credibility (i.e., internal validity in quantitative studies), dependability (i.e., reliability), and transferability (i.e., external validity; Morrow, 2005). Specifically, credibility refers to the researcher truly understanding the verbal and nonverbal messages given by the participants (Gilgun, 2009). Morrow (2005) highlights three ways in which trustworthiness and credibility can be measured in narrative inquiry: (a) the researcher confirms the participants' story through additional research methods (e.g., outside sources, other narratives, empirical literature on military culture); (b) the researcher engages in prolonged, continuous collaboration with the participant; and (c) the primary researcher involves other investigators to cross-check coding and analysis. Dependability is achieved through documentation of the research process, including session running times, identification of themes, and analytic procedures (Morrow, 2005). Transferability, or generalizability to other populations, is ensured through proper cataloguing of the overall project content, participant information, and the data collection and analysis process (i.e., interview, coding, analysis).

Participants. There currently exists no consensus in the qualitative literature regarding sample size recommended for narrative inquiry. However, Creswell et al. (2007) and Lieblich et al. (1998) indicated that at least six participants are necessary to achieve credibility and data saturation, which occurs when there is redundancy of information in participant interviews. In the present study, participants included voluntarily self-selected male service members and veterans who experienced MST. Participants were at least 18 years of age, proficient in English, former or current active status in any branch of the U.S. Armed Forces, and experienced MST; importantly, participants were not required to have served in combat contexts and may have served in any war era (e.g., World War II, Vietnam, Gulf War, OEF/OIF, etc.).

Participants were recruited over the course of 13 months from multiple sources unaffiliated with the VA or federal government, including health support agencies, a university, and one community mental health clinic. However, given the challenges of recruiting this population, primary recruitment took place through national Internet advertising sites (e.g., Craigslist community/volunteer section) and social media forums. The study opportunity was communicated to interested individuals by providing the recruitment invitation information. This recruitment process provided connection with eligible and interested participants throughout the United States. In addition to Internet recruiting to maximize participation in the present study, incentives were provided; empirical literature highlights the utility of including participant incentives in narrative inquiry methodology (Denzin, 2009). For their participation, individuals were offered a $20 gift card to an online store (i.e., Amazon.com or Walmart.com) and the option to enter a drawing to win a technology tablet (Kindle Fire HD). A total of 27 individuals

contacted the principal researcher with interest in study participation. After completing screening procedures, 17 individuals met inclusion criteria and were offered interviews of which 5 declined due to reported anxiety or failure to attend scheduled interview. Therefore, 12 individuals participated in the study.

Procedure.

Interviews. The primary investigator conducted 11 of the 12 interviews, with a trained research team colleague conducting the remaining interview. All interviews took place either in-person or through secure, HIPAA-compliant, confidential video-teleconference in a designated, secure, private space that ensured the privacy and confidentiality of the participant. Specifically, two interviews were completed in person at private meeting rooms in a public library, while 10 interviews utilized the secure video-teleconference technology. Initial interviews lasted no more than two hours. In accordance with narrative inquiry procedures, collaborative engagement occurred between the researcher and participant (Morrow, 2005); thus, after the initial interview participants were invited to contact the investigator with additional questions, concerns, or information that they would like to provide. No participants contacted researchers to provide further information. With the consent and permission of each participant, all interviews were audio recorded in entirety on a digital recording device. Interviews were transcribed verbatim, including silences, pauses, and changes in affect and voice modulation. During interviews participants were not identified by name, and all personal identifying information (e.g., names, military unit, etc.) were removed from the transcripts in order to protect the privacy of the participants; digital recordings and transcripts were stored securely.

The initial interview process began with the investigator reviewing and explaining the informed consent document, ensuring the full understanding of the participant. The participant was offered a signed copy of the informed consent and was reminded that their participation is voluntary and can be withdrawn at any time during the interview. Following informed consent, the participant was cautioned that some psychological distress may be experienced through sharing their story. The investigator briefly lead a collaborative dialogue about self-care and safety in preparation for answering questions that may cause distress; each participant disclosed a plan for their day and at least one self-care strategy (e.g., spending time with a spouse or friends, attending a support or faith-based meeting). No participants endorsed significant distress in disclosing their experiences, and all participants voluntarily opted to proceed with the interview. In order to establish rapport and gradually present questions that may be more emotionally challenging to discuss, the participant was first asked demographic information including age, ethnicity, relationship status, sexual orientation, vocation, etc. Creswell et al. (2007) advised that little structure be utilized in the interview with the exception of open-ended, broad topic specific questions (i.e. overall experience with MST). Thus, in accordance with narrative inquiry procedures, the interview continued with questions organized according to a particular life event (MST encounter) and chronologically oriented about the individual's experience (Creswell et al., 2007; Gephart, 2004); questions were open-ended and non-directive. These broad questions were followed by more detailed questions if further detail was needed (Reissman, 1993). An important component of the narrative inquiry process is asking questions that allow the participant to give his responses in a way that is meaningful to him. Therefore, the participant was initially

prompted only to share his story (i.e., "Please share your story regarding your experience of unwanted sexual encounters while you were in the military"). In addition, participants were given the opportunity to suggest any further topics that they found relevant to share. At the interview's conclusion, each participant was provided with personalized contact information to local, free/low-cost community mental health clinics, veteran resources, and regional/national support and informational telephone hotlines, as well the incentive digital gift card and the optional link to participate in the raffle for the technology tablet. Immediately following the interview, notes and impressions about the interview process and the participant's experience were documented and available for review during the interview analysis.

Analysis. As mentioned previously, the present study utilized a narrative inquiry methodology to allow for a rich account of a male individual's psychosocial experience of surviving MST and to illuminate themes associated with interpersonal functioning. In this qualitative process, the language and story of the participant *is* the data and was coded and analyzed simultaneously (Creswell et al., 2007; Ryan & Bernard, 2003). Narrative inquiry requires that the unique elements of each interview between participant and researcher be examined for coding and analysis by means of a structured method (Gephart, 2004; Ryan & Bernard, 2003). In the present study, all interviews were listened to for initial transcription and again reviewed a second time to verify accuracy of transcription. Transcriptions included the researcher and the participant's words (including all questions and responses), tone of voice, pauses, external sounds, and any other notable features (e.g., crying, rustling paper, etc.). The thorough transcription

process facilitated the analysis of the narrative, capturing the co-constructed, collaborative nature of the method.

There are numerous procedures appropriate for conducting analysis of narrative interviews (Creswell et al., 2007; Gilgun, 2009; Lieblich et al., 1998). Based on methods utilized in previous research on sexual trauma, and congruent with an ecological theory, the present study utilized Lieblich et al.'s (1998) holistic content analysis in conjunction with systematic procedures outlined by Ryan and Bernard (2003). Therefore, analysis was conducted as follows: (a) transcripts were read and re-read to establish familiarity with the content, (b) any initial and lasting impressions of the content and/or any unusual components of the narratives (e.g., emotions, behaviors, institutional responses) were noted, (c) sentences and paragraphs were read, re-read, and broken down into fragments, (d) fragments were organized into a code that was extracted from the narrative, (e) codes were then clustered together into broader themes, (f) themes were clustered together into larger groups called categories, (g) categories were then clustered into the largest group called concepts, and (g) selected portions of the interview transcript were used to support the concepts.

Each interview transcript was re-read and re-analyzed multiple times to foster ongoing thematic development until no new information was able to be obtained from analysis (i.e., the point of saturation is reached; Creswell et al., 2007). The point of saturation was reached after reading and reviewing each transcript for holistic, content, thematic, and form information, as well as completing reflexive journaling to promote transparency in the qualitative process (e.g., evaluate bias, encourage researcher self-

reflection, limit drift toward therapist role; Denzin & Lincoln, 2005; Lieblich et al., 1998; Ortlipp, 2008; Ryan & Bernard, 2003).

CHAPTER III

Results

Demographic Information

As previously noted, in accordance with qualitative methodology standards, data collection must continue until saturation—the point at which no new information is elicited from participants (Creswell et al., 2007). Due to diversity in participants' stories, the point of saturation in the present study was achieved with 12 participants representing all major geographic regions of the United States. All interviews occurred between April 2015 and December 2015. Participants ranged in age from 26 to 63 years, spoke English fluently, completed at least a high school level education, were current or former members of the U.S. Armed Forces, identified and presented as male during military service, and experienced MST as enlisted men early in their military career. Table 3.1 provides participant demographics.

Table 3.1

Participant Demographics

	N
Current Gender Identity	
Male	11
Other	1
Ethnicity	
European American	6
Hispanic	2
African American	1
American Indian	1
Multiracial	2
Sexual Orientation	
Heterosexual	9
Homosexual	2
Other	1
Partner Status	
Single	2
Married	7

Divorced	3
Highest Education Level	
High School	4
Some College	1
Associates	1
Bachelors	5
Masters	1
Current Employment Status	
Employed	8
Disabled	3
Retired	1
Branch of Service	
Army	6
Navy	2
Air Force	2
Marine Corps	2
Military status	
Active duty	2
Veteran	10
War Era	
Vietnam	1
Post-Vietnam	3
Gulf War	3
OEF/OIF/OND	5
Combat exposure	
Yes	7
No	5
Highest grade	
E2	1
E3	2
E4	4
E5	2
E7	3
Grade when experienced MST (includes multiple MST events)	
E1	2
E2	2
E3	5
E4	6
	Mean
Age in years	45.42
Number of children	2.28

Data Analysis Review

Prior to initiating narrative inquiry analysis, interviews were reviewed to confirm fitness of the data in terms of chronology and coherence. In the present study, all participants generally shared their experiences in a meaningful chronological order with limited tangentiality. Two participants initially indicated uncertainty regarding their timeline of disclosing MST; however, both corrected any chronological errors during the interview process. All participant narratives were logical and clear for the duration of the interview, and participants appeared to provide an appropriate amount of temporal weight to discussing their experiences following MST. Therefore, all data were suitable for inclusion in the study.

