Institutional Support After Military Sexual Trauma: The Experiences of Canadian Women Service Members

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ABSTRACT

The purpose of this paper presentation is to share research findings of a study that explored the individual experiences of military sexual trauma of 19 women Veterans of the Canadian Armed Forces during their service. Specifically, the presentation will focus the experiences that women had with various departments and organizations throughout their journey of recovery from military sexual misconduct during service. It is important to understand individual experiences, particularly experiences related to the departments and organizations that are meant to help people who have been impacted by MSM/MST. The findings of this study directly address the challenges identified in the current workshop- that strategies are often targeting individual-level factors rather than addressing military culture as a whole. The presentation is grounded in individual experiences of how military culture has informed services within the organization that are meant to help (e.g., health services, mental health services, reporting mechanisms). Interviews in our study focussed on the impacts of the trauma on participant daily functioning, mental, physical, and emotional health, relationships, careers, as well as experiences of reporting and receiving help.The study has found that positive experiences including validation and support from military departments and organizations during recovery process resulted in better overall outcomes. The experiences described in the study are significant to understanding what is required within the CAF to be trauma-informed.

1.0 PREAMBLE

The McMaster University Trauma and Recovery Research Unit with Dr. Margaret McKinnon as principal investigator completed a study entitled, “Impact of sexual trauma during military service on Canadian female-identifying military members and Veterans”. The study consisted of two main parts, Arm One, that analyzed the data from 2941 respondents to the 2018 Canadian Armed Forces Members and Veterans Mental Health Follow-up Survey and the second part, Arm Two, that focused on the conducting 19 qualitative interviews with women Canadian Armed Forces (CAF) Veterans. The current paper presents some of the results from Arm Two of the larger of the study. The authors of this paper would like to acknowledge contributions of the team: Alexandra Heber, Andrea Brown, Ashley Ibbotson, Heather Millman, Bethany Easterbrook, Ashley Williams, Anita Acai, Senay Asma, Jillian Lopes, Charlene O’Connor, Anthony Nazarov, Ruth Lanius, and Rosemary Park

2.0 BACKGROUND

Recent research has pointed to the mental and physical health impacts that women experience due to exposure to military sexual misconduct (MSM) and military sexual trauma (MST) during service. In women service members, MST is associated with physical health challenges and difficulties in work and other activities. For example, MST has been shown to affect military operational readiness in a sample of United States military members (Millegan, 2015). In addition, women Veterans’ exposure to MST is associated with

specific physical health problems such as chronic pain conditions (Cichowski et al., 2017) and greater risk of incident hypertension (Yalch et al., 2018).

Military sexual trauma is also associated with greater risk for the development of mental health disorders, including substance use disorder and post-traumatic stress disorder (PTSD) (Goldberg et al., 2019; Yalch et al., 2018). Further, when treatment is available, women Veterans who have experienced MST may struggle to identify their feelings (O'Brien et al., 2008), regulate their emotions, and engage in treatment (Lopez et al., 2022).

Another factor linked to MST and MSM is institutional betrayal. Institutional betrayal can occur when harm is caused by an institution that is trusted and depended upon by the affected individual. In a 2016 study by Monteith and colleagues, they found that US Veterans exposed to military sexual trauma reported perceptions that the military, as an institution, created a workplace where sexual misconduct was commonplace and that it did little to proactively prevent misconduct from happening. This is in part to challenges faced by study participants when reporting incidents of MST and inadequate institutional response to reporting. These factors contributed to feelings of institutional betrayal and were associated with PTSD symptoms, depressive symptoms, and overall poorer physical and mental health outcomes (Monteith et al., 2016; Monteith et al., 2022).

The focus of the current paper is to describe the experiences that women had with military departments, and organization, programs and/or services within and external to the military during their recovery journey from military sexual misconduct during service. It is important to understand individual experiences, particularly experiences related to the departments and organizations that are meant to help people who have been impacted by MSM/MST.

