MILITARY SEXUAL TRAUMA AND INTIMATE PARTNER RELATIONSHIPS

IN ARMS: EXPLORING THE EFFECTS OF MILITARY SEXUAL TRAUMA ON INTIMATE PARTNER RELATIONSHIPS

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Lay Abstract

The present thesis explores how military sexual trauma may affect intimate partner relationships. The work highlights how the literature discusses and describes the link between sexual assault that occurs in the military, posttraumatic stress disorder, and intimate partner relationships. In addition, the work explores concepts related to the experience of sexual assault in the military, such as betrayal, guilt, shame, as well as military culture. The thesis also identifies and summarizes information about therapeutic interventions being used with couples who are affected by military sexual trauma. The present body of work contributes to the growing understanding of how military sexual trauma affects intimate relationships and survivors, while also informing research, clinical services, and policymakers who are making meaningful change in the health and wellbeing of military members and their partners.

Abstract

Introduction: Sexual misconduct is a pervasive and deleterious issue within military contexts. Commonly cited psychological sequelae of sexual assault include anxiety, depression, suicidality, posttraumatic stress disorder (PTSD), as well as interpersonal relationship functioning issues. The experience of military sexual trauma (MST) is unique in that the environment in which the harm occurs, the culture, plays a significant role in the impact of the harm on survivors. MST is often also related to feelings of institutional betrayal and moral injury. While clinical treatment of interpersonal trauma history is common, there is a lack of research regarding the development and efficacy of clinical interventions used with couples affected by MST. The objective of the thesis is to examine how dimensions and impacts of MST affect intimate partner relationships.

Methods: A multi-method qualitative approach was taken in the thesis, including a scoping review and two narrative reviews, contextualized using primary qualitative data in the conclusion chapter.

Results: MST affects dimensions of intimate partner relationships including communication, trust and attachment, intimacy, conflict, aggression, as well as sexual function and satisfaction. The present work highlights the unique considerations for those affected by MST, suggesting that the relationship between adverse psychological outcomes, such as PTSD, and relationship distress appears to be greater for military than among civilian populations. While clinical work aims to amplify positive outcomes within couple relationships, and reduce individual symptomatology, there exists a lack of interventions tailored to meet the needs of couples affected by MST specifically.

Discussion: The present thesis contributes to the growing understanding of how MST affects intimate partner relationships, as researchers and clinicians continue to seek to improve supports available for military members. The work is an appropriate start to inspire and inform future research, identifying existing gaps in the literature spurring on forthcoming work that aims to improve the wellbeing of military-connected intimate partner relationships.

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None to report.

List of Abbreviations and Symbols

AUD: Alcohol Use Disorder

BCT: Behavioural Couple Therapy

bCBCT: Brief Cognitive Behavioural Conjoint Therapy

CAF: Canadian Armed Forces

CBCT: Cognitive Behavioural Conjoint Therapy

CBTT: Cultural Betrayal Trauma Theory

CIMVHR: Canadian Institute for Military and Veteran Health Research

COPE: Couples Overcoming PTSD Everyday

CPT: Cognitive Processing Therapy

CTAP: Couple Treatment for Alcohol Use Disorder and Posttraumatic Stress Disorder

DND: Department of National Defence

EFCT: Emotionally Focused Couples Therapy

GBA+: Gender-Based Analysis Plus

HOPES: Helping Overcome PTSD and Enhance Satisfaction

IBCT: Integrative Behavioural Couple Therapy

IECR: Independent External Comprehensive Review

IPV: Intimate Partner Violence

MB-CBCT: Mindfulness-Based Cognitive Behavioural Conjoint Therapy

MSM: Military Sexual Misconduct

MST: Military Sexual Trauma

OEF: Operation Enduring Freedom

OIF: Operation Iraqi Freedom

pf-CBCT: Present-Focused Cognitive Behavioural Conjoint Therapy

PMIEs: Potentially Morally Injurious Experiences

PTSD: Posttraumatic Stress Disorder

SAIM: Sexual Assault in the Military

SAT: Structured Approach Therapy

SMRC: Sexual Misconduct Response Centre

STRAT: Strategic Approach Therapy

USVA: United States Veterans Affairs

VA: Department of Veterans Affairs

VCIIR: Veteran Couples Integrative Intensive Retreat

VHA: Veterans Health Administration

2SLGBTQIA+: Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, Plus

Declaration of Academic Achievement

The work described in the present thesis was performed by Jillian Lopes (hereafter referred to as "the primary researcher") and supervised by Dr. Linna Tam-Seto and Dr. Margaret McKinnon. The qualitative findings described in Chapter 5 were collected with the assistance of a team of researchers within the Trauma and Recovery Research Unit, Department of Psychiatry and Behavioural Neurosciences at McMaster University.

Chapter 1

Introduction

BACKGROUND

Brought to the forefront in 1998, military sexual misconduct (MSM) and military sexual trauma (MST) were of high public interest following the publication of an article by *Macleans'* magazine titled "Rape in the Military" (O'Hara, 1998). The story illuminated the experiences of women survivors of MST and the institutional circumstances that allowed abuse and harm to occur and perpetuate throughout various ranks of the Canadian Armed Forces (CAF). In March of 2015, the Deschamps Report was published, confirming many of the previous claims from the media release. Justice Deschamps, former puisne justice of the Supreme Court of Canada, reported on the sexualized nature in the CAF, "characterized by the frequent use of swear words and highly degrading expressions that reference women's bodies, sexual jokes, innuendos, discriminatory comments about the abilities of women, and unwelcome sexual touching" (Deschamps, 2015, p.ii). Justice Deschamps also noted how certain cultural behaviours within the CAF were correlated with the prevalence of sexual misconduct: "it was clear that the occurrence of sexual harassment and sexual assault are integrally related, and that to some extent both are rooted in cultural norms that permit a degree of discriminatory and harassing conduct within the organization" (Deschamps, 2015, p.13).

In response to the release of various accounts of abuse and survival within the CAF, the Department of National Defence (DND) created the Sexual Misconduct

Response Centre (SMRC), an arms-length organization to provide resources and supports for CAF members or leaders looking for information and assistance. Concurrently was the instigation of Operation HONOUR, a campaign against sexual misconduct in the CAF, approached like a military operation. Despite these historical and presently ongoing efforts, disclosures of MST within the CAF prevail, underscoring the need for a reimagined approach to not only address the need for culture change within the Canadian military, but also for opportunities for survivors to heal.

In light of recent social movements such as #MeToo, incidents of MST continue to be highly relevant in Canada. Published in 2022, The Report of the Independent External Comprehensive Review (IECR) of DND/CAF, or more commonly referred to as The Arbour Report, compiled by former justice of the Supreme Court of Canada, Justice Louise Arbour, denotes recommendations related to sexual misconduct and leadership practices within the CAF. The report offers 48 recommendations that fall within 11 categories that seek to prevent and/or eradicate sexual harassment and misconduct in the DND/CAF. Arbour notes,

> "One of the dangers of the model under which the CAF continues to operate is the high likelihood that some of its members are more at risk of harm, on a day to day basis, from their comrades than from the enemy. This must change. […] What the sexual misconduct crisis in the CAF reveals is complex and subtle. It combines abuse of power, antiquated practices unsuited to a more diversified workplace, the glorification of masculinity as the only acceptable operational standard for CAF members, and the continued unwillingness to let women in particular, as well as members of the LGBTQ2+ community, visible minorities and equity-seeking groups occupy their proper place in the military" (Arbour, 2022, p. 9, 14).

In Canada, the CAF and DND refer to MSM, which constitutes "conduct of a sexual nature that causes or could cause harm to others, and that the person knew or ought

reasonably to have known could cause harm" (Government of Canada, Department of National Defence, 2019). Comparatively, the United States Veterans Affairs (USVA), uses the term MST to refer to "experiences of sexual assault or sexual harassment experienced during military service. […] MST includes any sexual activity that you are involved with against your will" (Government of the United States of America, United States Veterans Affairs, 2021). Among the Five Eyes Nations (i.e., Australia, Canada, New Zealand, the United Kingdom, and the United States) only the USVA is currently using the term 'military sexual trauma'. Although these definitions serve to delineate what does and does not constitute MST, they fall short of capturing the insidious effects of this type of harm on survivors and the context in which they occur.

Canadian data from 2016 state that since joining the CAF, approximately 25% of women and 4% of men have experienced sexual assault on at least one occasion (Cotter et al., 2016). Among CAF Regular Force members, over the span of a year, approximately 13% of men and 28% of women have experienced targeted sexualized or discriminatory behaviours, and 70% of men and 75% of women witnessed or experienced sexualized or discriminatory behaviour (*Military Sexual Misconduct and Military Sexual Trauma Fact Sheet*, n.d.). Other sources within the international literature estimate between 9.5% and 33% of women experience an attempted or completed rape while serving (Bostock & Daley, 2007; Sadler, 2000; Suris & Lind, 2008). Among men, prevalence rates of reported sexual assault are estimated between 1% to 12% (Krinsley et al., 2003; Smith et al., 1999). With respect to sexual harassment among men while serving in the military, reported rates vary from 36% to 74% (Rosen & Martin, 1998; Street et al., 2007),

although men are reportedly less likely to deem these experiences as sexual harassment compared to women (Rosen & Martin, 1998). Across studies, there is little consistency in methodology, sample, and definitions of sexual assault, which may account for some of the variance in prevalence rates (Bostock & Daley, 2007). Despite the nuances around determining accurate estimates of MST among active CAF members and Veterans, extant data consistently report higher rates of MST among women as compared to men (Department of Defense, 2004). Of note, however, is that although women are more likely to experience MST, given the greater proportion of men in the military, the total number of men and women survivors of MST may be approximately equal (i.e. Kimerling et al., 2007).

The adverse psychological effects following the experience of sexual assault that occurs in the military is well-documented within the literature for both men and women. The literature notes that those who have been assaulted report high incidences of depression and anxiety (Elliott et al., 2004; Kimerling et al., 2007; Ratner et al., 2003), substance abuse (Ullman & Brecklin, 2003), sexual dysfunction (Elliott et al., 2004; Van Berlo & Ensink, 2000), posttraumatic stress disorder (PTSD; Elliott et al., 2004; Surìs et al., 2007; Suris & Lind, 2008), feelings of self-blame and shame (Isely & Gehrenbeck-Shim, 1997), suicidality (Ratner et al., 2003), and interpersonal relationship difficulties (Crome & McCabe, 1995; Walker et al., 2005). Furthermore, those with a history of MST were found to have poorer emotional and psychological functioning relative to those who experienced civilian sexual assault, or those with no history of sexual trauma (Surìs et al.,

2007). For women Veterans in particular, the literature notes that they are nine times more likely to develop PTSD following MST (Surís et al., 2004).

Gender-Based Analysis Plus and Intersectionality

Research in pursuit of better understanding the experiences of MST survivors necessitates the utilization of gender-based analysis plus (GBA+) and an intersectional lens. The Government of Canada renewed its commitment in 2015 to GBA+ in aims to ensure that the differential impacts of people of all genders are considered when policies, programs and legislation are developed (Government of Canada, 2020). The "plus" in GBA+ acknowledges that GBA goes beyond biological sex and sociocultural constructs of gender differences (Government of Canada, 2020). The term 'intersectionality' refers to the existence and intersection of multiple identity facets that results in an individual's unique identity. GBA+ leverages an intersectional lens, accounting for a spectrum of identity factors, including race, ethnicity, sexuality, religion, age, and mental or physical disability (Government of Canada, 2020).

A GBA+ lens was used throughout the development, data collection, and analysis of the present thesis. The study of trauma experiences more broadly, in addition to the exploration of more specific experiences such as MST, is rooted in the appreciation of the multidimensionality of individuals' lived experiences, as well as how relations of power shape these experiences (Misra et al., 2021). Literature searches and screening intentionally sought out the experiences of various gender and sexual identities, in order to highlight intersectional experiences. The collection of these publications allowed for a consideration of how themes may differ by intersecting group statuses (McGuffey, 2005)

or within a given status (Acosta, 2013; Kong, 2010). Comparing findings across groups, time periods, or experiences across socially constructed dimensions of difference, provides important intersectional insights that are rooted in an understanding of the role of power and oppression, as well as the complexity of the social world (Misra et al., 2021).