As previously outlined in the Method section, each of the 12 audio interviews was listened to at least twice: initially for transcription and a second time to verify accuracy of transcription. Analysis procedures followed Lieblich et al.'s (1998) recommendations for holistic content analysis, and incorporated systematic procedures described by Ryan and Bernard (2003). Specifically, each transcript was reviewed at least four separate times: one reading focused on the participant's complete, chronological story (holistic), and at least two readings focused on the subject matter (content) and details shared between participants (categorical elements), followed by one reading that attended exclusively to the emotion and deeper meanings of the story (form; Lieblich et al., 1998). The analysis process further included the consideration of ecological features, such as intrapersonal, interpersonal, contextual, and cultural factors when organizing the data. First, individual paragraphs and sentences were broken into fragments, which were then classified into a code that represented the ecological, holistic, content, and form of the fragment. Next,

parallel codes from across narratives were synthesized into broader themes, which were then similarly clustered into larger groups called categories. Finally, related categories were grouped together to create overarching core concepts existent across all data. Next, the themes, categories, and concepts were organized in digital spreadsheet form. In total, over 2500 codes and 28 themes were identified, which were grouped into 10 categories and four core concepts. Figure 3.1 presents all themes, categories, and concepts extracted from the data.

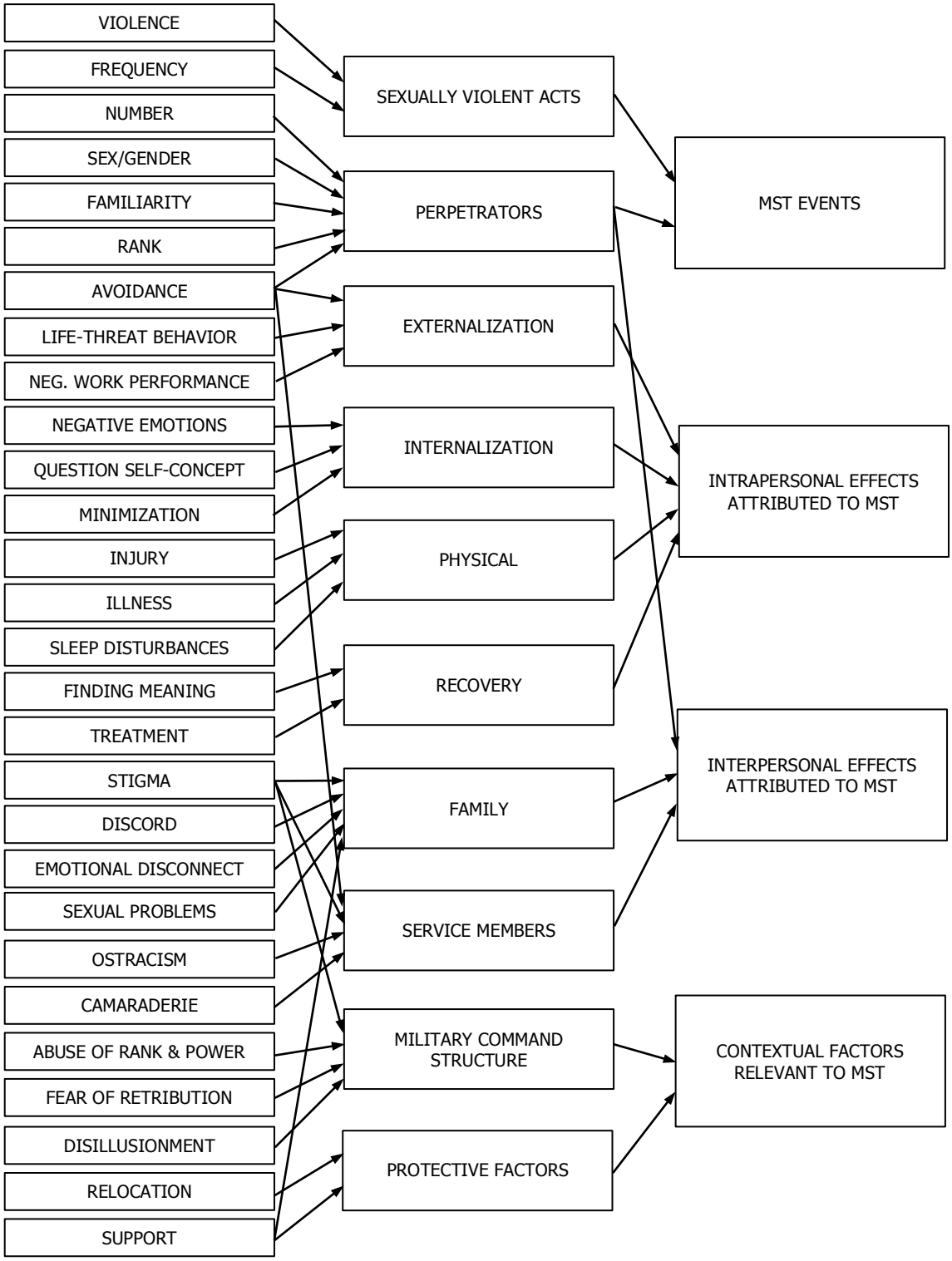

Figure 3.1. Pictorial representation of themes, as related to categories, as related to concepts identified during analysis.

Conceptual Development

To clarify conceptual development, the following section outlines each core concept along with its underlying categories and themes. Information is presented in a top-down approach, first introducing the overarching concept, followed by the synthesized categories that make up the concept, and finally, the themes extracted from the narrative are discussed. Analytical development will be further illustrated through use of example passages from the data. Direct quotes presented in this section may be edited slightly for readability and maintaining confidentiality of participants; however, the meaning and intent of each passage was preserved.

MST events. At the start of each interview, participants were broadly asked to share their story of unwanted sexual encounters while in the military. All participants described their experiences of MST, including descriptions of the event(s), as well as information about the perpetrator(s). Two categories emerged and were identified as sexually violent acts and perpetrators.

Table 3.2

Themes and Categories of MST Events Concept

Theme	Category	Concept
Violence Frequency	Sexually violent acts	MST events
Number Sex/gender Familiarity Rank	Perpetrators	

Sexually violent acts. The category of sexually violent acts arose from two themes: violence and frequency of acts.

Violence. All participants disclosed experiencing at least one form of violence during their MST encounters, and there was significant diversity in the types of sexually

violent acts. Over the course of the MST events, the participants reported that perpetrators hit with fists and objects, kicked, bit, gagged, used bondage with hands and other restraints, groped, drugged participants, performed oral sex, forced participants to perform oral sex, forced anal penetration with body parts and objects, and urinated on participants. Participant B described his experience of physical assault and rape, "It was like, being awakened, attacked, and…you know, just groped and sexually molested and beaten. And, you know, raped. It was a gang rape in the middle of the night." Participant C reported violence of another nature:

> It's like she attacked me, not in a like 'beat me up' way, but like, just very forcefully. She was on top of me and stuff, and it was more just like her dominating... And I remember her, like sticking, shoving her tongue in my mouth and it was just like, it was just like a very gross feeling. It was a violation of my person.

Participant G described another MST event that took place as a form of hazing:

> They grabbed my legs, two on either side of me and one behind me, like holding my upper body. And they spread my legs open, and took me out to the flagpole and they rammed me up against the flagpole. And they did it over and over again, and then they just dumped me down on the ground at the flagpole and just left me there.

Frequency. The majority of participants reported experiencing one distinct MST event. However, four participants endorsed multiple MST events perpetrated by either the same individual(s) or different people. For example, Participant E disclosed multiple occurrences in which the same perpetrator "started kind of coming at me, patting me on

the ass and on the back and back rubs, rubbing my shoulders in line, and stuff like that. She was constantly on me." Conversely, Participant G endorsed experiencing multiple MST events perpetrated by different individuals and groups of individuals throughout his military career.

Perpetrators. The second category under the concept of MST Events focuses on perpetrators of sexual violence. All participants characteristically described perpetrators of the MST event, which is outlined in table 3.4 (of note, number of events will not sum 12 due to participants who experienced multiple MST events and/or multiple perpetrators). Main themes within this category include sex/gender, number of perpetrators, familiarity, and rank.

Table 3.3

Perpetrator Data Across MST Events

	Number of Events
Gender	
Male	8
Female	5
Number of perpetrators	
One	8
Multiple	5
Familiarity	
Known	10
Unknown	3
Rank	
Higher	6
Same	3
Lower	1
Unknown	3
Most severe MST event perpetrated	
Rape	6
Oral sex	3
Touch	5

Sex/gender and number of perpetrators. Participants reported nearly equal experience of MST perpetrated by females and males; specifically, eight participants

endorsed male perpetrators and five reported female perpetrators. Similarly, eight participants reported singular offenders, while five participants endorsed events in which two or more perpetrators were present. When singular perpetrators were reported, there was substantial diversity in the type and frequency of MST events. However, when multiple perpetrators were reported, all MST events involved attempted or completed rape with the exception of one event, which included ritualistic sexual battery. Participants A, B, J, and K described events in which multiple individuals forced oral and/or anal penetration. Of individuals who experienced multiple attackers during an MST event, only Participant A disclosed having both a male and female involved in his MST. He reported:

> He takes me to the bedroom and she follows him in. And he pulls my pants down and proceeds to perform oral sex on me, and I'm just kind of frozen. And she's just watching, but at the moment that I, like, reached climax she bends over and bites me really hard.

Familiarity. The majority (10 of 12) of participants reported knowing to some degree at least one of their perpetrators. Familiarity ranged from a fellow service member in the same military unit to an entirely unknown individual. Participant A endorsed a previous casual dating relationship with one of his perpetrators, noting, "We dated a couple of times, nothing serious going on or anything." Conversely, Participant B noted that he was unable to see his attackers and they remain unknown. However, the significant majority (9 of 10) of known perpetrators were reported as military service personnel; only one participant expressed uncertainty if all offenders were involved in the military system.