The paper is grounded in individual experiences of how military culture has informed services within organizations and programs that are meant to help (e.g., health services, mental health services, reporting mechanisms). Interviews in our study focussed on the impacts of the trauma on various areas including participant daily functioning, mental, physical, and emotional health, relationships, careers, as well as experiences of reporting and receiving help.

3.0 METHOD

Nineteen qualitative interviews with women CAF Veterans were conducted by the research team. These same participants also completed 9 self-administered psychometric scales that evaluated their emotional and mental health and wellbeing that are not included in the current paper. Taking a social constructivist approach, this study focused on allowing women to narrate their own experiences of MST and MSM with the use of guided questions in combination with psychometric evaluations. The study questions centred on how MST and MSM influenced participants' experiences of the world with respect to daily functioning, relationships, identity, and military culture. Questions on military service, the responses of leadership to MST and MSM, and access to supports related to MST and MSM, were also included.

A constructivist perspective was used to inform the development of the qualitative interview guide. Constructivism defines knowledge as socially constructed through language used and interactions people have with one another and their environment (Tracy, 2013; Giacomini, 2013). The social constructivist perspective of this study enabled participants to engage in reflection of their experiences to create shared meanings of their experiences and effects of military sexual misconduct and trauma while taking into consideration the role of the environments and relationships that shaped those experiences. *Reality* as explored and described in this study is but one claim among multitudes possible. The perspective that knowledge is relative and not absolute offers findings that are contextualized within the specific lived experiences of the study participants and therefore, are open to ongoing interpretations.

Constructivist researchers aim to understand meaning and context of the experiences of study participants (Potvin et al., 2014; Tracy, 2013) while taking into consideration how participants experience and reflect on their realities. *What is reality* is always mediated through the observer, in this case, knowledge of reality is understood through the researcher (Tracy, 2013). Because of this mediation, it is important to acknowledge that research cannot be truly neutral and unbiased because the researcher, as mediator, will always affect the outcome of the study. Instead of focussing on neutrality, qualitative researchers including those working within a constructivist framework seek to understand their own biases and how the social construction of their own lives as researchers colours the process and interpretation of their research.

It is important to note that our qualitative interviews are context specific. Therefore, findings cannot be generalized beyond the specific context of woman-identifying Canadian Veterans who experienced military sexual misconduct and military sexual trauma during service.

The interview questions encouraged participants to explore various aspects of their lives to understand the effects of MSM/MST and any potential development of moral injury. Interview questions were focussed on impacts on participants' mental and physical health, social functioning, relationships, activities of daily lives, as well as their experiences of reporting and/or seeking support, if relevant.

3.1 Recruitment

The study protocol was granted ethical clearance by the Hamilton Integrated Research Ethics Board (no. 11563). A study Standard Operating Procedure document was created by the lead research coordinator and shared with the team to ensure each team member followed the same processes for recruitment, initial contact with participants, the interview, participant follow-up, study progress/data tracking, and secure data storage as outlined in the research ethics board approval.

Purposive sampling was used to recruit participants, Veterans of the CAF who have experienced MST and MSM during service. Recruitment methods included distribution of study information through existing networks such as the Canadian Military Sexual Trauma Community of Practice, and INJ20K and social media including Twitter which was shared by various network collaborators (e.g., Altas Institute for Veterans and Families, Canadian Institute for Military and Veteran Health Research). Researchers' professional networks and snowball sampling were also used to support recruitment efforts.

A dedicated email address, that was only accessible by the research team, was set up to correspond with potential study participants. When potential participants emailed the dedicated address expressing interest, they were sent a salutation email which included a unique REDCap link. REDCap is a secure web application regularly used by the McMaster Trauma and Recovery Unit and the wider Faculty of Health Sciences at McMaster University for building and managing online surveys and databases and for the virtual collection of study data. The REDCap link took participants to a detailed Letter of Information and Consent that outlined the scope of the current study, as well as any risks and benefits, permission to audio record the interview, permission to share direct quotes, etc. On clicking the link, participants could sign the virtual consent form and complete the series of mental health and wellbeing questionnaires. Once the informed consent and questionnaires were completed on REDCAP, participants were contacted via email to schedule an interview.