RESEARCH OBJECTIVES

The purpose of the present thesis was to explore the effect of MST on intimate partner relationships. Over the course of several research phases, including a scoping review and two narrative reviews, contextualized with primary qualitative data, the thesis sought to examine how dimensions and impacts of MST have an effect on intimate partner relationships.

RESEARCH DESIGN

The thesis consisted of three distinct phases, all of which were necessary to explore the impact of MST on intimate partner relationships. The first study, a scoping review, sought to explore how MST, PTSD, and intimate partner relationships intersect within the extant body of trauma literature. Upon the analysis of various themes that came out of the scoping review, a narrative review was undertaken to identify and synthesize knowledge of the relationship between sexual trauma and moral injury, within a military context. This research highlighted a focus on clinical interventions, hence, creating space to learn more about clinical interventions available to intimate partners. Therefore, the final phase of the present thesis consisted of a second narrative review that aimed to

explore the conjoint clinical interventions available to couples whereby one or more partners has experienced MST and potentially lives with MST-related PTSD.

ORGANIZATION OF THESIS

This thesis is presented in a manuscript-style consisting of five chapters. Chapter 1, Introduction, provides background and research design information for the thesis. The following three chapters, Chapter 2, 3, and 4, are manuscripts that are all either under review in peer-reviewed journals or will soon be submitted for publication. Finally, Chapter 5, Conclusion, summarizes the various phases of the thesis through a discussion of findings, research limitations and strengths, as well as contributions and future implications for clinicians, researchers, and policymakers that aim to improve the wellbeing of military members, Veterans, and their intimate partners.

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Chapter 2

Unseen battles: The effect of military sexual trauma on intimate partner relationships

PRELUDE

The present thesis begins with a scoping review of the extant body of literature. The aim of this chapter is to better understand the breadth and depth of published works that speak to the conceptualization and intersection of the following three phenomena: military sexual trauma, posttraumatic stress disorder, and intimate partner relationships. Given emergent work in this area, as well as the lack of clarity surrounding the mechanism by which these phenomena are interconnected, the scoping review methodology is used.

Abstract

Introduction: Canadian data estimates that since joining the Canadian Armed Forces, approximately one in four women and one in 25 men have experienced sexual assault at least once. Commonly cited psychological sequelae of sexual assault include shame, anxiety, depression, suicidal ideation, attempted suicide, and posttraumatic stress disorder (PTSD). PTSD following sexual assault is known to be associated with maladaptive cognitive schemas that are relevant to engaging in interpersonal relationships. The aim of this study is to understand how the literature conceptualizes and describes the link between sexual assault, PTSD, and intimate partner relationships within a military context.

Methods: A scoping review as described by Arksey & O'Malley (2005) was used to identify and synthesize knowledge on the intersection between sexual assault, PTSD, and intimate partner relationships within a military context. Five databases were searched, including MEDLINE, EMBASE, Web of Science, PsycINFO, and CINAHL to include English-language peer review articles from 1995 onwards. A total of 1679 articles were retrieved, 94 of which included in a full text review, and a total of 21 articles were included in the study.

Results: The search has indicated that most of the research is being conducted in the United States. The results indicate that the literature generally identifies intimate partner relationships as being heterosexual, highlighting a paucity of research on 2SLGBTQIA+ relationships. Sexual functioning between couples may be a salient issue for sexual assault survivors' mental health and relationship functioning, while highlighting the

unique sociocultural considerations for those affected by military sexual trauma. Moreover, the relationship between adverse psychological outcomes, such as PTSD, and relationship distress appears to be greater among military members than among civilian populations.

Discussion: The purpose of the current scoping review is to determine how the literature understands and describes the intersectionality of sexual assault, PTSD, and intimate partner relationships within the military. This scoping review identifies existing gaps in the literature spurring on future work that aims to improve military member and Veteran wellbeing, as well as potentially inform the development of clinical interventions and supports for couples affected by military sexual trauma. Additionally, this work will contribute to the growing understanding of how a history of sexual assault affects individuals, relationships, and the couple unit more broadly as researchers and clinicians continue to seek to improve supports available for military members.

Key words: sexual trauma, intimate partner relationships, couples, posttraumatic stress disorder, scoping review

INTRODUCTION

Sexual violence is most closely associated with the risk of developing posttraumatic stress disorder (PTSD) among all forms of traumatic events for civilian and military populations (Kang et al., 2005; Kessler et al., 1995). Survivors of military sexual trauma (MST) frequently meet criteria for depressive, anxiety, and substance use disorders, as well as suicidal ideation and behaviour, and disordered eating. However, PTSD is the most commonly diagnosed psychological disorder following an experience of MST (Elder et al., 2017; Suris & Lind, 2008; Yaeger et al., 2006). Empirical data suggest that there are five- to eight-fold higher rates of PTSD among women Veterans who have experienced MST compared to those who have not. Among men Veterans who have survived MST, there are three- to six-fold higher PTSD rates as compared to the general population (Kang et al., 2005; Sexton et al., 2017; Tolin & Foa, 2008).

MST is different from sexual trauma that occurs in the civilian world in that military culture has a substantial impact on the institution's response to and repercussions of the harm on survivors (Loyer, 2015). Military culture is characterized by the values of duty, honour, and sacrifice that inform an organization built upon hierarchy and structure. These unique socioenvironmental contexts create nuanced considerations for people when deciding whether to disclose experiences of being a victim of or witnessing MST, especially in circumstances where a person must decide whether to report their superiors for inappropriate behaviour. Further exacerbating the harm may be the inadequate or insufficient response of the institution when survivors do choose to report the incident(s). In Canada, institutional betrayal, defined as the failing of an institution to respond

appropriately, or if at all, to a traumatic event, is consistently reported as a key issue for survivors of MST (Andresen et al., 2019). Relatedly, a growing body of research suggests that perceptions of betrayal and failed leadership following MST have the potential to contribute to experiencing a moral injury, defined as "the existential, psychological, social, emotional, and/or spiritual damage arising from a violation of the core moral framework, and manifesting through feelings of shame, guilt, self-condemning, and/or self-sabotaging behaviours" (Shay, 2014, p. 183). While there is scant evidence on the relationship between MST, PTSD, and intimate partner relationships within military contexts, there is a substantial body of literature to support the connections between these phenomena among civilian populations.

Interpersonal trauma involves personal violation, assault, and/or physical or sexual violence with a human victim and perpetrator (Badour et al., 2017; Lilly & Valdez, 2012; VanBergen et al., 2020). Extant literature clearly describes the association between interpersonal trauma and a variety of phenomena, including: depression, suicidal thoughts and attempts, anxiety disorders, substance use (Fergusson et al., 2013; Norman et al., 2012), as well as other aspects of psychological, behavioural, and sexual health (Maniglio, 2009; VanBergen et al., 2020). PTSD can be caused by a number of traumatic situations, however, individuals with a history of interpersonal trauma are particularly vulnerable to developing PTSD (Du Mont et al., 2021; Kessler et al., 1995; Resnick et al., 1993; Tipsword et al., 2022).

Trauma has been seen to potentially hinder healthy functioning of intimate partner relationships by contributing to fear, distrust, and psychological ambivalence towards

relationships, as well as increased negative beliefs, emotional expression issues, and avoidance behaviours (Dekel & Monson, 2010; Goff et al., 2006; Liu et al., 2021; Nelson Goff & Smith, 2005). Within relationships, difficulties may emerge as a consequence of one or both partners having a history of trauma (Nelson Goff & Smith, 2005). Interpersonal trauma history has known associations with decreased levels of relationship satisfaction (DiLillo et al., 2009; Nguyen et al., 2017), lower relationship quality (Monk et al., 2014), heightened levels of physical aggression (Miller, 2016), impaired communication (Campbell & Renshaw, 2019), as well as boundary and intimacy issues in romantic relationships (Henry et al., 2011; VanBergen et al., 2020).

It is well documented that a history of sexual trauma, and subsequent PTSD symptomatology are associated with harmful effects on intimate partner relationships (i.e. Lambert et al., 2012). Correlations between PTSD and impaired relationship functioning may be particularly strong for actively serving military members and Veterans (Taft et al., 2011). Some studies propose that PTSD is more strongly associated with romantic relationship issues for military-affiliated individuals due, in part, to the nature of stressors related to combat exposure and the resulting impact on information processing and aggression (Chemtob et al., 1997; Taft et al., 2011). Furthermore, the core values of integrity, loyalty, courage, stewardship, and excellence (Department of National Defence and Canadian Forces, 2012), as well as the intrinsic power differentials within military culture, underscore the need to understand how sexual trauma, PTSD, and intimate partner relationships uniquely exist within actively serving and Veteran populations. While the literature widely conceptualizes and describes the intersection between these

phenomena in civilian populations, they have yet to be fully explored within a military context. Therefore, the objective of this scoping review aims to explore how MST, PTSD, and intimate partner relationships intersect within the extant body of trauma literature.

METHODS

A scoping review was conducted to better understand how the literature conceptualizes and describes the link between sexual assault, PTSD, and intimate partner relationships in a military context. Given the emerging work in this area, as well as the lack of clarity surrounding the mechanism by which these phenomena are interconnected, the scoping review methodology was selected.

This review was carried out in accordance with the five-step framework suggested by Arksey & O'Malley (2005), and later built upon by Levac et al. (2010). The five steps include: 1) identifying the research question; 2) identifying relevant studies; 3) selecting studies; 4) charting the data; and 5) collating, summarizing, and reporting the results (Arksey & O'Malley, 2005; Levac et al., 2010). The present study fulfils the preferred reporting items for systematic reviews and meta-analyses extension for scoping reviews (PRISMA-ScR) checklist (Appendix 1).

Step One: Identifying the Research Question

In order to better understand the breadth and depth of literature existing in this area, the following research question was posed: "How does the literature conceptualize and describe the link between sexual assault, PTSD, and intimate partner relationships within a military context?"

Step Two: Identifying Relevant Studies

The search terms were developed by means of expert consensus, followed by the iterative drafting of the search strategy. To create the search protocol, the research question was centred around three topics: MST, PTSD, and intimate partner relationships. Synonyms and related terms for each of these concepts were selected, and a search code was constructed. Five databases were searched, including MEDLINE, EMBASE, Web of Science, PsycINFO, and CINAHL to include English-language peer review articles. Each database was searched by using the keywords military sex* trauma OR military sex* misconduct OR sex offen* OR sex* violence OR sex* abus* OR sex* trauma* and post-traumatic stress disorder OR posttraumatic stress disorder OR PTSD and intimate partner* OR romantic partner* OR spous* OR intimate partner relationship*. The initial search yielded 1679 results.

Step Three: Selecting Studies

The literature search was conducted from November 2021 to January 2022. Peer-reviewed, English language articles, published from 1995 onwards, that incorporated a focus on conceptualizing or describing the relationship between MST, PTSD, and intimate partner relationships were included in the present study. Quantitative, qualitative, mixed-method studies, as well as reviews were included. Grey literature, in addition to articles that did not discuss a relationship between at least two of the three phenomena of interest were excluded from the study. Since the current study focused on the effects of MST experienced as an adult on subsequent intimate partner relationships, articles about child sexual trauma, or intimate partner violence with a current partner were excluded.

Two reviewers (JL and LTS) independently screened the titles, abstracts, and full texts of all articles against the inclusion criteria. Any conflicts in inclusion were resolved through discussion and eventual consensus.

A total of 1679 articles were collated from five databases and handsearching, of which 525 duplicates were removed. The full text of 94 articles were screened for eligibility, and 21 studies were included for this review. The full text of four articles were unable to be retrieved and were not screened for eligibility (Figure 1).

Step Four: Charting the Data

Items for data charting comprised of fundamental study characteristics, including the study type, country, setting, year, population, concept(s) of interest, purpose/aims of the study, and key results, in addition to the following phenomena-related data: how the literature defines ‘sexual trauma’ or ‘intimate partner’; a description of how sexual trauma affects intimate partner relationships, or the psychological outcomes of sexual trauma; and subsequent effects on intimate partners.

Step Five: Collating, Summarizing, and Reporting the Results

In accordance with the additions proposed by Levac et al. (2010), the three following steps were undertaken: 1) analyzing the data; 2) reporting the results; and 3) applying meaning to the results. Basic qualitative coding was completed to identify key characteristics related to the phenomena of interest (Peters et al., 2020). The data were coded in a deductive manner, informed by conventional qualitative content analysis methodology (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Codes were iteratively sorted into categories and subsequently into meaningful collections of themes.