Rank. Six of these 10 participants reported that at least one perpetrator outranked them (e.g., perpetrator was a commanding officer or senior leadership), highlighting the role of power differential in MST, which will be discussed later in the concept of Contextual Factors Relevant to MST. Only two participants described MST events in which the perpetrator was of the same rank. For both of these participants, the peer perpetrators offended in the shower following physical training. For Participant I, the perpetrator physically attacked the participant and forced oral sex, while Participant H described threatening verbal sexual harassment and an "attempt to, you know, to grope, grab, my privates."

Intrapersonal effects attributed to MST. Analyzing data with an ecosystemic lens reveals the intrapersonal, interpersonal, and contextual factors relevant to MST in males. A prominent concept that formed out of participants' narratives was identified as the intrapersonal effects attributed to MST. Underlying categories include externalization, internalization, physical, and recovery. Experiences shared by participants illuminated the immediate and long-lasting effects of MST on the individual.

Table 3.4

Themes and Categories of Intrapersonal Effects Concept

Theme	Category	Concept
Avoidance Life-threatening behavior Negative work performance	Externalization	Intrapersonal effects attributed to MST
Negative emotions Self-stigma and questioning self-concept Minimization	Internalization	
Injury Illness Sleep disturbances	Physical	
Finding meaning Treatment	Recovery	

Externalization. Participants commonly described behavioral changes following their experience of sexual violence. In fact, all participants described attempts to manage distress through engaging in maladaptive outward behavior (i.e., externalization). Participant B explained, "[MST] drove me to do things most people wouldn't consider in everyday life… That I wouldn't have considered before [MST]." Participant G further elaborated on dramatic changes in his behavior following MST:

> I think it speaks volumes on how my mind was changed and how I had changed. Because what I was doing is not something that I wanted to be a part of, and not something I ever dreamed to be a part of before. I never knew that this life of using, drinking, promiscuity existed. I had never experienced anything like that before.

The externalization category is comprised of the themes avoidance, life threatening behavior, and negative work performance.

Avoidance. Expectedly, avoidance was endorsed by all 12 participants across concepts. Relevant to intrapersonal functioning, they disclosed avoiding stimuli that reminded them of the MST event in an effort to prevent negative thoughts and feelings. For example, Participant L described avoiding married men and specific locations because they reminded him of his perpetrator:

> I would avoid such people because [the perpetrator's] married. It's because he's married and that's what happened before, this one could come after me too… And I avoided that place—that bar—that I used to hang out at all the time.

Participant H endorsed an avoidance response proximal to the MST event, nothing that he "attempted to stay away from anyone, any guy, who looked like they may be homosexual

because what if they had it out for me too." Participant G described the long-term experience of avoiding any veterans out of "fear that I might run into those men [perpetrators], or even just seeing veterans makes me think of [the MST event]" which was echoed by multiple other participants.

Life-threatening behavior. Eleven of 12 participants endorsed engaging in dangerous, life-threatening behaviors following MST, and specifically attributed these behaviors to being related to their trauma. Participant D described new engagement in life-threatening acts. He said, "After [the MST event] I just became totally reckless. I mean, you know, I completely didn't care about—and I really didn't have too many concerns about—hurting myself, but I actually was hurting myself." Substance use, risky sexual behavior, and aggressive behavior were most commonly reported. Substance use to manage negative emotions and distress was reported by 10 participants. Participant B stated, "You know, I guess, like the only way you can get through a day is to do a line of crystal meth along with your coffee." Participant E reported, "I self-medicate with weed [cannabis]. The smoke has definitely helped with keeping thoughts and feelings suppressed that you know shouldn't be there—the sadness, the depression, you know—because I still think about it, losing a career." Participant G disclosed a similar experience of substance use to forget about traumatic events and to avoid rumination:

> I was in my free time self-medicating through alcohol, through overuse of legitimate prescription drugs, even, you know, illegal substances and stuff like that… It made it easier for me to forget about participating in [sexual hazing] and to forget about experiencing [MST]. The drugs and stuff would typically be

> something that I would turn to in a time of extreme distress, extreme emotional distress.

He went on to describe engaging in related life-threatening behaviors, such as "getting black-out drunk, drinking and driving, and breaking more and more laws and things like that."

Five participants reported newly engaging in risky sexual behavior following the MST event. Participant B discussed the underlying shame that led him to seek what he considered "dark, punishing" sexual experiences:

> You know it would drive me to go see sex workers… to relieve the stress. Like I, I'd see sex workers that were into sadomasochism. And I would, like, want to be punished because of the shame. I'd think it was, you know, my fault or something.

Participant G endorsed participating in life-threatening sexual behaviors:

> I'd have unprotected sex with strangers, people that I know very little about. And then having sex with people that use harder drugs than I was using—like injecting drugs—and I could have gotten, you know, like HIV.

More than disregard for his safety, after experiencing MST Participant J reported desire to end his life through risky behavior:

> I was very sexually active for a great period of time where I was actually going out there with the intention to harm myself by exposing myself to—without protection—exposing myself to diseases… I guess I was just looking for a way out, kind of like suicide.

In a different way, Participant C described engaging in new sexual behaviors that he found "upsetting, not like me." He reported:

> I was really into like, I guess you could say, well, rape porn or even porn that was associated with kind of like bondage stuff, or rough. And I was really interested in the fear aspect of it, or the scenario aspect of it rather than the sex part of it.

Participants endorsed further engagement in life-threatening aggressive behavior, including physical fighting and instigating fights with weapons. Participant B reported, "I'd have these violent outbursts where I'd pick fights. Any fights, bar fights. I'd get into street fights with skinheads, and all sorts of shit." Participant D endorsed congruent experiences of "getting rough and fighting with whoever," as well as "defying others just to see what they'd do, if they'd want to fight."

Negative work performance. Another example of externalizing behavior includes decline in work performance, which was reported by approximately half of participants. Participant D stated, "My overall performance in the Navy was affected. You know what I mean? I wasn't as good a Sailor as I was before… I faced administrative action and that affected my pay grade." Participants E and J reported discharge from service that was directly related to their MST experiences. Participant E described inability to concentrate during training school following MST. He said, "I failed, I failed one week. I couldn't focus or study with that, that stuff going on… Eventually I couldn't do it." Participant J expounded, "With Don't Ask Don't Tell and being labeled as homosexual for that I was… forced out and I couldn't do it [my job] even if I could have."

Internalization. In conjunction with externalization, all participants reported frequent experience of internalizing immediately following MST events, as well as long-

term. Themes related to negative emotions, self-stigma and questioning self-concept, and minimization led to the development of this category.

Negative emotions. Expectedly every participant endorsed negative emotions following MST. Depression, anger, fear, guilt, and shame were most commonly reported. Participant D summarized the experiences of most participants:

> I developed depression because of what happened. That depression went at least a decade long, a lot of depression. All I wanted to do was just stay in the bed, you know, really, I just had no motivation. I imagine I'm mentally burnt. So there was all that, and like, there was a period of time where I was depressed and fearful and anxious and just, you know, uneasy. And angry. Anger would come in at [the perpetrator], at everyone, at me.

Further, Participant B reported, "There's definitely a lot of self-hate, and self-loathing… It's like an internal pressure cooker, an internal war."

The experience of self-stigma and shame was pervasive. Eleven participants endorsed feeling embarrassment, shame, internalized stigma, and questions about self-concept related to MST. For example, Participant J disclosed, "So I have to live with the shame of this stuff, of what happened. It was something that I felt guilty about it. I felt that it was my fault that it happened." Participant G echoed:

> I just remember feeling stupid, feeling worthless, feeling regretful and ashamed. It's weakness; that's the way I interpret the feeling I have when I think about [the MST event], is that I feel inferior, weak at a time when I should have been strong, you know. Looking back, I'm a young man in the military, and I have this story, and to me it's demeaning to myself to even mention it. So I just don't. It's easier

> just to keep it in and I can deal and mitigate and all of that, and I don't want to crap on the rest of the world. I don't want to rain on anybody's parade, saying like, "Sorry your military hero is really a molestation victim, and, you know, maybe I'm not the man you thought. I'm not the hero you thought I was…"

Self-stigma and questioning self-concept. Participants commonly endorsed homonegativity and homophobia, questioning their own sexual orientation or gender identity, and perceived lack of masculinity or fulfillment of gender roles. For example, Participant B stated, "It got to me, the stigma. It was like embarrassment, shame. Unmanliness, un-masculineness. Who's going to say, 'Hey, I got raped by a woman.'" Participant K described an intersection of guilt and masculinity:

> How did somebody take advantage of me? Here I am, trained and I couldn't protect myself; I'm guilty of that. I mean I tried to fight them off and everything but, I mean, it was just taken over. I wasn't the man I was trained to be."

Participant C demonstrated participants' frequent questioning of sexual orientation following MST. He noted, "I mean, am I gay if I didn't, like, enjoy this [MST perpetrated by female]?" Participants who experienced female-perpetrated MST endorsed questioning their sexuality (i.e., that they are not attracted to women) if they were not aroused during the sexual violence. Furthermore, many individuals assaulted by males reported questioning if they were attracted to men, or reporting that they began noticing attraction to men following MST. For example, Participant G stated:

> Yeah, I do question my sexual orientation to this day. I think about it frequently. I never did before [the MST events] and, you know, I have a child with a woman,

but I think I legitimately believe that I have an attraction to men now. I don't know. It's very conflicting and different for me.

Minimization. Along with negative emotions and questioning, eight participants expressed attempts to minimize their MST and the intrapersonal effects they experienced. They noted a desire to return to work as usual or deny being affected by the sexual violence. Participant E demonstrated this attempt to minimize by stating, "I told myself it was just how things go, so I can go on with my life." Further, Participant A stated, "It wasn't that bad, right?"

Physical. Another category of intrapersonal effects attributed to MST includes the physical effects of sexual violence. Themes include illness, injury, and sleep disturbances.