Interviews were completed via Zoom video conferencing platform by an experienced, trauma-informed, qualitative interviewer from the Trauma and Recovery Research Unit. Care was taken to ensure that interviewers had an opportunity to debrief and receive support with the project lead who is a registered mental health clinician. All interviews were digitally recorded and uploaded to a secure McMaster University cloud-based server, MacDrive. The interviews were all voice modified using Audacity Software, a multi-track audio editor recorder, prior to forwarding to a professional transcriptionist. Care was also taken to ensure the safety and well-being of the transcriptionist. Once interview transcripts were completed, they

were stored on MacDrive for analysis. All transcripts were de-identified of names, locations (e.g., names of city/town, deployments, years of service, and service elements/occupations). Safety of participants was considered paramount, so the protocol included a check-in call or email to each participant 24 hours after their interview, as well as provision of a mental health resources document.

3.2 Data Analysis

All de-identified interview transcripts were uploaded for analysis using MAXQDA, a computer-based software analysis program to support qualitative data analysis. Directed approach of content analysis was used to inform the process of data analysis. Directed approach to content analysis is typically used to augment existing research or prior knowledge about a specific phenomenon (Hsieh & Shannon, 2005). The objective when using the directed approach is to validate or supplement what has already been established (Hsieh & Shannon, 2005) and as such, is a suitable method for analysing data exploring the effects of MSM/MST on women servicemembers in Canada.

All interview transcripts were subjected to initial rough coding based on categories articulated in the coding book which was informed by the research objectives of the study and interview questions used. During the initial or open coding, transcripts were reviewed, and segments were broken down, examined, and classified. Axial coding followed, which involved comparing and contrasting the codes generated during the open coding process that resulted in a classification tree. Selective coding then identified main themes which framed the findings of this study. Constant comparison was completed throughout to ensure saturation of data. Throughout this process, primary themes, or codes, were identified from participant discussions that arose from the question guide. Study rigour was ensured through an audit trail, multiple independent coders, and data triangulation.

A GBA+ lens was used in the analysis of both qualitative and quantitative data by examining factors such as gender-identity, sexual orientation, and ethnicity (including First Nations status and Indigenous identity) to better understand potential impacts of these factors. Data from the demographic questionnaire and screening tools has been analyzed using descriptive statistics. Overall estimates of positive screen for each questionnaire have been calculated using the mean scores and published guidelines for cut offs. Correlations have been done between symptom scores on each screening measure and the total sample.

4.0 RESULTS

4.1 Sample Description

All participants completed a demographics questionnaire to better understand who completed the study. The demographics are presented in Table 1 and Table 2 below.

Figure 1-1: Demographics

Demographic characteristics (n=19)	Frequency (%)
Gender	
Cisgender woman	13 (68%)
Other gender identity	6 (32%)

Age		
	30-49	9 (47%)
	50+	10 (53%)
Ethnicity		
	North American	11 (58%)
	European	9 (48%)
Province		
	Central Canada (ON/QC)	11 (58%)
	Other (BC, AB, SK, MB, NB, NS, NL, PEI)	8 (42%)
Education		
	High School or College (some or diploma)	6 (31%)
	University (some or graduated)	13 (69%)
Marital Status		
	Married/common law	12 (63%)
	Other	7 (37%)
Sexual orientation		
	Heterosexual	13 (68%)
	Other	6 (32%)
Children		
	Yes	13 (68%)
	No	6 (32%)
Income		
	$50-100k	8 (42%)
	$100+k	10 (53%)

Prefer not to say	1 (5%)
Employment status	
Part-time	6 (32%)
Full-time	6 (32%)
Retired/other	7 (36%)