RESULTS

Following the full text review, 21 sources were selected for full analytic data extraction. The majority of the sources were quantitative studies (n = 16), comprising of survey-based measures (Hannan et al., 2021; Mercado et al., 2015) and various types of statistical analyses (Baca et al., 2021; Bannister et al., 2018; Blais et al., 2022; Blais, 2020, 2021; Blais et al., 2018, 2020, 2022; DiMauro & Renshaw, 2021; Gilmore et al., 2016; McCall-Hosenfeld et al., 2009; Millegan et al., 2016; Tannahill et al., 2021; Wiblin et al., 2021). The remaining sources were comprised of review studies (n = 3; Lambert et al., 2012; Pulverman & Creech, 2021; Taft et al., 2011), a qualitative study (n = 1; Elder et al., 2017), and a mixed-method study (n = 1; Campbell & Renshaw, 2019). These sources were published between 2009 and 2022; all of which were published in the United States, with collaborators from Canada (Taft et al., 2011) and Australia (Bannister et al., 2018) on two of the studies. Of the included articles, they primarily focused on either the experiences of women (Blais et al., 2022; Blais, 2020; Blais et al., 2018, 2020; DiMauro & Renshaw, 2021; McCall-Hosenfeld et al., 2009; Mercado et al., 2015; Pulverman & Creech, 2021), or both women and men (Baca et al., 2021; Bannister et al., 2018; Blais et al., 2022; Gilmore et al., 2016; Hannan et al., 2021; Tannahill et al., 2021; Wiblin et al., 2021), while only n = 3 articles focused exclusively on the experience of men (Blais, 2021; Elder et al., 2017; Millegan et al., 2016), and n = 3 articles focused exclusively on the experience of couples (Campbell & Renshaw, 2019; Lambert et al., 2012; Taft et al., 2011). Of the three articles that discussed the experience of couples, all studied heterosexual couples (Campbell & Renshaw, 2019; Lambert et al., 2012; Taft et

al., 2011). A range of relationship dimensions are examined in the literature: relationship quality (Blais, 2020, 2021; Campbell & Renshaw, 2019; Hannan et al., 2021; Lambert et al., 2012; Taft et al., 2011), intimacy (Campbell & Renshaw, 2019), sexual satisfaction and functioning (Blais et al., 2022; Blais, 2020; Blais et al., 2018, 2020; DiMauro & Renshaw, 2021; Elder et al., 2017; McCall-Hosenfeld et al., 2009; Pulverman & Creech, 2021), intimate partner violence (Mercado et al., 2015), partner accommodation (Campbell & Renshaw, 2019), attachment orientations (Bannister et al., 2018), and worthiness (Elder et al., 2017; Wiblin et al., 2021). Furthermore, there is an appreciation that adverse psychological outcomes experienced by MST survivors affect not only mental health but also physical health, with approximately half of the included articles emphasizing mental health outcomes (Bannister et al., 2018; Blais et al., 2022; Lambert et al., 2012; Taft et al., 2011; Tannahill et al., 2021; Wiblin et al., 2021), while the remaining half focused on a combination of mental and physical health outcomes (DiMauro & Renshaw, 2021; Elder et al., 2017; Gilmore et al., 2016; Sumner et al., 2021), predominantly focusing on sexual health (Blais, 2020; Blais et al., 2020, 2022; Campbell & Renshaw, 2019; Pulverman & Creech, 2021) and overall quality of life indices (Elder et al., 2017; McCall-Hosenfeld et al., 2009; Mercado et al., 2015; Millegan et al., 2016; Taft et al., 2011). There were two main themes identified across the sources including: differences in PTSD and relationship distress among military and civilian populations; and the effects of MST differ from civilian sexual trauma, which can be further categorized as relating to either trust and attachment, behaviour, or sexuality.

Differences in PTSD and relationship distress among military and civilian populations

PTSD is associated with poorer relationship functioning and satisfaction for both military trauma survivors and their partners (Campbell & Renshaw, 2019; Lambert et al., 2012; Taft et al., 2011). Researchers have highlighted survivors' heightened irritability and conflict, emotional withdrawal, and compromised communication as plausible factors for these correlations (Campbell & Renshaw, 2019; Lambert et al., 2012).

Studies that used linear regression modelling found that the strength of the association between PTSD and relationship discord was higher in military as compared to civilian samples (Blais, 2020; Lambert et al., 2012). Likewise, such studies found that the strength of the association between PTSD and physical aggression was higher in military as compared to civilian samples (Lambert et al., 2012; Taft et al., 2011; Tannahill et al., 2021). These findings suggests that military-related PTSD may have a greater impact on one's intimate relationship than civilian PTSD because it is more strongly associated with anger and hostility. A handful of included studies discussed how the differences between military and civilian samples may be attributed to the specific nature of military stressors, in which military personnel may be exposed to life-threatening events for extended periods of time, leading to impairments in social information processing and anger management issues, characterized by heightened physiological arousal, hostile appraisals of events, and a lower threshold for responding to threatening social stimuli aggressively beyond a combat context (Lambert et al., 2012; Taft et al., 2011; Tannahill et al., 2021). The nature of combat-related work, in addition to the sociocultural norms enforced in

basic training, may also serve to disinhibit aggressive behaviour and reinforce more aggressive responses to difficult situations, resulting in dysfunctional problem-solving abilities and conflict resolution skills with intimate partners following the return from deployment (Baca et al., 2021; Mercado et al., 2015; Taft et al., 2011). It is also feasible that discrepancies between military and civilian populations can be explained by variations in these groups pre-deployment or by military selection characteristics (Taft et al., 2011).

With respect to specific PTSD symptom clusters, symptoms of emotional numbing, which includes components of anhedonia, were associated with higher intimacy issues and poorer relationship functioning in military-connected populations (Blais et al., 2020, 2022). While these correlations were present in both men and women Veterans and their partners, the effects were heightened in women Veterans and partners relative to men Veterans and partners (Blais et al., 2018, 2022). Among women service members and Veterans, PTSD-related anhedonia symptoms mediated the relationship of MST to both sexual function and satisfaction, implicating PTSD-related anhedonia as a key mechanism by which MST affects sexual health. These findings support Barlow's (1986) theory of sexual function and highlight the role of negative affect as a risk factor for sexual dysfunction in women military personnel and Veterans who are survivors of MST (Blais et al., 2022).

One study identified the role of partner accommodation in the association between PTSD and relationship satisfaction. The literature defines accommodation as modifying activities, emotional responses, or behaviours in response to another’s PTSD symptoms,

to alleviate or prevent PTSD-related or relationship distress (Campbell & Renshaw, 2019; Fredman et al., 2014). Despite its intended positive effect, accommodation is thought to have the ability to perpetuate PTSD symptoms, with current data linking it to the maintenance of situational avoidance over time, and lower relationship satisfaction overall. The study by Campbell & Renshaw (2019) posited that intimacy is the mechanism by which accommodation can influence relationship satisfaction. Intimacy is defined as a "feeling of closeness and connection" (Campbell & Renshaw, 2019; Laurenceau et al., 2005, p. 314) to a significant other, whereas relationship satisfaction tends to encompass a variety of constructs, such as agreement about addressing major issues, occurrence of arguments, and perceived happiness. Among civilians, low levels of relationship intimacy have been associated with adverse psychological health outcomes and relationship dysfunction (Campbell & Renshaw, 2019). Amidst trauma survivors, intimacy may be a particularly important component of relationship functioning, as individuals with PTSD demonstrate generally low levels of intimacy, with numbing/avoidance symptoms exerting the strongest influence on this aspect of an intimate relationship (Campbell & Renshaw, 2019).

The effects of MST differ from civilian sexual trauma

Of the reviewed papers, there appears to be consensus regarding the definition and spectrum of experiences that constitute MST. Most papers cite an iteration of the definition of MST proposed by the Department of Veterans Affairs (VA), one of which describes MST as "sexual assault or repeated, threatening sexual harassment that occurs during military service" (Baca et al., 2021; Blais, 2021; DiMauro & Renshaw, 2021;

Gilmore et al., 2016; Mercado et al., 2015; Pulverman & Creech, 2021; Tannahill et al., 2021). A more detailed definition of MST, also proposed by VA, is referenced in some of the included studies, which refers to MST as "unwanted and uninvited sexual harassment (e.g., pressure for sexual favors, verbal remarks) or assault (e.g., force or threat of force to have non-consensual sexual contact) that occurred during military service" (Blais, 2020; Blais et al., 2020, 2022; Elder et al., 2017; Hannan et al., 2021). The delineation of MST as constituting both harassment and assault experiences appears to be ubiquitous across included studies. One study explicitly cited the sexual harassment scale to assess MST as including sexual harassment (i.e., gossip/rumors regarding sexual behavior, crude sexual remarks), threats for not engaging in sexual activities, sexual assault (i.e., unwanted sexual touching, attempted touching/rape, and/or rape) from unit members, other unit leaders, or civilians during time in the military (Elder et al., 2017). Of the studies that discussed sexual trauma within a military context, only one did not use the term MST, and instead referred to 'sexual assault in the military' (SAIM; McCall-Hosenfeld et al., 2009).

Military culture creates distinctive consequences of sexual trauma that differentiate the experience from civilian sexual assault. Women survivors of MST are more likely to develop PTSD than women who have been sexually abused as civilians (Baca et al., 2021; Blais, 2021; McCall-Hosenfeld et al., 2009; Tannahill et al., 2021). Furthermore, MST has been shown to be a stronger predictor of PTSD symptoms than other military-related risk factors such as combat exposure, pre- and post-military sexual trauma, as well as non-military sexual traumas, life-threatening illnesses, and accidents

(Bannister et al., 2018; Gilmore et al., 2016; Hannan et al., 2021). Some studies suggest that the aforementioned findings may be due, in part, to the inability of MST survivors to flee their perpetrator(s), as perpetrators are often relied upon, given their roles as commanding officers or fellow comrades (Bannister et al., 2018; Mercado et al., 2015).

Military socialization, understood as the process by which service members are informed and acclimatized to military sociocultural norms, may result in fewer variations between men and women on some factors related to trauma reactions. For example, both men and women Veterans have affirmed the perceived value of disguising "weaknesses" and maintaining control of one's emotions, both of which may influence psychological functioning following trauma (Hannan et al., 2021). Furthermore, the environment and characteristics of MST may be more similar to that of civilian sexual assault. Perpetrators of MST are likely to be individuals on whom their victims rely, irrespective of the gender of the victim. Contrastingly, in civilian sexual assault, women victims may have a more variable relationship to the attacker than male victims (Hannan et al., 2021). The level of affiliation and dependence between a victim and perpetrator is closely related to distress levels following sexual trauma (Hannan et al., 2021; Mercado et al., 2015).

Across included studies, consequences of MST could be categorized into three domains: the effect of MST on trust and attachment (Bannister et al., 2018; Blais et al., 2022; Elder et al., 2017; Millegan et al., 2016; Tannahill et al., 2021; Wiblin et al., 2021), the effect of MST on behaviour (Elder et al., 2017; Gilmore et al., 2016; Hannan et al., 2021; Millegan et al., 2016; Tannahill et al., 2021), and the effect of MST on sexuality (Blais, 2020, 2021; Blais et al., 2018, 2020, 2022, 2022; Campbell & Renshaw, 2019;

DiMauro & Renshaw, 2021; Elder et al., 2017; McCall-Hosenfeld et al., 2009; Pulverman & Creech, 2021).

The Effect of MST on Trust and Attachment

Veterans are more likely to utilize deactivation methods such as withdrawing themselves from others and refusing to ask for or accept emotional support when they are in need, particularly within romantic relationships (Bannister et al., 2018). Individuals are more likely to develop PTSD if they believe their romantic partners cannot be trusted and hence avoid seeking their emotional assistance, which may constitute possible emotional and behavioural avoidance (Bannister et al., 2018; Tannahill et al., 2021; Wiblin et al., 2021). In one study of survivors of MST that are men, Veterans were afraid that if their loved ones found out about their sexual assault, they would be considered as physically or mentally weak or morally despicable, and they would be abandoned or alienated from their civilian communities (Elder et al., 2017). This contributed to hypervigilance about keeping the assault secret, hypersensitivity to any indication that others were distancing themselves, and a strong need to project an image of emotional strength (Blais et al., 2022; Elder et al., 2017). The majority of participants claimed that they were continuously afraid of being rejected by others, which led them to favour vocations that allowed them to work alone due to the likelihood of being ridiculed. Some Veterans went as far as staying in romantic relationships despite being victims of violence and mistreatment, including physical abuse and infidelity, out of fear of not finding another romantic partner (Elder et al., 2017). This sentiment was echoed in other studies, as Veterans with MST-related PTSD reported experiencing trauma-related negative

cognitions about the self, including unbearability, unlovability, and unsolvability (Wiblin et al., 2021).