Illness and injury. As anticipated, the types of physical effects endorsed by participants varied based on type of MST experienced. Participants who reported penetration endorsed injuries, such as tearing of tissues, bleeding, pain, swelling, development of hemorrhoids, and loss of teeth. Other participants described feeling physically ill in the days following assaults, noting nausea, vomiting, headaches, and muscle aches. Three participants endorsed serious, long-term physical health consequences from MST. For example, following multiple MST experiences of rape and genital battery, Participant K reported a lifelong inability to achieve erection "or anything like that, my penis just never worked again. I guess it was broken." Participant G described severe injuries and illness as a result of multiple physical assaults to his genitals both immediately and long-term:

> I mean right after, you get the big green-purplish bruises on the inside of your thighs, also testicles swelling, penis, just hurt in general. And you have trouble walking immediately after or doing physical fitness for a long time… And I got diagnosed with cancer down there. Even my doctor said, "You must've, boy, you must have had some sort of an injury at some point down there." You know, and because it wasn't testicular cancer, it was actually cancer on my penis. I firmly believed that the hazing—that strong, physical hazing—on the genitalia led me to have the cancer diagnosis that I have.

Another participant disclosed contracting HIV following rape perpetrated by multiple attackers. He stated, "I was diagnosed on a health screen with HIV and I, it was then—that time [MST event]—that I got infected; I'd never had intercourse before."

Sleep disturbances. Sleep disturbances were another common physical effect attributed to MST. Participants endorsed difficulty both initiating and maintaining sleep due to racing thoughts related to trauma, fears for safety, and nightmares. Participant B experienced MST in his barracks and expressed the inability to feel safe sleeping in the place where his assault occurred. He stated, "After that, you know, you can't sleep at all anymore. What if they come back? No, you've got to not sleep." Participant I noted proximal and long-term insomnia, stating, "I don't think I slept very good any nights after [MST event]. So, I was just sort of sleepwalking through the day."

Recovery. The final category of the intrapersonal effects attributed to MST concept is resiliency and recovery. This category arose through the identification of themes related to meaning making and mental health treatment.

Making meaning. Over half of participants shared examples of how they have worked to recover from MST and promote their resiliency. Participant A described finding meaning in his experiences. He stated, "I had found a way to make the MST acceptable to me. You know, like to turn something so terrible into something you can bear." Participant C also disclosed his process of making meaning through exploration of his emotional experience and learning:

> I've done a lot of my own research on why I feel the way I do, and I think that, you know, you can definitely try to understand your feelings, and that helped me to feel better about it… And I feel I learned a really good lesson.

Three participants described the importance of faith and spiritualty. Participant K noted, "I mean I brought in my God to help me, that's what keeps me going." Likewise, Participant D reported, "I became spiritual throughout the process," noting how he found meaning through faith. Participants I and L endorsed finding meaning through increased empathy for others. Participant I stated, "I understand a lot better on women's victimization, you know, how society treats them, and all that stuff. So I have a much stronger empathy for that."

Mental health treatment. Seven participants endorsed making meaning and healing through the process of therapy and/or discussing their experiences. For example, Participant D shared how healing represents a continual process; he stated, "I'm still getting better. I'm still dealing with this issue, and one of the best ways to get better is talk about it." Participant G noted, "I went to therapy, a lot of therapy. And I did Prolonged Exposure and Cognitive Processing Therapy [evidence-based treatments for PTSD]."

Interpersonal effects attributed to MST. Emerging from the participants' narratives, the concept of interpersonal effects attributed to MST was identified. Three fundamental categories arose: perpetrators, family, and fellow service members.

Table 3.5

Themes and Categories of Interpersonal Effects Concept

Theme	Category	Concept
Avoidance	Perpetrators	Interpersonal effects attributed to MST
Stigma Discord Disengagement and emotional disconnect Sexual functioning problems Support	Family	
Ostracism Stigma Avoidance Camaraderie	Service members	

Perpetrators. Every participant narrated the effects of MST on their encounters and interactions with perpetrators. One major theme—avoidance—led to the development of this category.

Avoidance. Although overlapping with intrapersonal avoidance (i.e., avoidance in attempt to prevent experiencing negative thoughts and feelings), participants' reports of interpersonal avoidance were specifically related to interactional behaviors. Expectedly, following MST, all 12 participants disclosed efforts made to avoid interactions with perpetrators, although they noted varying degrees of ability to limit contact. Participant L stated, "Every time I would see him my stomach would turn. I would have a lot of anxiety and I would go out of my way to avoid him at all. Not see him, not near me." Participant E followed suit and disclosed, "That's basically all that I did—well all I tried to do—was avoid her." Even participants with unknown attackers noted desire to avoid situations and places in which they may encounter their assailants. For example, Participant K endorsed, "I tried not to go there, near there again. So [the perpetrators]

couldn't find me." The majority of participants also disclosed the inherent abuse of power when perpetrators were senior leadership, as well as fear of retribution or punishment, which will be discussed later in the results.

Family. Participants' narratives were complex when disclosing the impact of MST on family and significant persons. The following themes developed from the data: stigma, discord, disengagement and disconnect, sexual functioning problems, and support.

Stigma. One of the most commonly disclosed effects of MST across systems was stigma related to sexual violence perpetrated against males. All 12 participants reported concerns related to masculinity and gender roles (e.g., power-weakness), as well as sexual orientation. For every participant—regardless of the sex/gender of the perpetrator—it was anticipated that others would consider the participant to be homosexual or weak for experiencing MST. When perpetrators were male, participants expressed concern of ridicule, ostracism, violence, or loss of career for being viewed as homosexual or un-masculine; they further worried that others believe the participant welcomed the sexual encounter with another male. Participants whose perpetrators were female expressed similar fears that others would view them as homosexual if the participant reported disliking the experience, feeling violated, or experiencing negative consequences of the sexual violence.

Many participants reported concerns of stigma within their family or close relationships. Participant I disclosed, "I was thinking about my father. And I think he would tolerate that [MST] happened, but it would be like a piece of our relationship would be gone, you know, forever." Participant K noted the stigma related to how family

would view him as a person. He stated, "I didn't tell my family because I felt like I'd be labeled. I mean, I didn't want to be, I didn't want my family to go think that I was gay or something like that, so I just never brought up the situation."

Discord. Discord within family relationships posed a significant problem for half of the participants. Four participants endorsed dissonance within their marriages. For example, Participant A stated,

> I think it has caused stress from time to time in my marriage. Like when I have thought about the experience [MST], especially because I wasn't talking to anybody about it. So anytime I did think about it, anytime I took it out of the box to look at, I was very angry and I took that out on my wife sometimes.

Congruently, Participant D noted, "I was struggling to be good and have good interpersonal relationships… And the MST, really clearly that affected my relationship with my wife. Couldn't talk about anything; nothing was the same."

Several participants described difficult interactions with families of origin, noting problems with behavior changes and lack of support. For example, Participant B explained how MST contributed directly to discord in family relationships due to changes in his behavior. He said, "Yeah, it caused a lot of problems, definitely with my family. Fights about everything." Conversely, Participant G shared experiences in which family did not believe his disclosure of MST:

> I remember feeling like my mom didn't believe me and that kind of put the brakes on me ever mentioning anything again. I pleaded with her because I could hear it in her voice and stuff that she didn't believe that that man would do

> something like that [perpetrate MST]. And after that there was about a three year gap, up until recently, that I didn't talk to my mom.

Disengagement and emotional disconnect. Following MST, over half of participants described disengagement from family members, whether purposefully or without intention. Participant B described the interpersonal disconnect with family and others following MST:

> When something like this happens, there's that separation to deal with, and you have a feeling you've nowhere else to turn. It's like compounded isolation. You feel disconnected. You feel different. You feel like you're not gonna fit in… And actually with the people I was closer with, it was harder.

Participant J reported the purposeful long-term experience of separating from family post-MST despite family's desire to maintain a relationship:

> Well, I try to kind of keep my distances, even though I think they do try to make an effort to, you know, to make contact with me, but I try to kind of keep them at a distance and not get too close to them. I haven't really told them too much about things that have happened to me. I try to kind of be very cordial, but yet, kind of distant. I don't allow them to really know, what I'm really like, what I really feel. I don't express my opinion too much towards them. I just like go along with what they have to say and just kind of to get through, and hope, hopefully they hear what they want and they can go away… Wasn't always like that.

In addition to discord within family relationships, Participant G endorsed avoidance and disconnect:

> I detached myself. I didn't feel comfortable trusting them with what's in my heart. It'll just be, it'll just be how it is, you know… That part of my interpersonal skill has been very much affected because I tend to not want to connect anymore now.

Finally, Participant K summarized the impact of MST on significant relationships, also noting both disengagement and separation:

> I was very isolationist, isolating myself as much as I could, and I tried to kind of stay away from a lot of people that I normally would hang around with, whether it be family or friends. I lost a lot of people. I, you know, tried to. I stayed away from family functions and friends' functions and relationships that could have been… I basically found excuses to back away, so I would not put myself in a relationship, and the relationships that I did have, it seems a lot of them were reminders of the time I was raped because I didn't feel like I really wanted to be involved sexually.

Sexual functioning problems. As illustrated by Participant K's statement, nearly all participants disclosed sexual dysfunction following MST. Participant B stated, "You don't want to get physical, you can't. It almost repulses you. Having intimacy, I almost felt like I wanted to throw up." Participant A explained the complexity of sexual intimacy following MST:

> I think that [MST] also caused me to—I hate to say—to distrust [my wife]. Because I do trust my wife. But in an intimate situation, sometimes I feel like looking up over my shoulder to see, you know, what's the catch here? I feel like I

> can't be sure of a lot, when it comes to being intimate. Even after all these years, it's like, is there an agenda behind this?

Participant J described worries that he himself may become a perpetrator, which contributed to difficulties with sexual functioning and intimacy:

> I'm always afraid that I'll become a mean person, an abuser. Like that might be what happens to me. So I'm always very aware of things that I do, and I always try not to get too physical or touchy-touchy with anybody because I feel like I'm being the perpetrator, like what happened to me. For some reason, my thought goes to that incident and what happened.