All participants in the study identified as female with 13 (68%) identifying as cisgender. While 32% of our sample identifying as 'other' is notable, it is not reflected in how participants discussed their relationship to gender and identity in our interview data, even when discussing gender expression. It is possible that participants may have not understood some of the terminology or may have been referring to sexuality rather than gender, as not all the women in the sample were heterosexual. Approximately half of the sample were under the age of 50 and 90% identified as white. Most participants (58%) lived in central Canada. Most (90%) attended or graduated from post-secondary institutions. At the time of the study, 63% of the sample were married or living common-law with a partner and 68% had or were raising children. Approximately two-thirds of the sample were working part-time (32%) or full-time (32%).

Figure 2-1: Military Demographics

Military Service Demographics (n=19)	Frequency (%)
Service	
Army	10 (53%)
Air Force/Navy/Other	9 (47%)
Release	
Voluntary	9 (47%)
Medical	9 (47%)
Years in military	
0-10 years	7 (37%)
11-20 years	7 (37%)
21+ years	5 (26%)
None	

Slightly more than half of the study participants had served in the Army (53%) and a third had served in the

Air Force (31%). Occupations served included logistics, infantry, medical, and administrative. Sixty-three percent of participants served for 10 years or more with the range being from two years to more than 30 years. Approximately half of participants had released voluntarily (47%) or had received a medical release (47%).

4.2 Resources, Services, and Supports

Participants reported accessing a variety of mental health professionals including psychiatrists, social workers, counsellors, psychosocial support personnel, and psychologists within CAF Health Services and civilian communities while serving or ongoing care in their communities as Veterans. Participants shared receiving 1:1 counselling as well as therapist-facilitated group sessions such as those offered through Operational Stress Injury (OSI) Clinics across Canada. One participant expressed her wish for more peer-led groups as another support option:

> It was one of the things we wanted is to have a peer support network because uh, that can be very powerful but every individual does healing in a different way and needs different resources so some may be fine uh, with nothing, some may be fine with getting a hug from a friend, all the way up to intense counselling and intense uh, peer sessions, right, like it really is, is different so I think it's important that we have many tools in the toolbox uh, to give people just different avenues of how to get help if they need it.

Peer-based programs were identified as being helpful as a source of information for additional services and resources available to those who experienced MSM/MST. This participant shared her involvement in a Veteran women's workshop where she met other women creating an informal support network for her:

> Back in March I went to this um, uh, this uh, a life shop for Veteran women and um, it was a weekend retreat type thing. I went, I was completely out of my comfort zone but something was telling me I needed to do this so I went there, there was absolutely nobody there that I knew um, and I walked outta there with some pretty amazing female bonds who all live in the (name of city) area and that was the biggest thing is I moved to this area in, in the midst of Covid so I didn't know what type of resources and stuff were out there for me but because I've met all of these women who are also MST survivors um, they um, have hooked me up with a lot of other types or resources that I can tap into with regards to support um, and I think that's very important is to have, have a network of people that you can trust and um, and they can help you with those types of things um, because otherwise I would not have known where to start and that wasn't because of Veteran's Affairs, I mean they're all about psychiatrists and trauma therapists and all of that so um, but yeah there's just so many other things that are you there you know, whether it be art therapy or, you know those types of things.

Awareness of what resources, services, and supports are available within the military and community was generally poor, according to the participants. Some report that Veterans Affairs Canada, by way of their Case Manager, was the gatekeeper to enable access to mental health supports. Other participants shared that that

they learned about MST-specific resources, services, and supports through friends, the media, or on-line discussion groups, such as those found on Facebook, or on-line support groups like INJ20K.