The Effect of MST on Behaviour

The literature identifies several behavioural consequences of MST, including fear of interpersonal violence (Elder et al., 2017), conduct and vocational issues (Elder et al., 2017; Hannan et al., 2021; Millegan et al., 2016), and substance abuse (Elder et al., 2017; Gilmore et al., 2016). Multiple studies highlighted hypervigilance and anticipation of how one would escape potential danger among MST survivors (Elder et al., 2017; Tannahill et al., 2021). In a study by Elder et al. (2017) that focused exclusively on the experience of men, MST survivors reported avoiding situations and friendships with other men as a means of coping with the fear that precipitated as a result of the MST incident (Elder et al., 2017). Additionally, in a study by Sumner and colleagues (2021), survivors of MST reported a history of conduct problems while serving in the military related to a lack of concentration and managing anger. The literature notes that sexual trauma in service members has a strong detrimental impact on work functionality that lasted beyond military service and continued to damage the survivor's productivity and overall quality of life. Veterans who reported recent MST were 76% more likely to later report being disabled or unemployed upon their transition to civilian life (Sumner et al., 2021). Lastly, Elder and colleagues (2017) found that as a means to relieve shame-inducing thoughts and attenuate hypervigilance, survivors of MST report drinking excessively and/or using illicit substances, sometimes resulting in legal and drug-related charges (Elder et al., 2017).

The Effect of MST on Sexuality

A large proportion of the included studies focused on the effect of MST on a survivor's sexuality, specifically, one's sexual function (Blais et al., 2022; Blais, 2020, 2021; Blais et al., 2020, 2022; Campbell & Renshaw, 2019; Elder et al., 2017; Pulverman & Creech, 2021) and satisfaction (Blais et al., 2022; Blais, 2020; McCall-Hosenfeld et al., 2009). Among women Veterans, a history of MST is strongly linked to lower sexual satisfaction (Blais et al., 2022; Blais et al., 2018, 2020; DiMauro & Renshaw, 2021; McCall-Hosenfeld et al., 2009; Pulverman & Creech, 2021). Due to the nature of the relationship with the perpetrator being a close or trusted colleague, the use of a weapon, or the sense of an inadequate reaction by the justice system, MST may be more traumatizing than sexual violence within other settings (McCall-Hosenfeld et al., 2009). MST survivors reported avoidance of sexual activities and discussions about sex (Elder et al., 2017), as a means to decrease trauma reminders or to prevent feelings of vulnerability in the presence of another person (Blais et al., 2022), as well as sexual dysfunction. Furthermore, anxiety about sexual activities was compounded by a romantic partner's frustration, or concern that one's impaired sexual performance would lead to relationship discord (Blais et al., 2020).

Certain depression and PTSD symptoms may be acutely important in increasing risk for sexual dysfunction among victims of MST. Assault-based MST, as opposed to harassment-only MST, and sexual function/satisfaction were mediated by increased PTSD-related anhedonia and dysphoric arousal symptom cluster severities. Actively serving military members and Veterans who reported a history of MST have higher

distress, lower sexual function, and lower sexual satisfaction relative to those who experience non-sexual traumas within the military, as well as civilians who report a history of sexual trauma (Blais et al., 2022; Blais, 2020; Blais et al., 2018, 2020; Pulverman & Creech, 2021).

DISCUSSION

The present scoping review aimed to better understand the depth and breadth of the intersection between MST, PTSD, and intimate partner relationships within extant literature. While the implications of sexual trauma, and potential resulting PTSD diagnosis, among civilian intimate partner relationships were well-documented, it is important to understand these phenomena within a military context given the unique experience of service members and Veterans within military culture relative to civilians.

Extant research suggests that service members and Veterans may be at heightened risk for sexual trauma relative to their civilian counterparts (Stander & Thomsen, 2016). In 2003, a meta-analysis was conducted that assessed workplace sexual trauma among military, academic, government agencies, or private sector workplaces. Findings from this study highlighted how sexual trauma was most frequently reported in the military setting (Ilies et al., 2003). Among women Veterans, the literature notes that MST led to PTSD in more cases (60%) than did other types of trauma (43%; Yaeger et al., 2006). This finding supports additional literature that noted how women survivors of MST were three times more likely to develop PTSD than women who were sexually assaulted outside of the military, and nine times more likely than women who had never experienced sexual assault (Lyons, 2009; Suris & Lind, 2008).

In addition to being at an increased risk of experiencing sexual trauma, extant literature highlights how MST is even more deleterious on the psychological wellbeing of service members and Veterans than civilian sexual trauma due to the military context. According to betrayal trauma theory (Freyd, 1996), the effect of traumatic experiences is dependent on the degree of betrayal involved, which fluctuates based on the extent to which the survivor previously trusted, or physically and/or emotionally depended on the perpetrator. Perceptions of betrayal may be acutely salient in the military context where cultural values of trust, loyalty, and social cohesion are highly emphasized (Collins, 1998; Howard, 2006) and interdependence is further promoted by living within the workplace. Therefore, betrayal trauma theory suggests that perceived violations of these tenets can be exceptionally distressing as they go against well-established cultural norms and expectations. Additionally, feelings of interpersonal betrayal may be exacerbated by feelings of institutional betrayal, whereby inaction or an inappropriate response from the institution can worsen psychological distress following trauma (Smith & Freyd, 2013). Within the military, an adverse institutional response following the reporting of MST, which might include blame, inaction, or dismissiveness, has been proven to negatively impact wellbeing in various domains (Bell et al., 2014).

Organizational psychologist Gareth Morgan proposed the psychic prison metaphor, which can be applied to understanding how the military cultural environment allows for the perpetration of MST (Morgan, 2006). This theory is centred upon how unconscious power structures act as a control measure for those who are involved. Morgan notes how powerful, future-oriented visions can lead to blind spots, and strong

groupthink mentality can lead to organizational pathology, which illuminates internal aspects of an organization that have become dysfunctional, counterproductive, inefficient, disruptive, or destabilizing (Morgan, 2006). The psychic prison metaphor notes how cultural structures, norms, behaviours, and core values define an organization, and are "personal in the most profound sense" (p. 236). In addition, Morgan notes that the psychic prison "plays a powerful role in drawing attention to the ethical dimension of an organization" (Morgan, 2006, p. 238). Military culture and organization can be understood through this lens. The military strongly endorses values such as trust, loyalty, and camaraderie that are critical for operational efficacy (Drescher et al., 2011). The military is also built upon power differentials; however, this power is abused, and enables an environment that perpetuates MST. The very system that is conducive for individuals to abuse power is the same system whereby survivors are pressured to remain quiet about such injustices, thus perpetuating a cycle of oppression and abuse that should not be ignored.

It is also important to note the type of research that is being done within the realm of sexual trauma and resulting adverse physical and psychological outcomes. The predominance of literature regarding men's wellbeing research, particularly with respect to sexual function and satisfaction, has been centred on previous experiences of combat trauma within the military. In contrast, the predominance of research on women's sexual function and satisfaction research has been centred on previous experiences of MST. This finding may inadvertently reinforce stigma and stereotypes around sexual assault, alluding to the notion that women are the only victims. In fact, relative to women

survivors of MST, men who have experienced MST tend to report a greater range of interpersonal difficulties (Mondragon et al., 2015), increased rates of emotional dysregulation (Kimerling et al., 2007), and negative self-concept, including gender-specific stress regarding issues of masculinity and sexual orientation identity (Turchik et al., 2013). Survivors of MST that are men have also endorsed decreased self-efficacy and men rape myth acceptance. This research suggests that beliefs entrenched within military culture regarding men not getting raped may cause men to feel trapped and socially isolated, subsequently causing men to seek treatment later than women survivors, or, once in treatment, keeping the nature of their trauma confidential (O'Brien et al., 2015). Such pervasive "rape myths" highlight the need to do more inclusive research, leveraging a perspective that MST has no identity, thus men, women, and 2SLGBTQIA+ populations alike are all uniquely affected. For researchers, there exists a need in future work to continue to identify the nuanced experiences of MST among survivors of differing identities.

Given the interpersonal nature of sexual trauma and the resulting impacts on not only the survivor, but their partners as well, interventions that target the couple unit could be particularly effective at improving intimacy and overall relationship functioning. One such example includes cognitive behavioral conjoint therapy for PTSD (CBCT). Initially proposed by Monson and Fredman (2012), CBCT has been shown to be effective for service members and Veterans with a trauma history (Monson et al., 2004; Monson et al., 2011; Schumm et al., 2013). Other couples' therapy interventions have also been proposed, including one conducted by Erbes, Polusny, MacDermid, and Compton (2008),

which studied integrative behavioural couple therapy (IBCT; Erbes et al., 2008). Some have been proven effective in reducing distress in actively serving military members and Veterans (Kugler et al., 2019), although, like CBCT or IBCT, they are not specific to specific relationship aspects, such as communication tactics, sexual function, or attachment orientations. Couples Overcoming PTSD Everyday (COPE) is a peer-based program offered by Wounded Warriors Canada. Informed by the experiences of Lt. Col. (retired) Chris Linford, COPE is a multi-phase therapy for Veteran intimate partners suffering from the impacts of an operational stress injury, which may include MST. The first phase of the initiative consists of a retreat for intimate partners who are experiencing an operational stress injury and want to work on their relationships as a group. The second phase provides ongoing family counselling through three telephone-based sessions per month over the course of six months to ensure that the skills taught in the first phase are maintained (Wounded Warriors Canada, 2015). Across available programs and interventions available to couples, there is a dearth of evidence-based approaches that are oriented towards couples that have been impacted by MST. The unique facets of MST that differentiate it from civilian sexual trauma, as well as other military-related traumas, highlight a worthy potential area of future research that can aim to fill this gap.

Among partners of actively serving military personnel or Veterans, there exists gender-based differences that influence relationship functioning and satisfaction. The literature describes how the association between PTSD and relationship quality is stronger when the partner with PTSD symptoms is a man and the spouse is a woman. The researchers posit that this could be a result of differences in emotional attunement to

partners, differences in expression of symptoms, or other facets of gender roles. Experimental research with heterosexual couples (Klein & Hodges, 2001), reveals that women are more accurate in their appraisals of feelings and thoughts of others, particularly when they identify more strongly with traditional women gender role attributes (Laurent & Hodges, 2009). Women partners of trauma survivors that are men may be more acutely aware of their partner's emotional distress and behavioural changes (e.g., emotional numbing, withdrawal), which subsequently influences their partner's level of relationship satisfaction (Lambert et al., 2012). Furthermore, gender differences in the expression of symptoms might influence relationship satisfaction (Taft et al., 2011). Gender differences in internalizing versus externalizing syndromes have been discussed in research on general psychopathology (Kramer et al., 2008) and PTSD (Miller & Resick, 2007), with women being more prone to endorsing internalizing syndrome symptomatology. This suggests the potential of certain externalizing behaviours as having a greater impact on relationship satisfaction (Lambert et al., 2012). This finding also underscores the paucity of research that is not focused exclusively on heterosexual couples, and the need to pursue research that extends beyond heteronormative experiences, seeking to better understand the experience of 2SLGBTQIA+ relationships, and the unique ways in which MST, with or without associated PTSD, can affect relationship functioning and satisfaction.

Limitations

This study is not without limitations. The search terms were not standardized, and sources could have been missed if the title, abstract, or key words were not inclusive of

the search terms utilized in this study. Furthermore, it is possible that different databases could have identified additional resources.