While most participants identified the source of sexual problems to be related to psychological effects of the sexual violence, three participants also disclosed physiological damage that contributed to functional problems. For example, as previously mentioned, Participant K disclosed permanent inability to achieve erection following his MST, which negatively impacted the relationship with his spouse. Additionally, two participants endorsed contracting diseases that affected ability to engage in sexual relationships.

Support. Although the majority of participants endorsed family problems stemming from MST, several individuals identified family members as a source of support when recovering from sexual violence. For example, Participant F reported that experiencing unwanted sexual encounters "probably brought my wife closer" due to "trusting her entirely with the situation and having her rise to it." In addition, Participant E disclosed having the support of his father to navigate the process of reporting MST.

Service members. The third category under the concept of interpersonal effects attributed to MST is the focus on interactions with fellow service members. Themes emerging from the data include stigma, ostracism, avoidance, and camaraderie.

Stigma. Similar to stigma experienced with family members, fears and experiences of stigma with fellow service members were reported by 11 of the 12 participants. Overall, stigma was again perceived to be related to expectations about masculinity and sexual orientation. Participant I reflected the thoughts of most participants when he reported his fears related to how his service member peers would view him if they knew of his MST. He expounded, "It was more the social stigma that I was afraid of than any physical punishment." Furthermore, stigma significantly contributed to many participants' reported hesitancy to disclose MST to their peers. For example, Participant D discussed the gender-related stigma of experiencing MST perpetrated by a female, which he believed would arise if he disclosed the event to his fellow service members. Participant D elaborated, "The other guys thought, you know, what guy wouldn't want that? What guy wouldn't want to have some strong woman forcing themself on you, you know what I mean?"

Ostracism. Interwoven with the previous theme of stigma is the experience—or feared experience—of fellow service members ostracizing the participant due to MST and surrounding stigma. Participant G described participation in sexual hazing out of fear of being ostracized:

> If you didn't go along with it, then you're gonna be shunned or you're not gonna have any type of promotion, or you could possibly get extra duty. I remember an instance where I didn't participate, where I didn't grab the solder, and where I

> didn't force him, and I remember somebody actually said to me, "What are you? A bitch?" you know, for not doing it. And I remember them demeaning me. There was this attitude of 'you're not a part of our crew.' You'd get a sense that if you complained about it, or if you got upset about it, you'd be laughed at, called a crybaby, bitch, sissy and they would try to force some paperwork on you and move you to another platoon or to another unit, because they would see you as a problem soldier then.

Participant I also noted the fear of being ostracized and how he modified his behavior to better fit in following MST. He stated:

> With everyone [fellow service members], I remember putting on a show, so to speak. I was being guarded, so I think I was acting more macho, just consistent with how you, you know, wouldn't be if this [MST] happened to you. I think I had what happened [MST] in the back of my mind in all my interactions. And I was afraid that [the MST event] would come out somehow, like, through osmosis, somebody would say, "Oh, I know what happened to you." So I tried to, you know, act tougher, and more serious, more authoritative so they wouldn't shun me too.

Participant J elaborated on being ostracized by his peers after experiencing MST. He reported, "It just seemed it was a hostile environment at the time and, like, no one would touch me with a pole. I was really alone and, you know, they wanted it that way."

Avoidance. Related to fears of stigma and ostracism, many participants endorsed avoiding contact and interactions with other service members proximally and distally from the MST event. As previously described, Participant G reported avoiding any

active duty personnel or veterans due to re-experiencing and remembering his traumatic events. Participant L noted similar behavior in the months following his MST event. He described, "So, I disengaged from a lot of people. I avoided a lot of the other men [service members], acquaintances, even some friends."

Camaraderie. Conversely, several participants shared about the continued sense of camaraderie, support, and family within their immediate military community following MST. For example, Participant K reported:

> I mean, my comrades that I had, my comrades in arms that I worked with and was with them since almost from boot camp to the day that we got out, they became more my brothers than anything, because, I mean, we didn't interact that way [with sexual violence]. They would never initiate anything like this. This happened completely out of my platoon.

He further reported feeling safe and protected with his fellow service members. He stated, "While I was on duty I didn't worry about [repeated MST events occurring] because I knew my brothers would take care of me, and I would take care of them." Likewise, Participant H noted, "Nothing changed with my comrades, you know. I still trusted them the same, it wasn't all of them who were doing this [perpetrating]."

Contextual factors relevant to MST. The final concept of contextual factors relevant to MST represents one of the most important findings revealed through the narrative analysis. All 12 participants disclosed how their experiences of sexual violence were unique due to the military environment in which they occurred. Clearly articulating the distinct impact of the military context in experiencing, reporting and discussing, or healing from sexual violence, Participant L stated:

> This situation of being in the military did really create the environment for that particular situation – well, for any sexual assault where you're trapped or whatever. You're told not to rock the boat, not to accuse. Just to, you know, deal with it, be a man. And so that is the hardest part of experiencing sexual assault in the military.

Two categories comprise this concept and were identified as military command structure and protective factors.

Table 3.6

Themes and Categories of Contextual Factors Concept

Theme	Category	Concept
Abuse of rank and power Stigma Fear of retribution or punishment Disillusionment	Military command structure	Contextual factors relevant to MST
Relocation Support	Protective factors	

Military command structure. The hierarchical command structure of the military significantly contributed in some way to all participants' overarching experiences with MST. Each participant endorsed to some extent that the power structure negatively impacted either the occurrence of the MST event, the disclosure or reporting of MST, the consequences of reporting, and/or the intra- and interpersonal effects of MST. Themes within this category include abuse of rank and power, stigma, fear of retribution or punishment, and disillusionment.

Abuse of rank and power. As previously mentioned, 10 participants reported that at least one of their perpetrators was military personnel, with six participants identifying their perpetrator as senior leadership. This illuminates the role in MST that abuse of rank and its inherent power may present within the military hierarchy. For example, Participant C disclosed his familiarity with a commanding officer that eventually led to

MST. He stated, "We had kind of known each other, a little bit, and obviously, she's a higher rank than me, I'm just a private. I can't do anything." Similarly, Participant F reported that his perpetrator "was in a leadership position where she outranked me." Participant D disclosed that his perpetrator held higher rank and was also a substance abuse counselor:

> The counselor that I was assigned to was someone senior to me in rank, and part of that counseling was me telling about my life. And at some point that person just decided to make, um, sexual advances. And this was a female and she was an authority figure, but I actually didn't welcome that, and I tried to express that I didn't welcome that… I didn't really want to go, but I had no choice because I was ordered to attend these meetings. And over the course of that time it just continued to happen. Maybe not every time, and maybe not every time actual intercourse, but there was always sexual contact to some degree.

Participant G further described an experience in which a an individual senior in the chain of command used his power to assault the participant:

> The supply sergeant said, "Well are you a man?" and I replied, "Yes," and he said, "Well it takes a man with big balls to be a tanker." And I remember I was kind of perplexed… And so he proceeded to reach down and grab the bottom zipper [on my uniform], and I remember I actually came out of at-ease, and he snapped me back real quick and gave me a real angry look, and I think he may've even said something like, "Boy you better listen to me" or something like that… So I put at-ease, put my hands behind my back. And he proceeded to reach into my pants, and he grabbed my genitalia for about 5 to 10 seconds, and he held it

> there, and he actually looked over his shoulder and made a comment to the other soldiers in the room that, yeah, I am, in fact a man and I can be a tanker now. And he released me and actually zipped me back.

Similarly, Participant E revealed that his perpetrator was his staff sergeant training officer and with "her being in an area of power, [he] didn't know what to do." During the MST events, all of these participants described uncertainty about how to behave given the power differential, or expressed an explicit inability to change the situation. Participant F stated, "I still was confused, I guess, on the rank structure, as to like, what, I should do, what I could do. That was confusing." Similarly, Participant C echoed confusion and uncertainty when he stated, "What am I supposed to do? She's a noncommissioned officer, above me." As previously described, Participant G attempted to prevent his assault from occurring and was immediately ordered back into a position of vulnerability.

Stigma. Again, stigma arose as a concern for all participants, and in particular in regard to its extension into the command structure and overarching military culture. As with stigma with family and fellow service members, the stigma existent within military culture posed a significant barrier to disclosure and treatment of MST, as well as taking steps to promote safety from perpetrators. Participant I illuminated the stigma around sexual violence in the military, as well as fear of punishment and negative consequences:

> As far as the Air Force finding out, you know, I'd feel that even if they did go after the guy I think I would still be tarnished, and probably, you know, never live it down… They probably wouldn't discharge me, but, you know, it would follow me. And people would find out, and people would know forever, and, you know, just keeping the secret seemed like the best thing.

Again, much of the stigma reported was related to sexuality and gender roles. For example, Participant K noted fear of the command structure, "I figured that I'd be probably told that I was gay or something like that and get kicked out of the Marine Corps for something that I didn't, you know, ask for but it happened." Similarly Participant I disclosed hesitancy to report MST due to stigma surrounding homosexuality within command:

> I couldn't tell the drill instructor because, well, actually, just a couple nights before I heard him ranting about catching two gay men asleep on the couch. And he said they were having sex, and he was just screaming at the top of his lungs how disgusting it was, and there was feces all over the guys' penises, and blah-blah-blah, and so obviously, I didn't think I could go tell him about [the MST event], because, you know, he clearly felt this way, and I didn't want to get kicked out.