This participant noted that many, while serving, are not aware that there are resources, services, and supports available to them that are outside of the military. One participant expressed that there should be a system established within the military to communicate information about organizations accessible to members, as explained here:

> They need to have these teams that can actually sit down and be like okay we need to discuss, we need to whatever or just also have people more readily available and let people know that they can access outside sources without going through your medical team. So like I know that if I wanna go see somebody off base, I can go see them off base, like and if they wanna slap my hand for it they can fucking do it, I don't care but my care and my health and my mental state is gonna come first from now on, period, end of story. Whereas a lot of other people don't have that mentality, right, they have that nope the military tells me I can only do this one thing so I have to go and I have to see my clinician and this is the only thing I can do. So there just needs to be more um, more verbalization that you can access outside services too, 'cause there are sexual assault centres and, and services outside of the military right now that could be totally utilized but um, yeah, they just aren't because they tell you nope everything has to come on base.

Regardless of whether the resources, services, and supports were provided on-base or in the civilian community, the quality of care was emphasized in the discussions with participants. Service providers' ability to provide care that was informed by an understanding of the participants' experiences of MSM and MST was important to the overall quality of care received. This participant shared a positive example how her team of care providers gathered relevant information about her military trauma in preparation of meeting her as described here:

> …It's the (name of city) Wellness and before they did my assessment, they watched The Fruit Machine and they had my whole binder of my purge documentation, it had all the military medical, all the paperwork, SIU stuff, it had everything in there. The took it and read through it, and watched The Fruit Machine to understand that the hell is this purge because they haven't seen it. This was all new to them because nobody could come forth. They didn't, they didn't know any of this went on in the Canadian Armed Forces, they were kinda shocked but because they took the time to understand it before they assessed me, I had great respect for them, trust, and that's why I, I refer people to (name of city) for their uh, assessments 'cause I know they're gonna get a proper assessment.

For this participant, she reported having specialized trauma care in the civilian community as an important aspect of her recovery:

> I wanted like a, a specialized trauma therapist so I did get that, I had to wait a little while but that made a huge difference. So, and then the option to go off base to see an actual professional somewhere, that yeah really was nice to

> know, and I've told that to lots of other people um, that it is an option. So being able to have like yeah, services in the community, yeah, it's a lot better than, yeah that's really positive.

In contrast, was this participant's experience where she described how the service provider had no experience working with a Veteran:

> The first therapist I saw had never met a Veteran in her life, you know, let alone a female so I felt like a shiny penny and, and I, she was very unreliable and not, not helpful at all so I quit seeing her.

For another participant, even when service providers had experience working with Veterans, such as those in the OSI Clinics, she found that there is lack of understanding on the mental health effects of MSM and MST as she described here:

> I had asked to go to the Operational Stress Injury Clinic to see them in (name of city) and they kept telling me you didn't get hurt in Afghanistan you're not entitled to go so they just kept, they gave me different drugs and gave me all kinds of drugs and nobody put me in the hospital.

The same participant further discussed how there is a significant gap in knowledge about MSM and MST and their impacts within the health community and Canadian society. She shared:

> Yeah, I think, I think there needs to be more research on this, I think there needs to be more education on this because even, even now like my therapist, like I've, I've told little snippets now to friends, tried to tell my relatives really they were not supportive but uh, people, people don't get how much trauma it can cause, they get maybe that if, you know, you're overtly beaten up and raped that it can mess you up or if you see somebody blown up that can mess you up but they don't get just working in a threatening, unwelcoming, discriminating environment that day.

5.0 DISCUSSION

A variety of experiences were shared by participants when describing how and what resources, programs, and services were accessed throughout their recovery journey. Despite the many positive outcomes attributed to traditional forms of mental health care (e.g., psychology, social work, psychiatry), there were several comments made, asking for a greater variety of resources, with an emphasis on innovative, group, and peer-led support programs and services. Evidence-based, group-based treatment programs have been described throughout the literature as being successful for women who have experienced MST, including a study describing a trial of the Brief Warrior Renew group therapy for military sexual trauma (Katz & Sawyer, 2020). The Brief Warrior Renew is a manualized protocol targeting coping skills to manage emotions and address unique aspects of MST such as institutional betrayal. The study of this group therapy found that participants' scores reflect decreased symptom levels of anxiety, depression, posttraumatic stress disorder, and negative thinking with large to very large effect size (Katz & Sawyer, 2020), suggesting efficacy of such a program with this specialized population.