CONCLUSION

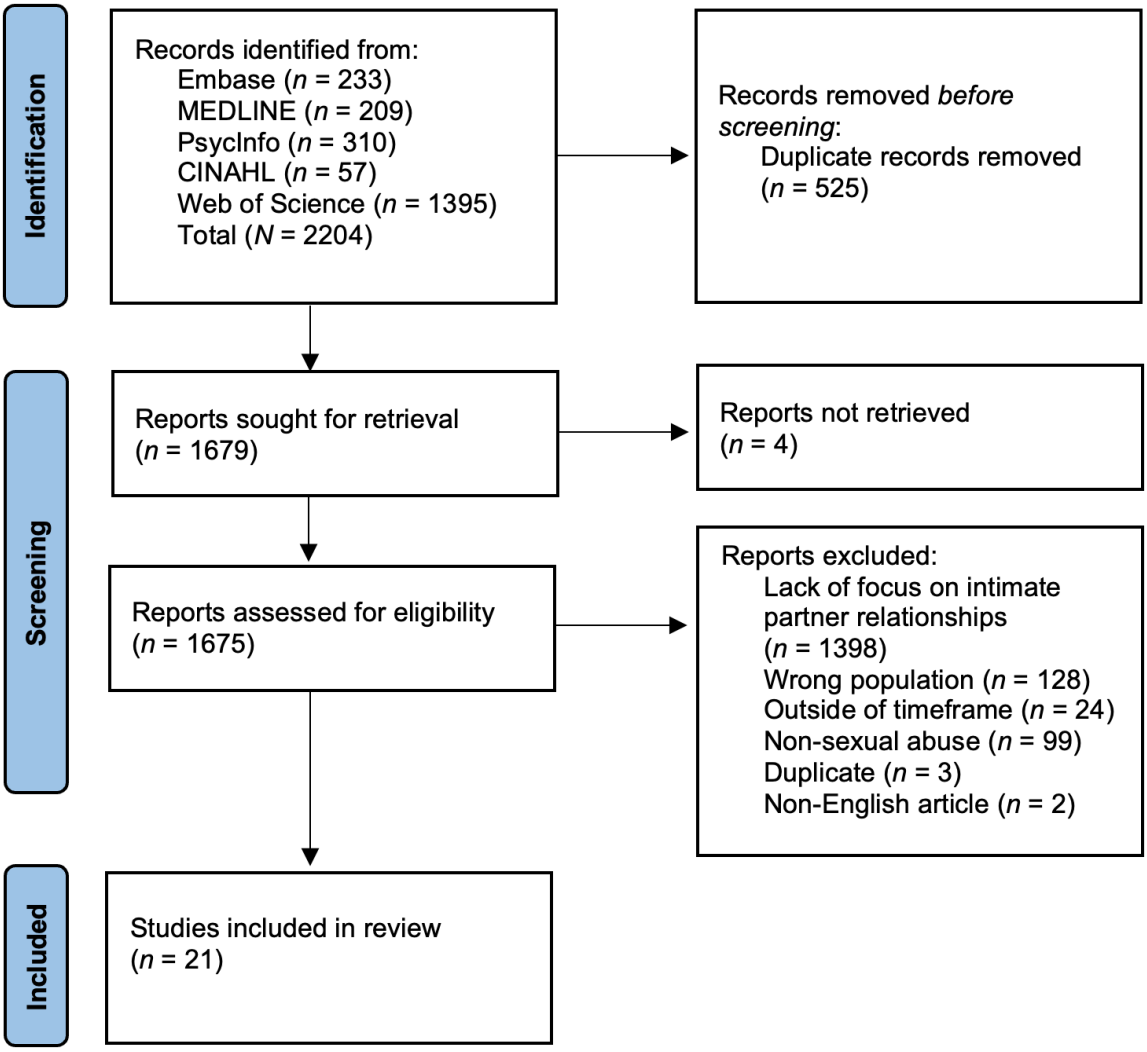
Research has noted that PTSD is related to decreased relationship satisfaction and higher levels of relationship conflict and aggression in both military and civilian populations (Meis et al., 2010; Taft et al., 2009). The symptoms of PTSD appear to impair an individual's ability to relate to close others, which subsequently leads to partners feeling less satisfied and perceiving a greater number of problems in the relationship (Monson et al., 2009; Nelson Goff & Smith, 2005). Emotional numbing, for example, might impede intimacy, while symptoms of anger and increased irritability may cause partners to experience a reduced sense of safety in the relationship (Dekel & Monson, 2010). Intimacy has the potential to be impaired particularly when an individual undergoes a traumatic event that is sexual in nature. For survivors of trauma, intimacy can become related to shame and fear, as opposed to warmth and tenderness, as well as concerns about dominance and submission over mutuality and reciprocal respect (Feiring et al., 2009; Martinson et al., 2013; Meston et al., 2006).

Despite some research suggesting that trauma type is irrelevant with respect to understanding the impact of trauma on interpersonal functioning (Yehuda et al., 2015), a growing body of literature suggests that differentiating between trauma types, as well as different contexts of trauma, may be useful when understanding the experiences of certain cohorts, such as those within the military. Further investigation is necessary to build a clinically useful conceptualization of the intersection between MST, PTSD, and intimate

partner relationships. Future research delineating the unique sexual trauma experiences and subsequent symptomatology between actively serving military members, Veterans, and civilians would be useful in the development of an informed treatment plan for survivors of MST and their main sources of social support, their partners.

Figures

Figure 1. PRISMA Flow Chart



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Chapter 3

Adding insult to injury: Exploring the relationship between moral injury and military sexual trauma

PRELUDE

Findings from the scoping review highlight guilt and shame, betrayal, core value systems, and ethics as salient aspects of military sexual trauma. Resultingly, given the known facets of moral injury, connections can be made between the increased risk for moral injury due to experiences of military sexual trauma. Therefore, a narrative review is presented in the following chapter that examines the associations between moral injury and military sexual trauma. The narrative review methodology is used as it is well-suited for presenting an amalgamation of broad perspectives on a given topic, while exploring a concept's phenomenology and management. Narrative reviews are also appropriate for understanding evolving and multidisciplinary subjects, such as moral injury.

Abstract

Introduction: The experience of military sexual trauma (MST) is unique in that the environment in which the harm occurs, the culture, plays a significant role in the impact of the harm on the survivor. MST often leads to experiences of posttraumatic stress disorder (PTSD) and moral injury, which can include feelings of institutional betrayal, as well as symptoms of PTSD. There exists a gap in the literature surrounding the relationship between MST and moral injury, which is important to understand given the prevalence of MST and the deleterious psychological sequelae of both MST and moral injury. The present study aims to address such gap.

Methods: A narrative review was conducted to identify and synthesize existing knowledge on the relationship between MST and moral injury. Five databases were searched, including MEDLINE, EMBASE, Web of Science, PsycINFO, and CINAHL to include English-language peer review articles.

Results: Moral injury may be a result of perpetration-based and betrayal-based acts that violate deeply held beliefs. The literature proposes multiple pathways for the development of moral injury following MST, some of which include perpetration and betrayal. The literature also discusses the potential consequences of MST-related moral injury. Research findings highlight how experiencing MST may be a morally injurious event based in betrayal that may benefit from a moral injury-focused intervention approach.

Discussion: This narrative review seeks to collate and begin to interpret the findings in the literature surrounding the relationship between moral injury and MST. The review is

an appropriate start to inform future research, as well as potentially enhance the conceptualization of moral injury. Future implications may include serving as a basis for trauma-informed clinical treatment options, developing health policies to support survivors, and providing greater context and foundation for military culture change.

Key words: military sexual trauma, military sexual misconduct, moral injury, institutional betrayal, military, narrative review

INTRODUCTION

The United States Veterans Affairs (USVA) defines military sexual trauma (MST) as "experiences of sexual assault or sexual harassment experienced during military service. […] MST includes any sexual activity that you are involved with against your will" (Government of the United States of America, United States Veterans Affairs, 2021). In Canada, the Canadian Armed Forces (CAF) and the Department of National Defence (DND), do not use the term 'military sexual trauma,' and instead use, 'military sexual misconduct (MSM),' which is conceptualized as "conduct of a sexual nature that causes or could cause harm to others, and that the person knew or ought reasonably to have known could cause harm" (Government of Canada, Department of National Defence, 2019). The current definitions of MST and MSM do not reflect the true nature of the harm, such as the moral injury and institutional trauma, that is experienced by the survivor. Furthermore, it is important to note how MSM describes the behaviour of the perpetrator, whereas MST refers to the victim's experience. For the purposes of the present study, the term MST will be used throughout.

In Canada, MST garnered tremendous public attention in 1998, following the release of a *Macleans'* article highlighting the experiences of women survivors of MST (O'Hara, 1998), and the institutional factors that contributed to enabling harm to occur and perpetuate throughout various ranks of the CAF. Despite numerous government efforts such as the commissioning of the Deschamps Report (Deschamps, 2015) that led to the creation of the Sexual Misconduct Response Centre (SMRC), and the implementation of Operation HONOUR, a campaign against sexual misconduct in the

CAF approached like a military operation, MST continues to prevail. Canadian data suggest that since joining the CAF, approximately 25% of women and 4% of men have experienced sexual assault at least once (Cotter et al., 2016). Among CAF Regular Force members, over a 12-month period, approximately 13% of men and 28% of women have experienced targeted sexualized or discriminatory behaviours, and 70% of men and 75% of women witnessed or experienced sexualized or discriminatory behaviour (*Military Sexual Misconduct and Military Sexual Trauma Fact Sheet*, n.d.). Despite the nuances around determining accurate estimates of MST among active CAF members and Veterans, extant data consistently report higher rates of MST among women as compared to men.

Embarking into military service is characterized by the breakdown of an individual's existing moral beliefs, and replacement with core values that contribute to behaviours and relationships that function to aid in the execution of military objectives (Drescher et al., 2011). However, when military members experience or bear witness to events, including betrayal from leadership or sexual violence, that transgress deeply held moral beliefs and expectations, a moral injury can occur (Jamieson et al., 2020). First mentioned by Camillo Mac Bica, a Vietnam Veteran and philosopher in the era of the Vietnam War, and further elaborated on and officially coined by psychiatrist Jonathan Shay, the term 'moral injury' is defined as "the existential, psychological, social, emotional, and/or spiritual damage arising from a violation of the core moral framework, and manifesting through feelings of shame, guilt, self-condemning, and/or self-sabotaging behaviours" (Jamieson et al., 2020). Since the construction of the term in the early 1990s,

a number of authors have elaborated on the concept, applying it to various disciplines (i.e. Boudreau, 2011; Brock et al., 2012; Kinghorn, 2012; Nash & Litz, 2013; Shay, 1994). Litz et al. (2009) are credited as the ones to introduce this concept to the trauma science community, later going on to explain how moral stressors and outcomes likely both occur on a spectrum of intensity and severity. On one end of the spectrum are lower-intensity moral challenges that cause moral frustrations, while on the opposite end of the spectrum are higher-intensity morally injurious events that have the potential to cause psychological, social, and spiritual harm (Litz et al., 2009; Litz & Kerig, 2019; Nash, 2019).

One proposed model for conceptualizing moral injury in the military is the stress injury model of moral injury (Nash, 2019). In the stress injury model, moral injury can be conceived as a wound to the mind, body, and spirit, perpetrated by an event that breaches deeply held moral beliefs regarding oneself and the world. In accordance with the Marine Corps stress continuum model (Nash, 2011) and Litz and Kerig's (2019) continuum model of moral stressors (Litz & Kerig, 2019), moral injuries exist on a spectrum. On one end of the continuum are benign or constructive moral challenges. Contrarily, the opposite end of the spectrum constitutes severe stressors. According to this model, the term moral injury can apply to posttraumatic stress disorder (PTSD) and other stress-related mental disorders that are rooted in the experience of one or more potentially morally injurious experiences (PMIEs).

Morally injurious experiences have the potential to prompt an array of psychological, social, and behaviour repercussions, which may include relational strain,

fundamental shifts in core beliefs regarding one's worldview, alterations in self-perceptions, thoughts of being bad, damaged or unworthy, loss of trust in others, and feelings of guilt, shame, and anger (Easterbrook et al., 2022; Nazarov et al., 2015; Smith-MacDonald et al., 2018; Wisco et al., 2017). Within military contexts, even low-level moral distress should not be ignored as it has the potential to negatively influence performance and institutional commitment (Phelps et al., 2022). Despite scant evidence, recent research by Easterbrook et al. (2022) notes how PMIEs are common and may have unique implications for military populations (Easterbrook et al., 2022). Moral injury can be associated with or serve as a precursor to PTSD and depression. In military samples specifically, exposure to PMIEs is related to PTSD, depression, substance use disorders, and suicidality, beyond the currently established connection between PTSD and suicidality among Veterans (Brock & Lettini, 2012; Easterbrook et al., 2022; McCarthy, 2016; Nazarov et al., 2015).