Fear of retribution or punishment. The majority of participants (9) reported fears of retribution or punishment due to experiencing MST. They endorsed fear of punishment from the individual perpetrator, as well as from the greater military system. Notably, when perpetrators were of higher rank, all participants expressed further fear of retribution. For three participants, this fear arose from the perpetrators' direct threats. Specifically, Participant L disclosed, "[The perpetrator] had told me I had better never tell anybody what had happened, and if I did he would kill me." Likewise, Participant J reported multiple threatening situations, both from the perpetrator and command:

> [The perpetrator] and command had made comments that they were going to tell my family and my friends everything that had happened if I didn't confess [to

> willingly engaging in a sexual act with a male]. They were basically kind of trying to make me do something that, you know, they were using that threat to tell my family… I was threatened. I was basically commanded to go talk to people in charge, you know, commanding officers and lawyers who were involved. I was promised it was going to be private, but they told the commanding officers the things that happened [MST events], you know, and I was going to be discharged. So, I was told one thing and I was also threatened. And I was told by my commanding officer that I need to kill myself. Basically, he tried to shame me over having any kind of contact with men.

For other participants, threats from perpetrators or the command were not explicit, but were inherent due to the power differential existent in the military hierarchical structure. For example, Participant E stated:

> Internally, there was a lot of anxiety that if I didn't do what [the senior ranking perpetrator] wanted, I'd be going home, kicked out. It was a threatening environment. Maybe not as threatening as most people would consider it. You know, people look at it from the outside. They'll tell you, "Ah that's nothing." Okay, well put yourself in my shoes. You're worried about your career. You've got family back home that is expecting you to last 20 years in the military. Make a career out of it.

Similarly, Participant D reported fear for his career when he disclosed, "If I did anything—like didn't do what [the perpetrator] wanted or told anyone—then I would possibly face discharge, and other disciplinary actions." Participant F also noted a barrier to reporting sexual violence perpetrated by an individual of higher rank; he reported, "I

guess it would have been her word against mine. And she was an officer. Who do you think would be punished?" Participant E summarized, "I felt more threatened by the power, by her rank than anything. Because I, I have no say."

Participant G highlighted the interaction of avoidance and fear of punishment when he explained his propensity to avoid other service members and veterans, "I'm worried about recourse, I'm worried about bad blood."

Disillusionment. The experience of MST impacted most (8) participants' perception of the Armed Forces system, including increasing distrust and feelings of disenchantment on both personal and systemic levels. Participant F reported, "I lost a lot of, basically, my trust in the military in general… I have very little trust in the Army as a whole." Participant B echoed such sentiment, saying, "I definitely had more mistrust. Towards authority, and the whole damn thing [military]." Many participants endorsed feeling shocked that sexual violence occurs in the military, and further expressed distress about the lack of response to the issue. For example, Participant D stated:

> Certainly, my feelings and my view on the military changed to a degree. I wasn't just a wide-eyed kid anymore. I found out, I found in one of the most ugly ways that stuff could happen to you, even when you are in one of these so-called greatest organizations in the United States.

Participant E echoed:

> Why is this sexual attacking happening and nobody does anything about it? I learned when it does happen nobody wants to help you, nobody wants to do anything about it; it's discouraging. It makes me mad that they put an image out

> there of the military that everybody is honorable and full of integrity when, yeah, not so much, right?

Many participants endorsed unmet expectations about the Armed Forces' support for the individual service member. Participant L reported feeling disappointed and let down by the military not only in relation to prevention or addressing of MST, but also in regard to providing adequate treatment opportunities for individuals. He stated:

> And so I was really disillusioned with command, and I felt like they could have done more, or there should be an easier way, especially in terms of the counseling. Like in my situation where I wanted to keep it confidential, where I didn't want it to blow up, but it would've helped if I could have talked to somebody about it. You know what I mean? There's always – it seems to me like they take away that part of it. They take away the intent of the counseling. They talk about wanting to help people, to help their Soldiers but it seems to be a zero sum game in which, in order to do that, you have to tell. It's like talking about a problem with your parent when they are the problem, or at least they're part of the problem.

Participant F, an active duty service member who works with "victims of sexual harassment," further reported:

> The military's show of concern is that they will, you know, authorize additional funding, or that they will pump in so much of that, but not that they care. It's more that they care about their career than anything. They'll kind of pump money into preventing MST, but not really care that the system or the situation's really being fixed; it's more a 'how-appearances-look' kind of thing.

Finally, Participant K summarized disenchantment with the military on a personal level, sharing the devastation that resulted from MST. He reported similar experiences to many participants when he stated, "In the service you become a family… At least I thought, you know, until that happened to me."

Protective factors. Although most participants endorsed disillusionment with the Armed Forces system, multiple (5) participants reported that the military context provided a unique set of protective factors that enhanced their ability to recover from MST. Two themes emerged from the data to comprise the category of protective factors: relocation and support.

Relocation. Four participants discussed how the frequent relocation component of military service (e.g., assignment to new post/base approximately every 3 years) proved helpful in mitigating the negative effects of MST. For example, Participant A noted:

> Since we get used to moving around and having a new group of friends or acquaintances every time we go someplace else, I think that may actually make it easier in some ways. I don't have to look at something face-to-face, you know, every day or even once a month or once a year. There's no one from that time that I have to deal with anymore.

Similarly, Participant L indicated his perceived benefits of frequent relocation during service. He noted, "I could leave that [sexual violence] behind me. It was a nice geographical change and a different change in companies to get away from it." All participants who endorsed the benefits of relocation expressed appreciation of the avoidance that is inherent in leaving behind reminders of MST.

Support. Despite the predominate negativity expressed toward the military system by most participants, three individuals reported feeling supported by some fellow service members, officers, and the military system following MST. As mentioned previously, Participant K disclosed feeling protected and cared for by his comrades. Furthermore, Participant J reported receiving support and assistance from one commanding officer, which he endorsed enabled him to "make it through" the turmoil and discrimination he experienced. Participant L noted how support from a fellow service member and chain of command helped him to feel able to "make sense of the whole thing" and to "not feel entirely alone."

Summary of Results

Overall, through narrative inquiry analysis 28 themes, 10 categories, and four concepts emerged from the data, which represents the ecosystemic experiences of males who survived MST. Notably, the data revealed the extensive impact of MST on the participants' lives, which Participant D well summarized:

> I can still feel deep down in my heart – I can still feel bad. So that means, despite how well I've done to overcome that sexual trauma past, that means, it still affects me to this day… There's always going to be something that affected me – affects me. It affected my soul, my spirit, everything in my life from me to my wife, to my job. It's affecting me.

The four concepts highlighting the systemic impact of MST were identified as the MST events, the intrapersonal effects attributed to MST, the interpersonal effects attributed to MST, and the contextual factors relevant to MST.

The first concept to develop from the data was the MST events. This concept is constructed from the category of sexually violent acts with themes of violence and frequency, as well as the second category of perpetrators with themes of number, sex/gender, familiarity, and rank. All participants reported experiencing some form of sexual violence during their military career perpetrated by at least one individual who was most often a familiar service member of superior rank.

The second concept to surface from the narratives was the intrapersonal effects attributed to MST. Externalization, internalization, physical, and recovery are the four categories that form this concept. Themes of externalization include avoidance, life-threatening behavior, and negative work performance. Internalization is developed from themes of negative emotions, self-stigma and questioning self-concept, and minimization. The next category, physical, is made up of injury, illness, and sleep disturbances. And finally, themes of the recovery category include finding meaning and treatment. Expectedly, all 12 participants reported intrapersonal effects related to MST.

Interpersonal effects attributed to MST represents the third concept identified during analysis, and it is comprised of three categories. The first category, perpetrators, was established through one main theme of avoidance. The second and largest category was identified as family. Themes include stigma, discord, disengagement and emotional disconnect, sexual functioning problems, and support. Service members are the final category of this concept, and its underlying themes are stigma, ostracism, avoidance, and camaraderie.

The fourth and final concept to emerge from the data—contextual factors relevant to MST—is composed of two underlying categories. The first and largest category is the

military command structure, which includes the following themes: abuse of rank and power, stigma, fear of retribution or punishment, and disillusionment. Protective factors represent the second category and is derived from the themes of relocation and support. Importantly, the unique military context with its inherent hierarchical command structure served as a predicate for the present study, and all participants reported that the military system constructed and impacted their ecosystemic experiences of MST.

CHAPTER IV

Discussion

The United States military is comprised of 1.2 million active duty male service members and there are an estimated 22 million veterans currently living in the U.S. (Office of the Deputy Assistant Secretary of Defense, 2015). Although prevalence rates differ dramatically (ranging from 1% to 42%), research suggests a moderate estimate that 6% of male veterans have experienced sexual violence beyond threatening verbal harassment during their military career. Thus, the results of the present study are important, given the potential for over 1.4 million male American service members and veterans living today who have experienced military sexual trauma (MST). Previous research has demonstrated pervasive negative effects of sexual violence in civilian and military populations (Mezey & King, 2000; O'Brien and Sher, 2013; Peterson et al., 2011; Schry et al., 2015); however, the current study is the first to investigate in-depth the overarching qualitative experiences of males who survived MST while in the military, and is the first known MST study fully unaffiliated with the VHA (i.e., no use of VHA data or recruitment).

The present study's lack of affiliation with the military or VA system is notable, and likely influenced the participant sample. Multiple individuals who endorsed interest in the study disclosed their willingness to participate only due to the study's separateness and privacy from the military and VA system. Participants expressed a purposeful avoidance of reporting their experiences to any affiliation of the federal government. Specifically, four participants reported their first ever disclosure of an MST experience within the context of this study, while an additional four participants stated that they had

only previously disclosed their MST experience to a trusted civilian, purposefully not reporting to their command or VHA. Therefore, the findings of this study provide the unique perspective of service members and veterans who have not contributed to previously published MST literature. Additional factors contributing to the participant sample include access to and proficiency in utilizing the Internet, as well as comfort speaking with a female primary investigator during the screening process. However, all participants endorsed preference for or comfort with speaking to a female researcher.