An innovative intervention that is being suggested to be used with evidence-based psychotherapies is

trauma-sensitive yoga (Zaccari et al., 2022). A pilot randomized-control study was conducted to explore the effectiveness of trauma-sensitive yoga compared to cognitive processing therapy for women Veterans with posttraumatic stress disorder related to military sexual trauma (Zaccari et al., 2022). This study found that yoga was helpful, particularly for African American women, warranting further research with more diverse populations of people affected by MST. The benefits of trauma-informed yoga with women service members in the United States who have experienced MST were also highlighted in a mixed method study by Braun et al. (2021). In this study, women reported improvements in their symptoms, diet, exercise, alcohol use, sleep, and pain, as well as decreased use of their medications. Quantitative measures used across various time points in the study found decreased affective dysregulation and shame, and increased use of mindfulness (Braun et al., 2021). Increasing the variety and availability of different resources and interventions such as those being provided in the United States, may be appropriate to meet some of the needs identified by women Veterans in Canada.

The need for increased military cultural competency has been identified for specific military-connected populations in Canada, such as families (Tam-Seto et al., 2018; Tam-Seto et al., 2019), of women Veterans (Tam-Seto & English, 2019), and health care providers (Ray & Heaslip, 2011; Robson, 2021); however, further education and training is required for those supporting women Veterans who have been affected by MSM and MST. Although the current study did not look specifically at the nature of the interactions that participants had with health care and social service providers, it was evident that positive experiences were reported when there was evidence of an understanding of how military sexual trauma differed from sexual trauma experienced in the civilian world. A dedicated study exploring how healthcare providers communicate with service members and Veterans who have experienced MST would be beneficial in the Canadian context. A similar study was conducted with Veterans Health Administration providers in the United States (Street et al., 2021) that saw generally quite positive experiences according to Veterans who were interviewed.

In Canada, there have been recent efforts made to address institutional responses and create mechanisms for prevention. From McMaster University's Trauma and Recovery Research Unit, "B.E.S.T.- Believe, Empower, Support, Together: A trauma informed sexual misconduct training for leaders at all levels of the CAF" has been developed and is currently being delivered across the CAF. B.E.S.T. is evidence-based training that was designed to engage participants from the CAF including commissioned and non-commissioned members, recruits, trainees, students enrolled in the Royal Military College and Department of National Defence employees. The program, facilitated by registered mental health professionals, uses discussion and role play to allow participants to identify Military Sexual Trauma (MST)- related scenarios and develop strategies that would be helpful for addressing these scenarios.

The principles of the B.E.S.T. training is grounded in the following:

1. Commitment to a collaboration between persons with lived experience (PWLE)[1] of MST and clinicians specializing in MST to deliver a training facilitated by members of both expert groups to leaders at all levels of the CAF.

2. Teaching facts (crucially, including statistics on the CAF) about MSM and MST through myth busting and small-scale group discussion and exploration.

3. Understanding how to create safe spaces by engaging with trauma-informed approaches and role playing a disclosure of sexual misconduct received by a supervisor.

[1] *We use the term "PWLE" over terms such as "survivor" or "victim" as it is a neutral term which allows the PWLE to explain how they relate to and experience the concept of their own identity as related to their own experiences.*

4. A closing discussion activity to solidify learning objectives. The discussion will take the form of a World Cafe activity to create dynamic and engaging discussions.