Accumulating research suggests that MST may lead to perceptions of betrayal and failed leadership, which has the potential to contribute to adverse psychological outcomes. However, there is a paucity of research focused on MST in the context of moral injury. Prior literature by Frankfurt et al. (2017) noting how MST may be one of the most pervasively reported PMIEs, particularly among women service members, underscores the need to study the relationship between MST and moral injury (Frankfurt et al., 2017; Hamrick et al., 2022). The current review begins to explore this gap, aiming to identify and synthesize knowledge of the relationship between sexual trauma and moral injury, within a military context.

METHODS

A narrative review was conducted to identify and synthesize knowledge on the relationship between MST and moral injury. The narrative review methodology is well-suited for presenting an amalgamation of broad perspectives on any given topic, as well as demonstrating a concept's phenomenology and management (Green et al., 2006). A narrative review was chosen to study this topic given the evolving and multidisciplinary nature of moral injury. Five databases were searched in June 2022, including MEDLINE, EMBASE, Web of Science, PsycINFO, and CINAHL to include English-language peer review articles. To construct the search protocol, the research question was centred around two topics: MST and moral injury. Synonyms and related terms for each of these concepts were selected, and a search code was constructed. Each database was searched by using the key words military sex* trauma OR military sex* misconduct OR military sex* harassment, military, sexual assault OR sexual trauma OR sexual harassment OR sexual misconduct OR sexual violence, military moral injury OR military moral distress OR moral injury OR moral distress, and institutional betrayal. The initial search yielded 172 results.

Manuscript titles and abstracts were screened, and a total of 24 articles were identified that included content on the conceptualization and relationship between MST and moral injury. Reasons for exclusion following the initial search included an absence of focus on moral injury or moral injury-related concepts as a result of sexual trauma within a military context. A hand search of bibliographies of the selected articles was

conducted, yielding an additional 27 relevant publications, for a total of 51 articles included in the review. Themes were derived through iterative thematic analysis.

RESULTS

The literature review yielded four predominant theme categories, including: individual and contextual antecedents of moral injury; consequences of moral injury; the response of the institution; and recent advancements in defining moral injury.

Individual and Contextual Antecedents

Some of the reviewed literature distinguished between individual and contextual antecedents in the conceptualization of moral injury within the military. Relevant individual antecedents include agency and betrayal (Jamieson et al., 2020). Agency involves one's perception of their effectiveness to enact change and control situations or actions. Tensions between an individual's personal values and military morality have the potential to violate one's moral framework and resultingly lead to a moral injury (Jamieson et al., 2020; Molendijk et al., 2018; Moore, 2016). Furthermore, betrayal is a necessary component of a moral injury as defined Jamieson et al. (2020). Betrayal in relation to moral injury may include interpersonal betrayal from leadership (Drescher et al., 2011; Nash, 2019; Nash & Litz, 2013), institutional betrayal from one's government (Bobek, 2011; Jamieson et al., 2020), and intrapersonal betrayal from oneself (Bobek, 2011; Jamieson et al., 2020). Of these types of betrayal, leadership betrayal was the most extensively researched in the extant literature (i.e. Brock et al., 2012; Maguen & Litz, 2012; Miller, 2016).

Supplementary to the individual antecedents are the contextual antecedents of the act/event and military culture. An act or event that has the potential to create a conflict within one's moral framework through commission or omission can be described as morally injurious (Alford, 2016; Carey et al., 2016; Jinkerson, 2016). The military environment can expose individuals to a variety of traumatic experiences, including harm or death of civilians, or executing orders that result in the loss of a fellow serving member, thereby increasing the risk for moral injury (Forbes et al., 2015). Military culture includes the attitudes and values that shape behaviour within the military environment, training practices, customs, and leadership norms (Shay, 2014). Cultural conformity is an early precedent established in initial training, and is based upon the notion that military initiatives are collective undertakings, with an emphasis on 'honour.' The idea of honour within the military constitutes always doing what is 'right,' and making decisions that are in the best interest of the military, even at the expense of oneself (Beard, 2015). In the context of MST, one such example of a morally injurious event might include failing to report a sexual assault perpetrated by a superior. Therefore, when such ethical tensions are present, that conflict with these entrenched values, a moral injury can result (Jamieson et al., 2020).

Consequences of Moral Injury

The review of the literature yielded numerous effects of moral injury including consequences on intra- and interpersonal relationships, and changes in worldview.

Intrapersonal Relationships

One key consequence of moral injury is the way in which one's relationship with themselves is disrupted (Drescher et al., 2011; Litz et al., 2009). An individual's self-concept is their perception of who they are and is rooted in their identity (Aderman, 2019). When one's self-concept is tainted as a result of a moral injury, intrapersonal difficulties and self-deprecating behaviours may ensue, thus leading to maladaptive cognitions about oneself and heightening the risk for suicidal rumination and attempts. Extant literature described the well-established and highly replicated association between PTSD and suicidality among Veterans, although the mechanism is not explicitly delineated within military contexts (Brock & Lettini, 2012; Easterbrook et al., 2022; McCarthy, 2016; Nazarov et al., 2015).

Interpersonal Relationships

The literature described how interpersonal relationships are pivotal to military service, training, and survival during deployment, particularly when trust is a core value and expectation among members. Research suggests that moral injury has the potential to exacerbate psychosocial tensions within an individual's personal and professional relationships through behaviours including despair, interpersonal violence, anger, substance abuse, and suicidality (Miller, 2016).

Worldview

Experiencing or bearing witness to PMIEs can undercut foundational beliefs about the trustworthiness and inherent goodness of oneself or others. In those experiencing moral injury, feelings of losing hope and questioning morality are common. Dissonance

experienced as a result of conflicting existential values and questions surrounding the existence of a just world can result in an individual having difficulty with adopting a clear worldview (Carey et al., 2016; Litz et al., 2009; McDonald, 2017; Sherman, 2015).

The Response of the Institution

The literature search yielded a great deal of data surrounding the response of the institution when posed with a sexual assault allegation. Some subthemes of this section include the notion of victim-blaming, betrayal trauma, and institutional betrayal.

Victim-Blaming

Negative and distorted alterations in cognitions and emotional states are associated with diagnoses of PTSD. One such example of a PTSD-related cognition involves wrongly blaming oneself or others about either the cause or effect of the traumatic event (Andresen et al., 2019). Survivors of MST who experience institutional betrayal may blame themselves or believe that they are accountable for instigating the sexual trauma (Bell & Reardon, 2011; Turchik et al., 2013). A qualitative study on MST confirmed that women Veterans experience victim-blaming within a military culture, which may cause the internalization of such beliefs, suggesting that victims perceive themselves as the cause of the MST (Andresen et al., 2019).

This phenomenon is in line with Farnsworth's prescriptive-cognition model for moral injury (Farnsworth, 2019). With respect to moral injury, Farnsworth argues that the core issue is the espousal of erroneous self- and other-condemning beliefs regarding culpability. In place of descriptive cognitions, individuals adopt prescriptive cognitions, which subsequently induce persistent damaging moral emotions, including guilt, shame,

and anger (Farnsworth, 2019). For example, a descriptive cognition about how dangerous the world is might be "the world is not a safe place," whereas a prescriptive cognition about how dangerous the world is might be "the world should be a safe place" (Farnsworth, 2019).

Betrayal Trauma and Institutional Betrayal

Betrayal trauma theory posits that distress in response to feeling betrayed can occur as a result of traumas related to the violation of trust and safety at the hands of an individual whom the survivor is dependent on (Freyd, 1996). Although this phenomenon was initially conceptualized to better understand children's responses to caregiver abuse (Reinhardt et al., 2018), betrayal trauma can result from MST, given the underlying expectations of trust and safety both in relationships with fellow members and the reliance on leadership, in exchange for tremendous sacrifice and service (Kelly, 2021). Institutional trauma, as it relates to sexual misconduct, is the failure of a trusted institution on which one depends for safety and support, or a response from an institution's behalf that exacerbates harm (Smith & Freyd, 2013). With respect to MST, both betrayal trauma and institutional betrayal commonly occur (Kelly, 2021; Reinhardt et al., 2018). Institutional betrayal has been associated with extreme stress reactions and dissociative symptomatology in military cohorts (Smith & Freyd, 2017). Survivors of MST must often continue to work alongside their perpetrators, which has the potential to prolong stress exposure and inhibit trauma recovery (Hunter, 2007). Following the experience of MST, many Veterans highlight stigma, fear of consequences, the loss of control, and the relinquishment of privacy when reporting (Sexton et al., 2017). This kind of experience

engenders a sense of betrayal, and results in tangible consequences, including ostracism and a loss of economic resources (Sexton et al., 2017). Monteith et al. (2016) noted that approximately two-thirds of MST survivors felt that their military institution failed to respond adequately to their claim, covered it up, or entirely denied their experience. Such negative responses and repercussions to the disclosure of MST experiences may cause unwarranted additional psychosocial distress, and contribute to decreases in subsequent help-seeking behaviours and perceived helplessness among survivors (Holliday & Monteith, 2019; Monteith et al., 2016; Wolff & Mills, 2016).

Recent Advancements in Defining Moral Injury

The literature reflected the iterative and evolving nature of how moral injury is conceptualized, and yielded some considerations with respect to defining moral injury and its relation to MST going forward, those being the differentiation between betrayal-based and perpetration-based morally injurious events, as well as the reimagination of moral injury as 'moral trauma.'

Betrayal-Based and Perpetration-Based Morally Injurious Events

Recent literature has made attempts to delineate the various pathways through which moral injury can occur because of MST. For the survivor, the experience of MST may be deemed as a betrayal-based morally injurious event (Frankfurt et al., 2018). Although, perpetrating MST has also been found to result in moral injury. The inclusion of both being a victim of and perpetrating MST within the domain of PMIEs has the potential to foster complicated clinical situations and theoretical debates. Recent moral injury measures distinguish self-directed moral injury, from other-directed moral injury

(Hamrick et al., 2022), (i.e., violence that occurs within one's rank, leadership failures, and acts of betrayal committed by trusted others or institutions; Drescher et al., 2011; Schorr et al., 2018; Shay, 2014; Yeterian et al., 2019). While self-directed moral injury describes maladaptive emotional responses and behaviours associated with acts of perpetration or direct involvement in a morally injurious event (i.e., "I am ashamed of myself because of things I did/saw during my military service"), other-directed moral injury describes one's reaction to acts committed by others (i.e., "When I look back on my military service, I feel horrified by things that I know other people were doing"). Other-directed moral injury may result, in these cases, from experiences of institutional betrayal (Smith & Freyd, 2013).

Clinical approaches to treat moral injury as a result of perpetrating MST, which includes feelings of guilt, shame, anger, and self-disgust, would likely require a very different treatment approach than those same emotions as a result of being a victim of MST (Frankfurt et al., 2018). Clinically, some literature suggests that it may be principally important for clinicians to focus on PTSD symptoms regarding maladaptive beliefs, cognitions, or emotional responses, rather than symptoms involving loss of interest, detachment, or restricted range (Andresen et al., 2019). Given that cognitive-behavioral interventions have verified the benefit of altering negative cognitions, such as self-blame, in reducing stress (Beck, 1995), research by Andresen et al. (2019) and Nash (2019) discussed how women who experience institutional betrayal and adverse cognitions as a result of MST may benefit from these types of cognitive-processing techniques (Andresen et al., 2019; Nash, 2019). Furthermore, there exists a potential for

iatrogenic harm if survivors of MST received treatment in the same clinical settings as MST perpetrators (Frankfurt et al., 2018). Given this recently delineated proposition for the different mechanisms by which moral injury can occur as a result of MST, moral injury remains an important issue in both a conceptual and clinical scope.

Moral Trauma

A recently published study by Jamieson et al. (2020) proposed the substitution of the term 'moral trauma' in lieu of 'moral injury.' The authors posit that while injuries may hurt, they are not always harmful, whereas trauma is considered an injury that can cause prolonged suffering and is nearly always harmful (Jamieson et al., 2020). Given the known psycho-syndromic impacts and documented consequences of moral injury, in addition to the notion that moral injury may in and of itself be the consequence of trauma for some, current definitions of moral injury may not accurately apprehend the betrayal and interpersonal trauma that currently serving military members and Veterans experience as a result of MST. Current definitions also do not embrace the significance and relevance of the systemic components in understanding moral injury within a military context (Boudreau, 2011; McCarthy, 2016). Instead, Jamieson et al. (2020) propose redefining 'moral injury' as 'moral trauma,' "the existential, psychological, emotional and or spiritual trauma arising from a conflict, violation or betrayal, either by omission or commission, of or within one's moral beliefs or code(s)."