Drawing on past research, it was anticipated that male survivors of MST would report myriad negative intrapersonal consequences as a result of their traumatic experiences. The findings of this study illuminate the recursive nature of MST; the experience of sexual violence in the military is impacted by and affects each ecosystem in an individual's life. These results corroborate data of previous trauma and sexual violence literature (Mezey & King, 2000; Neville & Heppner, 1999; Peterson et al., 2011; Polusny & Murdoch, 2005; Schry et al., 2015; Street et al., 2007; Suris & Lind, 2008; Turchik, & Wilson, 2010), and also present evidence of how sexual violence in a military setting uniquely impacts individuals' lives and interpersonal functioning. As in the civilian world (Breiding et al., 2014), events of MST are diverse. Participants reported experiences ranging from threatening noncontact sexual harassment to unwanted sexual touch to forced participation in sexual hazing rituals, rape, and gang rape. These events occurred across military contexts and geographical areas (i.e., across U.S. regions and overseas), including in barracks, in training theater, on deployment, in military education/training settings, and in private residences off station. Participants themselves represented multiculturally diverse backgrounds and were members of the Marine Corps,

Army, Navy, and Air Force. Although previous research suggested higher incidence of MST in noncombat veterans (Polusny and Murdoch, 2005), in the present sample, sexual orientation, education level, military era and branch of service, and combat status did not appear to impact the severity of ecosystemic consequences of MST. Importantly, these findings suggest that there exists no single pathway or overt intrapersonal, interpersonal, or contextual factors leading to sexual violence in the military system. However, all participants in the study were enlisted men and endorsed a grade/rank of E5 or lower when they experienced MST. These data suggest that enlisted males of lower rank early in their career may be at higher risk for MST, which supports previous research conducted by Mondragon et al. (2015).

Existent theories in empirical literature (e.g., feminist, emotional processing) conceptualize and explain the impact of sexual trauma on an individual's internal processes; however, these theories do not fully articulate the unique and overarching impact of male MST on multiple levels of functioning. The complexity of sexual violence occurring within a unique closed system such as the military necessitates employment of a theoretical orientation that underscores how a person simultaneously influences and is influenced by the multi-leveled environment. Thus, discussion of the present study's data and findings are framed within a three-tiered ecosystemic model; but first, factors existent across all three levels are presented.

Factors Present Across Ecosystemic Levels

Perpetrator factors affiliated with severity of reported effects. Previous research has demonstrated that MST is associated with higher levels of PTSD and depressive symptoms (Luterek et al., 2012; O'Brien & Sher, 2013; Schry et al., 2015).

Severity of reported PTSD symptoms and negative psychosocial consequences were associated with the number and gender of perpetrators as well as the type of MST event. Specifically, when MST included more sexually violent and invasive acts, participants reported deeper and more widespread negative experiences across systems of functioning. In particular, attempted and completed anal rape that included physical battery and more than one perpetrator were affiliated with the most severe intrapersonal and interpersonal problems. Conversely, the two participants who experienced MST events where the most severe action was threatening noncontact sexual harassment described fewer externalizing behavioral changes, but endorsed similar experiences of distrust in interpersonal relationships and negative views of the military system.

Further, when there were multiple, male perpetrators the participants reported more negative and long-lasting consequences in their lives. All four participants who experienced gang rapes or assaults reported symptoms consistent with a diagnosis of PTSD, as well as increased interpersonal distress and impairment consistent with findings described by Houppert (2005) and Turchik et al. (2012). In detail, these individuals reported increased interpersonal conflicts (e.g., fighting, arguing, intimate partner violence, couples sexual dysfunction) accompanied with isolation from family and friends and increased engagement in risky interpersonal behaviors (e.g., sexual behaviors, substance use, seeking physical fights). Further, each of the participants who experienced MST with multiple male perpetrators endorsed suicidal ideation, and two reported suicide attempts, which aligns with preliminary quantitative research by Schry et al. (2015) and Allard et al. (2011). This suggests the potential importance of more thorough, yet sensitive screening procedures and risk assessments of MST by

determining the number and gender of perpetrators in the MST experience to better identify individuals who may be at higher risk of lethal self-injury and interpersonal problems.

Stigma. Participants identified stigma as impactful across all conceptual levels of functioning. Hoyt et al. (2011), and Turchik et al. (2013) demonstrated that stigma—including fear of ridicule, accusations of homosexuality, and fear of ostracism—serves as a major barrier in reporting sexual trauma and seeking treatment. The present study supported these findings and provided further details about the impact of stigma. Participants experienced stigma (or fears related to stigma) interpersonally among fellow service members, military leadership, family members, friends, and medical providers. In addition to serving as barriers to disclosure and treatment-seeking, this fear of interpersonal stigma contributed to interpersonal avoidance and conflict both with other military personnel and with civilians immediately post-trauma and distally. However, data revealed that participants also experienced self-stigma, or internalized stigma and shame, regarding MST. For example, findings suggest internalized stigma associated with homosexuality and weakness. The high number of female perpetrators (i.e., disproportionate to the gender demographics of the military) reported by participants could indicate a greater comfort with disclosing MST perpetrated by a female than by a male, which suggests that stigma associated with homosexuality is greater than the stigma related to weakness. In addition, the participants disclosed an endemic stigma within the military culture, i.e., stigma not tethered to a particular person or group. Participants frequently anthropomorphized the Armed Forces or branches (e.g., saying, "the military" or "the Army") when discussing stigma present in the institution.

Another factor related to stigma existent across multiple ecosystemic levels centered on participant concerns related to cultural gender expectations and sexual orientation. Expanding on previous research presented by Turchik and Edwards (2012), findings demonstrated that on an intrapersonal level, male survivors of MST frequently questioned their masculinity and manhood, as well as their own sexual preferences or orientations. Intrapersonally, participants endorsed distress and negative emotions and behaviors based on questioning of their own self-concept. Overall, stigma's impact within the individual, micro/mesosystem, and macrosystem demonstrates its significance as a factor contributing to the overarching experience of MST in males, which must be addressed by both health providers and military leaders.

Recovery. Recovery and resilience represents an additional systemic element related to male MST across intrapersonal, interpersonal, and contextual levels. Consistent with trauma literature, healing was seen to be influenced by the individual's ability to identify meaning and value to their MST, which was often predicated by individual engagement in mental health treatment. Furthermore, as anticipated, participants noted that supportive relationships in their lives contributed to their ability to recover post-trauma. Some participants described contextual protective factors that may be relevant to recovery from MST (e.g., relocation that removes service members who experienced MST from the perpetrator), but also related to prevention. Although most participants described difficulties experienced within the military system, there exist many characteristics and aspects of the military that may be considered positive and protective factors against sexual violence. For example, as described by participants and previous empirical research (Hall, 2011), military units often serve as a surrogate family

where the service member feels a sense of belonging and protection. Although not reported in the context of the present study, this intimate environment could serve as a barrier to sexual violence, deterring assaults from occurring.

While perpetrator factors, stigma, and recovery were found to affect service members and veterans' lives across ecosystemic levels, multiple factors were determined to exist discretely within intrapersonal, interpersonal, and contextual levels.

Intrapersonal Level

On an individual level, the present study aligned with previously reported symptoms experienced following sexual violence in males both in civilian and military contexts (Katz et al., 2012; Kimerling et al., 2007; Luterek et al., 2012; O'Brien & Sher, 2013; Peterson et al., 2011; Schry et al., 2015, etc.). Emerging from the data, it is clear that individuals who experienced MST endorsed symptoms consistent with PTSD (e.g., avoidance, hypervigilance, heightened arousal, risky behaviors, sleep disturbance) and depression (e.g., anhedonia, low mood, thoughts of death). Further, participants endorsed immediate and enduring patterns of internalizing through questioning their inner experiences and self-concept, especially regarding safety, sexual orientation, and gender identity. Many individuals reported minimizing their experiences of MST, stating that "it wasn't that big of a deal" while simultaneously noting the far-reaching consequences of the trauma. Related to externalizing PTSD symptoms, many participants disclosed increased engagement in life-threatening behaviors in the years following their MST, which is consistent with reports by O'Brien and Sher (2013). These behaviors included suicide attempts, non-suicidal self-injury, actions reflective of lack of safety (e.g., dangerous driving practices, initiating physical fights), and substance use. Previous

research correlates were extended by the present study's findings that suggest increase in engagement in risky sexual behaviors (e.g., prostitution, promiscuity with high-risk partners, lack of prophylactic measures, self-harm during sex, and unsafe bondage and discipline/sadism and masochism practices) following MST.

The present study provided further information regarding both proximal and distal health-related consequences attributed to MST experience. Expectedly, participants endorsed physical injuries immediately following MST events (e.g., pain, tissue injuries, sexually transmitted infections [STIs]; Turchik et al., 2012); however, patterns of severe long-term physical effects were reported. Participants disclosed contracting STIs including HIV/AIDS, as well as testicular, prostate, and penile cancer, which participants stated were related to physical trauma endured during sexual violence. While multiple studies have reported health correlates of MST (Godfrey et al., 2015; Kimerling et al., 2007; Lapp et al., 2005; O'Brien & Sher, 2013; Schry et al., 2015; Turchik et al., 2012), quantitative studies have not captured these short- and long-term serious physical effects that may be related to male MST.

Interpersonal Level

In addition to intrapersonal information, data from the current study increased understanding of the micro- and mesosystemic effects of MST, addressing a gap in the MST literature. While general civilian trauma and PTSD research suggests deficits in interpersonal functioning (Anderson, 1982; Hall, 2011; Houppert, 2005; Mondragon et al., 2015), the present study provides insight into the individual's emotional and behavioral processes underlying the interpersonal deficits. Emerging from the data were numerous reports of immediate and longstanding turbulent, painful interpersonal

relationships following MST. Participants reported newly experienced distrust, caution, regret, fear, and avoidance across family, friend, and service member relationships. Consistent with emotional processing theory (Foa & Rothbaum, 1998), participants reported attempts to avoid any individuals that reminded them of an element of their MST experience. In addition, and similar to findings reported by Hall (2011) and Houppert (2005), some participants reported that fellow service members ostracized them for stigma-related reasons; other participants disclosed intense fears that they would be ostracized if their comrades learned of the sexual violence.