The program is designed to integrate active learning through activities such a structured sharing, role play, small group discussions, and learning and practicing the principles of active listening. The smaller sized group format enables participants to share their own experiences of dealing with disclosures, reflecting on their past role as bystanders and intervenors, and having open discussions on topics such as: how and when to intervene when a team member makes an inappropriate sexualized or discriminatory comment, when a comment or joke negatively targets certain groups, when one witnesses other negative or harmful behaviour.

Most significantly is that B.E.S.T. incorporates the voices of PWLE of MST who have helped create the program and facilitate training sessions. The session focuses on the lived experience as it relates to:

1. Strategies for engaging in general dialogue and speaking to a person with lived experience;
2. Methods for supervisors to approach difficult conversations, including conversations that may involve disclosure of sexual assault, harassment, violence, or other similar harm;
3. Strategies for building the personal and professional trust needed to facilitate difficult and personal conversations;
4. Awareness of the strong emotions that may arise for supervisors and PWLE when discussing psychologically and physically traumatic events;
5. The importance of using a Trauma-Informed Approach in conversations, to avoid sanctuary trauma, institutional betrayal, moral injury, and inadvertent increase in mental health-related symptoms.

6.0 LIMITATIONS

The findings of this study are limited to those who participated in the current study and therefore, may not be generalizable to the wider community of those impacted by MSM and MST in Canada. The sample size of the study is small and demographically quite narrow. The study would benefit from a larger range of participants representing the diversity of those affect by MSM and MST. Increased diversity in sex, gender, sexual orientation, race, ethnicity, rank, occupation, geographic location, and age are among the factors that require further representation.

7.0 WORKS CITED

[1] [1] Braun, T. D., Uebelacker, L. A., Ward, M., Holzhauer, C. G., McCallister, K., & Abrantes, A. (2021). “We really need this”: Trauma-informed yoga for Veteran women with a history of military sexual trauma. *Complementary Therapies in Medicine, 59*, Article 102729.https://doi.org/10.1016/j.ctim.2021.102729

[2] Cichowski, S. B., Rogers, R. G., Clark, E. A., Murata, E., Murata, A., & Murata, G. (2017). Military sexual trauma in female veterans is associated with chronic pain conditions. *Military Medicine, 182*(9), e1895-e1899. https://doi.org/10.7205/milmed-d-16-00393

[3] Giacomini, M. (2014). Theory matters in qualitative health research. In I. Bourgeault, R. Dingwall, & R. De Vries (Eds.), The SAGE handbook of qualitative methods in health research. SAGE.

[4] Goldberg, S. B., Livingston, W. S., Blais, R. K., Brignone, E., Suo, Y., Lehavot, K., Simpson, T. L.,

Fargo, J., & Gundlapalli, A. V. (2019). A positive screen for military sexual trauma is associated with greater risk for substance use disorders in women veterans. *Psychology of Addictive Behaviors*, *33*(5), 477-483. https://doi.org/10.1037/adb0000486

[5] Hsieh, H.-F., & Shannon, E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, *15*(8), 1277-1288. https://doi.org/10.1177/1049732305276687

[6] Katz, L. S., & Sawyer, W. N. (2020). Pragmatic trial of brief warrior renew group therapy for military sexual trauma in VA primary care. *Psychological Services*, *17*(4), 433-442. https://doi.org/10.1037/ser0000325

[7] Lopez, C. M., Gilmore, A. K., Brown, W. J., Hahn, C. K., Muzzy, W., Grubaugh, A., & Acierno, R. (2022). Effects of emotion dysregulation on post-treatment post-traumatic stress disorder and depressive symptoms among women veterans with military sexual trauma. *Journal of Interpersonal Violence*, *37*(15-16), NP13143-NP13161. https://doi.org/10.1177/08862605211005134

[8] Millegan, J., Milburn, E. K., LeardMann, C. A., Street, A. E., Williams, D., Trone, D. W., & Crum Cianflone, N. F. (2015). Recent sexual trauma and adverse health and occupational outcomes among U.S. service women. *Journal of Traumatic Stress*, *28*(4), 298-306. https://doi.org/10.1002/jts.22028