DISCUSSION

Institutional attempts such as Operation HONOUR, the creation of the SMRC, and ongoing teaching and learning initiatives to prevent MST within the CAF, are critical.

While efforts are aimed at addressing the problem at the source, there have been limited advancements in how to treat MST-related moral injury as researchers, clinicians, and policymakers still continue to encapsulate what constitutes moral injury and the repercussions it has on involved parties. As a result of MST, the consequences of moral injury are pervasive, spanning across individuals' physical health outcomes, psychological wellbeing, interpersonal relationships, professional identities, and self-concepts. Furthermore, the institutional response following MST appears to be important because many Veterans reported having difficulty coming forward about such experiences and no longer feeling like a valued member of the military institution following MST (Monteith et al., 2016).

Recent literature suggests that the institutional response to MST is an important factor in survivors' posttraumatic responses (i.e. Monteith et al., 2016; Smith & Freyd, 2017). Sexual misconduct within the military may engender the feeling that the institution to which one belonged failed to protect the individual from victimization or failed to act in an appropriate and supportive manner in response to an allegation (Smith & Freyd, 2017). In the event of an institution having a negative response to a sexual misconduct allegation, adverse emotional responses including shame, guilt, embarrassment, and self-blame may be reinforced (Holliday & Monteith, 2019). This type of unsupportive, blaming, or invaliding response on an institution's behalf is noted to be a contributing factor in whether survivors subsequently seek MST-related care (Turchik et al., 2013). In civilian samples, women who have experienced institutional betrayal following sexual assault tend to endorse more severe posttraumatic stress symptoms (Smith & Freyd,

2013). Academics have proposed how this response may be particularly salient within military contexts, given the foundational values of trust, loyalty, and camaraderie (Monteith et al., 2016; Smith & Freyd, 2013). This ingrained reliance on others may cause experiences of MST to be especially injurious, particularly when perpetrated by a fellow service member (Andresen et al., 2019).

Clinical Implications

The reviewed literature suggests that clinicians working with MST survivors should consider assessing their clients' perceptions of the institutional response to MST (Monteith et al., 2016). Those who experienced institutional betrayal after MST may have negative perceptions of the military organization and their time serving, which may have a negative impact on recovery and reintegration into civilian life following departure from the military (Andresen et al., 2019). Researchers have posited that institutional betrayal because of MST may act as a barrier for seeking help for MST-related sequelae from Veterans Health Administration (VHA) or other institutes affiliated with the institution where the sexual assault or sexual harassment occurred; thus highlighting an important area of research that would benefit from future investigation (Andresen et al., 2019; Holliday & Monteith, 2019; Monteith et al., 2016; Reinhardt et al., 2018).

Trust and safety beliefs are likely to drive the relationship between institutional betrayal and the likelihood of using MST-related care. Following sexual victimization, individuals' perceptions of trust and safety are frequently altered (McCann et al., 1988). When this happens, MST survivors may try to avoid further distress and re-traumatization by avoiding others, believing that disclosing MST will cause them to be hurt or betrayed,

and foregoing formal help-seeking (Dunmore et al., 2001). These strategies may be effective for avoiding distressing MST-related reminders, but they may also promote the development and reinforcement of dysfunctional interpersonal dynamics (Holliday & Monteith, 2019; Nishith et al., 2000).

These findings highlight the need for more culturally sensitive models of trauma theory to military culture. Research investigates the distinct effects that military service can have on health care, and emphasizes the need for military cultural competence among clinicians and health care providers. Subcultures, such as those associated with different ranks, services, and occupations, can form an important part of a patient's military cultural identity. Veterans who served in the military for a short period of time in the distant past frequently regard the military as their primary source of identity (Roberts & Warner, 2018). Some research suggests the implementation of cultural competency courses that focus on four core competencies, including an introduction to military ethos, military organization and roles, military stressors and resources, and treatment, resources, and tools (Atuel & Castro, 2018). The overarching goal of these coordinated programmatic efforts is to bridge the military-civilian divide. This divide, however, is more than just one of culture (Atuel & Castro, 2018). It is also a numerical one, as Meyer (2015) alluded to, with civilian providers in the (numerical) majority group and service members or Veterans in the (numerical) minority group (Meyer et al., 2015). This relationship between the military and civilian groups serves as an important backdrop when discussing military cultural competence (Atuel & Castro, 2018; Convoy & Westphal, 2013; Meyer et al., 2015; Nedegaard & Zwilling, 2017).

Cultural betrayal trauma theory (CBTT) is a novel framework for conceptualizing trauma-related mental health outcomes in immigrant and minority populations. This framework can be used to analyze and interpret the significance of the review findings. The predominance of trauma research has been oriented around White American cohorts (Briere & Scott, 2006; Tyagi, 2002); however, this theory highlights the importance of contextual factors on outcomes of violence victimization, including societal trauma, societal status, and cultural values (i.e. Bryant-Davis, 2005; Ford & Gómez, 2015; Klest et al., 2013). While this theory is a notable contribution to understanding the nuanced experiences of ethnic minority and other marginalized groups, it can be extrapolated to better understand the nuanced experiences of those entrenched in military culture (Gómez & Freyd, 2018).

Some individuals within minority populations can experience a sense of attachment towards other in-group members. This bond, coined as (intra)cultural trust, has the potential to act as a protective factor against the effects of violence or discrimination (BentGoodley, 2001; Tillman et al., 2010). Given the emphasis that CBTT places on relationships within larger sociocultural factors, (intra)cultural trust creates a vulnerability for cultural betrayal to be particularly deleterious (Gómez & Freyd, 2018). Within-group violence in immigrant and minority populations is conceptualized as a cultural betrayal trauma that predicts a variety of outcomes (i.e., abuse outcomes include PTSD, dissociation, anxiety, etc., and cultural outcomes include internalized prejudice, de-identification, and distinct shame), with other types of betrayals like interpersonal, institutional, and judicial betrayals contributing to these outcomes (Gómez & Freyd,

2018). This notion draws close parallels to the impact and repercussions of MST. Broken expectations of military culture and leadership, as well as feelings of betrayal may surface if a service member perceives the military organization as failing to uphold perceived obligations, may all contribute to the mental health consequences of military sexual harassment (Hamrick et al., 2022). According to Laws et al. (2016), poor unit relationship quality mediated the association between MST and posttraumatic stress symptoms during deployment (Laws et al., 2016). These elements could lead to an atmosphere of nearly familial intimacy among service members, which might intensify victims of sexual harassment's sense of betrayal (Hamrick et al., 2022). According to Northcut and Kienow (2014), two important mechanisms relate MST to poor mental health outcomes: loss of identity and experiences of revictimization during the reporting process. Given the perceived betrayal of core values, those who experience MST may exhibit symptoms of moral injury (Northcut & Kienow, 2014). This results in a loss of trust in the organization that has served as the cornerstone of one's personal and professional identity (Hamrick et al., 2022).

Service members must reconstruct their identities as they transition from civilian to military life in order for collective objectives to take precedence over individual needs. This change is pivotal for the preparation of service members for combat activities, which is unusual in the majority of civilian vocations (Hamrick et al., 2022). Based on the impression of shared values and familial bonds, individuals who have undergone identity fusion, or the union of personal identity with social identity (i.e., affiliation with a group), are more likely to make extreme sacrifices for the group (Swann & Buhrmester, 2015).

This fusion of one's personal and professional lives is reinforced by the military's hierarchical rank structure, which fosters a sense of being protected and cared for by higher ranking service members (Northcut & Kienow, 2014). Hence, given this strong identification with military culture and identity, in lieu of one's previously existing individual values, institutional betrayal can be especially damaging, leaving individuals feeling a sense of social isolation, estranged from their deeply held beliefs, and morally injured (Hamrick et al., 2022).

Since its introduction, the definitions of moral injury have continued to evolve; however, an agreed-upon definition has yet to be established (Griffin et al., 2019; Hodgson & Carey, 2017). When attempting to understand and treat moral injury, complication arises due to its subjective nature. Since there is no single, universal moral code, an incident that one person deems morally reprehensible may not be viewed in the same way by another, and vice versa (Jamieson et al., 2020). This review underscores the need for a unified, operational definition of moral injury that encompasses contextual sociopolitical norms and values, particularly for cohorts like military personnel, where socio-political influences are so impactful on shaping an individual's experience, and the hopefully subsequent course of reporting and treatment. One such proposed definition that incorporates these facets might describe moral injury as "the existential, psychological, emotional and/or spiritual trauma arising from a perceived conflict, violation, or betrayal, either by omission or commission, of one's moral beliefs or code(s) as they exist within one's broader sociocultural context."

Limitations

Acknowledging the limitations of this narrative review, only peer-reviewed publications were considered. Future research may benefit from the inclusion of grey literature, such as policy and governmental reports, which could add to the clinical understanding of moral injury. Furthermore, with respect to next steps for this field of research, it may be beneficial to conduct a more rigorous review that is scoping or systematic in nature.

CONCLUSION

Given that moral injury does not sit neatly within a particular discipline, a broadened and evolving understanding of the experiences an individual may encounter as a result of MST-related moral injury is critical. The present study found that moral injury may be a result of perpetration-based and betrayal-based acts that violate deeply held beliefs, and discussed various potential consequences of MST-related moral injury. Research findings highlight how experiencing MST may be a morally injurious event based in betrayal that may benefit from a moral injury-focused intervention approach. As formalized assessment tools continue to become refined within clinical contexts, a further challenge persists with respect to the design of effective recognition and intervention approaches that are specialized to moral injury, or future iterations of the phenomenon given the evolving nature of how it is being conceptualized. Looking beyond the individual, there exists a need for culture change within the military. Through fostering a culture of trust and safety, both in a physical and psychological sense, the military can

rightfully prioritize the need to protect the wellbeing of those who continue to make the ultimate commitment and sacrifice to their country every day.

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Chapter 4

Therapeutic interventions available to intimate partners with a history of military sexual trauma: A narrative review

PRELUDE

Findings from the previous two chapters highlight the need for suitable interventions to address the impacts of military sexual trauma on intimate partner relationships and potential resulting psychological sequelae. Another narrative review is presented here that identifies and examines the different therapeutic approaches that have been used to ameliorate the effects of posttraumatic stress disorder among couples. The present review also seeks to identify how current approaches may be amended to suit the unique needs of couples impacted by military sexual trauma. A narrative review is most appropriate for this next study given the evolving and multidisciplinary nature of military sexual trauma, and the relative paucity of interventions tailored to military couples compared to individuals affected by civilian sexual assault.

Abstract

Introduction: Sexual assault is a growing health concern, and is correlated with many psychosocial health risks, including posttraumatic stress disorder (PTSD), excessive drinking, and intimate partner violence (IPV). Among women Veterans, help seeking for their sexual assaults may be influenced by stigma related to military culture. The literature notes that women Veterans experience high rates of sexual assault before, during, and after military service. Women who have experienced military sexual trauma (MST) report substantial challenges to their sexual and relationship functioning following the assault. Clinical treatment of interpersonal trauma history is common, however there is a lack of research regarding the development and efficacy of the supports and clinical interventions used with couples where one or both individuals have a history of MST. This review seeks to begin to address this gap in the literature.

Methods: A narrative review was used to identify and synthesize knowledge on the therapeutic interventions and supports available to intimate partner relationships whereby at least one partner has military-related PTSD or has experienced sexual trauma. Exclusion criteria included a focus on sexual trauma not experienced during adulthood and interventions that were not conjoint. Five databases were searched, including MEDLINE, EMBASE, Web of Science, PsycINFO, and CINAHL to include English-language peer review articles from 1995 onwards.

Results: The literature identifies therapeutic approaches that have been proven to effectively reduce PTSD symptom severity, negative cognitions, and relationship distress when supporting couples who have experienced trauma. Several approaches are described

in the literature including solution-oriented frameworks, cognitive-behavioral models, and emotionally focused couple therapies. Clinical work aims to amplify positive outcomes and opportunities for growth within couple relationships, integrate sexual trauma healing into ongoing relationship and sex therapy, and reduce individual symptomatology. The results also highlight a paucity of research on 2SLGBTQIA+ relationships, as well as relationships whereby men have been impacted by sexual trauma.