Gender of perpetrators. The present study presented new detail about perpetrators of male MST, including gender-related associations and the role of superior rank. Notably, almost half of the perpetrators in the present sample were female, which to date has not been examined in MST literature. However, it is possible that the high rate of perpetration by females is not representative of all MST since the participants in the present study were self-selected and may have felt more comfortable disclosing perpetration by a female. Yet, intrapersonally in the present study, female-perpetrated MST in males was affiliated with increased minimization strategies and personal invalidation of trauma-related symptoms. Multiple participants endorsed that it "shouldn't be a big deal" and presented the notion that they "should have wanted it" from a female. As previously mentioned, male perpetrators were associated with increased severity of reported ecosystemic effects. However, regardless of perpetrator gender participants reported questioning their sexual orientation and masculinity in the long-term following MST. This finding builds upon previous empirical literature regarding rape myths and cultural misconceptions of male sexual violence (Belkin, 2008; Coxell &

King, 2002; Davies, 2002; O'Brien et al., 2015; Polusny & Murdoch, 2005; Turchik & Edwards, 2012). For example, when perpetrators were female, many participants wondered why they did not emotionally or physically enjoy the experience, which led to questioning their sexual orientation, and for two participants, their gender identity. With male perpetrators, participants questioned what personal characteristics or behaviors caused the event to occur and wondered about their sexual orientation if they found the sexual stimulation to be physiologically arousing.

Rank of perpetrators. Consistent with theory that sexual violence is often motivated by power over sexual desire (Jones, 2000; Turchik & Edwards, 2012), perpetrator rank was typically the same or higher than that of the participant, demonstrating the role of power in sexual violence within the military. The violation of assailants' rank and power to perpetrate MST and to intimidate survivors following MST significantly impacted participants' relationships with other service members, family, and others. Notably, violation and betrayal of the sense of family within units and an inability to trust others were prominent findings. Overall the information about the gender and rank of perpetrators provides additional data that sexual violence within a military system is unique, and ties in to relevant contextual factors of MST.

Contextual Level

Participants' experiences in their military environment appeared to greatly influence their views of the world and engagement following MST, which builds upon the work of Lebowitz and Roth (1994) and Hall (2011). As previously suggested, the impact of the military command structure was present throughout each participant's narrative, highlighting how rank influenced the experience of MST (e.g., perpetrator has

power), disclosure of MST, and treatment following MST. Many participants disclosed how MST affected their perception of and trust in military, which Houppert (2005) noted is essential for successful functioning within the hierarchical system. As a result, participants endorsed feelings of betrayal and disillusionment, which suggests that treatments could focus on this betrayal and loss of community and identity, as well as the trauma-related symptoms. Findings further demonstrate the interpersonal and contextual ramifications of MST in regard to the military system, as well as the need for further development of interventions targeting the military.

Recent policy changes have emphasized increasing military education about MST, offering protections for those reporting MST, and improving screening procedures for MST. However, all participants in the study who are serving or served during OEF/OIF stated that policy changes have not yet influenced the overall cultural views of the military system regarding MST. Participants disclosed that "in theory" policies support the survivor of MST; however, in practice there remains the strong possibility of negative repercussions for reporting MST both in mesosystemic and macrosystemic levels, which coincides with the traditional military cultural values of masculinity and strength (O'Brien et al., 2015). Specifically, participants' reports of military contextual effects build upon concerns described by in the literature (e.g., Hall, 2011; Wilson, 2008), including reassignment of duties or unit, inability to receive higher clearances, and medical discharge. Further, the negative interpersonal repercussions reported include continued sexual violence, harassment, and ostracism. Specifically, OEF/OIF service members endorsed the same barriers to reporting MST as veterans from previous war-

eras prior to policy change related to stigma, fear of retribution or punishment, and disappointment with treatment options.

Clinical and Systemic Implications

Findings of the present study confirm previous research exposing the significant problems associated with military sexual trauma in males, and illustrate a number of implications relevant to mental health and medical providers in clinical practice, as well as opportunities for systems-based changes (e.g., military institution, Veterans' Health Administration). An ecosystemic conceptualization of the effects of male MST illustrates potential areas for growth in developing or modifying screening protocols, education and advocacy efforts, family or military unit-based interventions, and individual therapeutic treatments.

Examining the individual level (i.e., intrapersonal factors) of males who survived MST, it is evident that service members and veterans experience far-reaching negative intrapersonal concerns related to MST. Although many clinicians and mental health providers are trauma-informed, to better serve this population, it is imperative that providers working with male survivors of MST learn about the unique cognitive, emotional, and behavioral difficulties associated with male MST. For example, experiences of betrayal within the "military family"; feeling trapped within a system that "owns" the individual; experiences of stigma and internalized stigma or shame; feeling the loss of masculinity within a system where one's worth is related to ability to be a warrior; and potential loss of career, livelihood, and identity represent several distinctive aspects of MST. Current evidence-based treatments for trauma survivors may be adapted to include attention to these areas.

In the micro- and mesosystems of males who experienced MST, many service members and veterans across war-eras do not receive the appropriate psychological or medical treatment indicated. There are numerous factors contributing to lack of treatment, and one primary reason disclosed in the present study was barriers to reporting MST due to fears related to interpersonal consequences both in families and in their immediate military units. Addressing stigma and other factors that inhibit disclosure of MST is important; data from the present study suggest that participation in mental health and PTSD-focused treatment helped to alleviate functional impairment and distress, promoting post-traumatic growth. Similarly, decreasing stigma would likely facilitate reporting of MST in medical contexts, which presents the opportunity for receiving medical diagnoses and treatments early to ameliorate potential short-term (e.g., STIs) and long-term (e.g., cancer, HIV) harm. Additionally, social support may be limited for these individuals, which may be increased through group treatments or peer support in therapeutic settings.

Examining the exo- and macrosystem levels highlights the importance of access to resources and treatment. Several participants in the present study noted distance and lack of funding from VHA facilities preventing their engagement in treatment. Although VHA has increased access by providing telehealth services and mental health at community-based outpatient clinics, veterans may benefit from additional resources allocated to increase knowledge of and access to these technological programs. Participants noted the ease at which they were able to participate in the present study due to the use of confidential, HIPAA-compliant telehealth technologies. This aligns with research conducted by Burgess, Lee, and Carretta (2016) who found that males who

experience MST are less likely to disclose MST and may do so for the first time in an online format. Further, findings of the present study demonstrate the need for additional development of interventions targeting the military system, including decreasing stigma around MST and general mental health treatment, increased education about male MST, targeting of prevention strategies, implementation of policies reducing the stigma of MST, increased access to treatment services (e.g., embedded mental health model), and development of MST-specific trauma-focused treatments.

Limitations

Although this study provides valuable information regarding the comprehensive ecosystemic effects of MST in male service members and veterans and important clinical implications, there are several limitations to the current research. First, as is common in qualitative methodology, the present study included data from a relatively small sample of 12 participants, which was determined to be the point of data saturation. While these participants were representative of the United States population in race/ethnicity, age, and geographical regions, results may not be highly generalizable. Specifically, the experiences of these self-selected 12 male service members and veterans are not representative of all male service members and veterans who experienced MST. Furthermore, 10 out of 12 participants were veterans, which limits the perspective of active duty service members in the data.

Additional limitations of the study pertain to methodological procedures that impact trustworthiness, credibility, and dependability of the study. Although the present study design adhered to Morrow's (2005) recommendations for increasing these psychometric properties in narrative inquiry analysis, one step—cross-checking of coding

and analysis by multiple researchers—was not completed. All coding and analysis was conducted independently by the primary investigator. Therefore, assertions regarding the dependability (i.e., reliability) of the study may be limited. In addition, because of the self-report and retrospective process of narrative qualitative design, it is not possible to determine the exact relationship (i.e., causality) of MST and the negative effects reported by participants, which, therefore, warrants further research to replicate findings.

Directions for Future Research

While causal attributions cannot be determined from findings of the present study, the depth and richness of the data present some patterns worthy of further empirical investigation. The unique findings of this study indicate further research is merited to attain a more comprehensive understanding of the far-reaching effects of MST in male service members and veterans. Results of this study are consistent with findings of previous research examining MST, yet there remain many gaps in the empirical literature surrounding conceptualization, prevention, and treatment of male MST on intrapersonal, interpersonal, and contextual levels. Therefore, further examination is needed across all ecosystemic dimensions related to MST. Specifically, future research should include inquiry into the experiences specific to the service member who endorsed MST (individual level), the interpersonal relationships impacted by MST (micro- and mesosystems), the relevant organizations and systems influencing and influenced by MST (exosystem), the overall cultural influence (macrosystem), as well as the impact of time and development on MST experiences (chronosystem).

The scientific community may best expand understanding of MST through continued qualitative research that identifies themes and concepts to next be examined

through quantitative methods both within the military or VA system, and through unaffiliated methodology. Some MST-related concerns requiring further inquiry include (a) risk factors for experiencing MST (e.g., prior histories of abuse, service member positions, organizational power, substance abuse as discussed by Schry et al., 2015 and Turchik & Wilson, 2010); (b) the overall experience of MST in diverse populations, such as sexual minorities and racial/ethnic minorities; (c) the experience of MST in active duty service members as opposed to veteran populations (d) the role of perpetrator factors (e.g., gender, rank, position) on the effects of MST; (e) barriers to reporting male MST in OEF/OIF service members; (f) preferences and access to MST-related treatment; (g) effectiveness and efficacy of treatments specifically for male MST; (h) development of interventions for families and military units impacted by MST; (i) systemic factors contributing to resiliency and recovery specific to male MST; and (j) systematic development and evaluation of protocols related to education, prevention, and management of MST within the military system and federal government.

Overall, findings of the present study indicate that the continued endeavor to better understand MST in males is particularly important given three main factors: (a) the undiscriminating prevalence of male MST across war-eras and military contexts, as well as irrespective of all demographic factors, (b) the history of discrimination and abuse of power experienced by those who survived MST, and (c) the extensive negative effects of MST that impact all domains—intrapersonal, interpersonal, and contextual—of a service member's life.

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