[9] Monteith, L.L, Bahraini, N.H., Matarazzo, B.B., Soberay, K.A., & Partnitzke Smith, C. (2016). Perceptions of institutional betrayal predict suicidal self-directed violence among veterans exposed to military sexual trauma. Journal of Clinical Psychology, 72, 743-755.https://doi.org/10.1002/jclp.22292

[10] Monteith, L. L., Holder, N., Iglesias, C. D., & Holliday, R. (2022). Institutional betrayal and closeness among women veteran survivors of military sexual trauma: Associations with self-directed violence and mental health symptoms. *Journal of Trauma & Dissociation*. Advance online publication. https://doi.org/10.1080/15299732.2022.2120152

[11] O'Brien, C., Gaher, R. M., Pope, C., & Smiley, P. (2008). Difficulty identifying feelings predicts the persistence of trauma symptoms in a sample of veterans who experienced military sexual trauma. *The Journal of Nervous and Mental Disease*, *196*(3), 252-255. https://doi.org/10.1097/NMD.0b013e318166397d

[12] Potvin, L., Bisset, S. L., & Walz, L. (2014). Participatory action research: Theoretical perspectives on the challenges of researching action. In I. Bourgeault, R. Dingwall, & R. De Vries (Eds.), The SAGE handbook of qualitative methods in health research. SAGE.

[13] Ray, S. L., & Heaslip, K. (2011). Canadian military transitioning to civilian life: A discussion paper. *Journal of Psychiatric and Mental Health Nursing*, *18*(3), 198-204. https://doi.org/10.1111/j.1365-2850.2010.01652.x

[14] Robson, H. (2021). *Cultural humility in health care: Why it matters and recommendations for the CFHS*. https://www.cfc.forces.gc.ca/259/290/22/305/Robson.pdf

[15] Street, A. E., Shin, M. H., Marchany, K. E., McCaughey, V. K., Bell, M. E., & Hamilton, A. B. (2021). Veterans' perspectives on military sexual trauma-related communication with VHA providers. *Psychological Services*, *18*(2), 249-259. https://doi.org/10.1037/ser0000395

[16] Tam-Seto, L., & English, A. (2019). Need for cultural competency in the mentorship of female Veterans during civilian transitions. *Journal of Military, Veteran and Family Health*, *5*(1), 115-118. https://doi.org/10.3138/jmvfh.2017-0049

[17] Tam-Seto, L., Krupa, T., Stuart, H., Aiken, A. B., Lingley-Pottie, P., & Cramm, H. (2018). Identifying military family cultural competencies: Experiences of military and Veteran families in Canadian health care. *Journal of Military, Veteran and Family Health, 4*(2), 48-60. https://doi.org/10.3138/jmvfh.2017-0030

[18] Tam-Seto, L., Krupa, T., Stuart, H., Lingley-Pottie, P., Aiken, A., & Cramm, H. (2019). The validation of the military and veteran family cultural competency model (MVF-CCM). *Journal of Military, Veteran and Family Health, 8*(1), 96-108. https://doi.org/10.3138/jmvfh.2017-0030

[19] Tracy, S. J. (2013). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. Wiley-Blackwell.

[20] Wieskamp, V. N. (2019). "I'm going out there and I'm telling this story": Victimhood and empowerment in narratives of military sexual trauma. *Western Journal of Communication, 83*(2), 133-150. https://doi.org/10.1080/10570314.2018.1502891

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

[22] Zaccari, B., Loftis, J. M., Haywood, T., Hubbard, K., Clark, J., & Kelly, U. A. (2022). Synchronous telehealth yoga and cognitive processing group therapies for women veterans with posttraumatic stress disorder: A multisite randomized controlled trial adapted for COVID-19. *Telemedicine Journal and e-Health*. Advance online publication. https://doi.org/10.1089/tmj.2021.0612