Discussion: The purpose of the narrative review was to identify the therapeutic interventions and supports presently available to couples with at least one partner having trauma-related PTSD. The review collated the findings in the literature, underscoring the need for increasing diversity in client populations undergoing current interventions, as well as highlighting the urgency to enhance future clinical interventions for individuals and couples with more unique circumstances, such as those who have experienced MST.

Key words: therapeutic interventions, sexual trauma, military sexual trauma, intimate partner relationships, couples

INTRODUCTION

Sexual violence is most closely associated with the risk of developing posttraumatic stress disorder (PTSD) among all forms of traumatic events for civilian and military populations (Kang et al., 2005; Kessler et al., 1995). Affecting approximately 25% of women and 4% of men in the Canadian Armed Forces (CAF), military sexual trauma (MST) is a pervasive issue warranting attention among military institutions (Cotter et al., 2016). Survivors of MST often meet criteria for depression, anxiety, substance use disorder, eating disorders, and suicidality. However, PTSD is the most commonly diagnosed psychological disorder following the experience of MST (Elder et al., 2017; Suris & Lind, 2008; Yaeger et al., 2006). Women survivors of MST are at particularly high risk; data suggest that they are more likely to experience interpersonal trauma, particularly sexual assault (Cortina & Kubiak, 2006; Hannan et al., 2021), twice as likely to develop a trauma-related disorder relative to their men counterparts (Hannan et al., 2021; Kobayashi et al., 2012), and are more likely to develop PTSD than women who have been sexually abused as civilians (Bannister et al., 2018).

Experiencing trauma may impede normal and healthy functioning of intimate partner relationships by contributing to fear, distrust, and psychological ambivalence towards relationships, increased negative attitudes, emotional expression issues, and avoidance behaviours (Dekel & Monson, 2010; Goff et al., 2006; Liu et al., 2021; Nelson Goff & Smith, 2005). Within relationships, difficulties may emerge as a consequence of one or both partners having a history of trauma (Nelson Goff & Smith, 2005). Interpersonal trauma history has known associations with decreased levels of

relationships satisfaction (DiLillo et al., 2009; Nguyen et al., 2017), lower relationship quality (Monk et al., 2014), heightened levels of physical aggression (Miller, 2016), impaired communication (Campbell & Renshaw, 2019), as well as boundary and intimacy issues in romantic relationships (Henry et al., 2011; VanBergen et al., 2020).

Specific PSTD symptom clusters have been found to be differentially related to relationship adjustment. Emotional numbing symptoms are strongly associated with relationship satisfaction and intimacy (Riggs et al., 1998), whereas hyperarousal symptoms are associated with intimate partner aggression (Savarese et al., 2001). PTSD treatments for individuals have been shown to be effective in lowering reexperiencing, effortful avoidance, and hyperarousal symptoms of PTSD (Nishith et al., 2002); however, they have not been as effective in addressing emotional numbing (Monson et al., 2006; Taylor et al., 2003).

Research has noted that sexual trauma-related PTSD is related to decreased intimate partner relationship satisfaction and higher levels of relationship conflict and aggression in both military and civilian populations (Meis et al., 2010; Taft et al., 2009). Some symptoms of PTSD appear to impair an individual's ability to relate to close others, which subsequently leads to the partner feeling less satisfied and perceiving a greater number of problems in the relationship (Monson et al., 2009; Nelson Goff & Smith, 2005). For example, emotional numbing might impede intimacy, while symptoms of anger and increased irritability may cause the partner to experience a reduced sense of safety in the relationship (Dekel & Monson, 2010).

Beyond the survivor, several adverse psychological outcomes have been observed among partners of individuals who have experienced sexual trauma. Among men partners of women who have experienced sexual trauma, the most commonly cited concerns include challenges understanding the experience of the partner, difficulty in providing emotional support to the partner, ineffective communication patterns, anger towards the perpetrator and the partner, guilt regarding inability to protect the woman, anxiety around the safety of the partner, and sexual difficulties (Connop & Petrak, 2004; Miller et al., 1982). With respect to anger, much of it appears to relate to issues of blame and responsibility for men partners of women sexual assault survivors (Connop & Petrak, 2004). Moreover, general concern for the victimized partner is frequent among most men partners of survivors of sexual assault (Miller et al., 1982), as are challenges with communication between partners, particularly regarding intimacy, sexual function, and desire (Connop & Petrak, 2004).

Within current clinical psychological and psychiatric practice, the majority of evidence-based psychosocial treatments for PTSD only address the needs of the person diagnosed with PTSD. Approaches aimed at describing, explaining, or treating PTSD or other stress and trauma-related disorders generally underappreciate the person's social environment. These individual-focused approaches have a 25% to 30% drop-out rate (Hembree et al., 2003) and data suggest that 50% of the intention-to-treat samples, whereby data is analyzed based on the initial treatment assignment and not on the treatment eventually received, do not respond or only partially respond to treatment (Van Etten & Taylor, 1998). Furthermore, there is little to no evidence that these treatments

result in improved intimate relationship functioning (Galovski et al., 2005), while in contrast there is evidence to suggest that individual therapy outcomes are impacted by the family environment (Tarrier et al., 1999).

More recently, the trauma literature has recommended that couple therapy only be offered at the cessation of the individual therapy. As a result, this has left trauma survivors and their partners experiencing a lack of support when encountering relationship distress. This change in practice also forfeits a therapist's opportunity to engage partners as allies in the healing process and to strengthen one's intimate relationship. Partners of sexual assault survivors indicate that they felt uninvolved in the therapy process and that therapists did not help survivors advance intimacy with their partners. Furthermore, partners reported feeling as though they were made to feel like perpetrators, and that they were eager for the therapy to conclude in order to continue their relationship (Ganz et al., 2022). There is, however, a growing awareness of the interpersonal context and impact of trauma, particularly regarding sexual trauma, given its interpersonal nature. As a result, there have been notable developments in integrating informal support systems into the process of treating trauma (Ganz et al., 2022).

Theoretical models of PTSD consistently identify informal social support, which typically includes an individual's family, friends, and peers, as an important factor that can affect the development and maintenance of symptomatology (Billette et al., 2008). A meta-analysis by Brewin et al. (2000) explored the risk factors associated with PTSD and found that an absence of social support was the strongest predictor of the development and maintenance of PTSD (Brewin et al., 2000). In another study, social support was

consistently rated among the strongest predictive factors of PTSD (Ozer et al., 2008). Additionally, social support is said to be associated with the development and maintenance of PTSD, as well as the survivor's recovery (Guay et al., 2006). Unlike treatment approaches aimed at supporting individuals, emerging evidence among Veteran cohorts suggests that conjoint approaches to PTSD have the potential to improve the full range of PTSD symptoms, including emotional numbing (Sautter et al., 2009).

Actively serving military members and Veterans are at an increased risk of interpersonal trauma, specifically sexual trauma, and more severe adverse psychological outcomes. These findings, in addition to the shortcomings of current individual-focused therapeutic interventions, underscore the need to explore the conjoint therapeutic options available to trauma-impacted couples. The present narrative review seeks to explore the conjoint clinical interventions available to couples whereby one or more partners has experienced MST and potentially lives with MST-related PTSD, or is experiencing trauma-related PTSD.

METHODS

A narrative review was conducted to identify and synthesize knowledge on the current clinical interventions available to couples whereby at least one partner has experienced sexual or military-related trauma. The narrative review methodology is well-suited for presenting an amalgamation of broad perspectives on any given topic, as well as demonstrating a concept's phenomenology and management (Green et al., 2006). A narrative review was chosen to study this topic given the evolving and multidisciplinary nature of informed clinical research. Five databases were searched in January 2022,

including MEDLINE, EMBASE, Web of Science, PsycINFO, and CINAHL to include English-language peer review articles. To construct the search protocol, the research question was centred around three topics: sexual trauma, PTSD, and couple interventions. Synonyms and related terms for each of these concepts were selected, and a search code was constructed. Each database was searched by using the key words military sex* trauma OR military sex* misconduct OR military sex* harassment, military, sexual assault OR sexual trauma OR sexual harassment OR sexual misconduct OR sexual violence, posttraumatic stress disorder OR post-traumatic stress disorder OR PTSD, and couple* therapy OR couple* intervention OR partner therapy OR partner intervention OR intervention OR therapy OR treatment. The initial search yielded 2486 results.

Manuscript titles and abstracts were screened, and the search results were narrowed down to 67 articles. Following full-text review, a total of 26 articles were identified that discussed clinical interventions available to couples whereby one or more partners has experienced sexual assault, or military trauma with resulting PTSD. Reasons for exclusion following the initial search included an absence of focus on a clinical intervention intended for couples, and therapies for individuals who experienced a trauma that was not during adulthood. A hand search of bibliographies of the selected articles was conducted, yielding an additional five relevant publications, for a total of 31 articles included in the review.

RESULTS

At present, one model was proposed in the literature to treat couples where one partner has experienced MST specifically. Drawing from knowledge of family systems,

sexuality, sexual assault research, personal military connections, and therapeutic work with actively serving military personnel and Veteran families, Goodcase, Love & Ladson (2015) proposed a therapy model aimed at helping the survivor of MST and their partner process the trauma. This model integrates transgenerational theory, attachment theory, emotionally focused therapy, and incest treatment models. Underscoring the model is the emphasis on the role of military culture, specifically the notion that the military is a family, to better inform the effect of MST on an individual, their partner, and the subsequent treatment (Goodcase et al., 2015). Therapy based on the model involves identifying projections present in the intimate partner relationship, heightening sensitivity to partners' emotional needs, and fostering a secure attachment within the romantic partnership. While the novel theoretical conceptualization and proposed model hold promise in treating MST, it has not yet been implemented in practice or evaluated for efficacy in improving psychological outcomes of MST and/or MST-related PTSD (Goodcase et al., 2015).

The search for literature about MST-specific clinical interventions did not yield work other than the model by Goodcase et al. (2015), although there is a larger body of literature that discusses different therapeutic options for couples whereby at least one partner is an actively serving military member or Veteran with military-related PTSD. Given the findings discussed in Chapter Two of this thesis, there exists an intersection between MST, PTSD, and intimate partner relationships. With this knowledge, clinical interventions that target PTSD symptomatology among military couples can serve as a

foundation to build upon with future research and intervention development tailored to meet the needs of survivors of MST and their partners.

Monson et al. (2015) evaluated evidence-based couple and family interventions for those who have experienced trauma. The authors identified four types of interventions in ascending order of focus on trauma or PTSD, those being: 1) education and family-facilitated engagement programmes; 2) generic couple therapy; 3) partner-assisted intervention; and 4) disorder-specific couple therapy. Disorder-specific couple therapy for PTSD has the most empirical evidence to attaining several clinical outcomes (i.e., decreases in PTSD symptomatology, increases in relationship functioning, and improvements in partners' psychological functioning). This particular therapeutic focus is advised regardless of the level of relationship distress, because these interventions have been studied with couples across the relationship satisfaction continuum (Maercker & Hecker, 2016; Monson et al., 2015).

Several couple-focused clinical interventions have been identified in the literature that have been used to target PTSD symptomatology among military and Veteran populations, however, were not developed specifically for the population. The present review discusses behavioural couple therapy (BCT; Sweany, 1987), cognitive behavioral conjoint therapy (CBCT) for PTSD (Monson & Fredman, 2012), several adaptations of CBCT including brief CBCT (bCBCT; Morland et al., 2022), mindfulness-based CBCT (MB-CBCT; Luedtke et al., 2015), present-focused CBCT (pf-CBCT; Pukay-Martin et al., 2015), as well as emotionally focused couples therapy (EFCT; Johnson, 2002), structured approach therapy (SAT; Sautter et al., 2009), strategic approach therapy

(STRAT; Sautter et al., 2009), and couple treatment for alcohol use disorder and PTSD (CTAP; O'Farrell & Fals-Stewart, 2000). The remainder of the Results will provide an overview of what has been identified in the literature.

Behavioural Couple Therapy (BCT)

Non-population specific couple interventions, such as behavioural couple therapy (BCT), focus on communication and problem-solving skills training as well as behavioral exercises to increase positive communication exchanges (Sweany, 1987). In a randomized controlled trial among Veterans with PTSD, Sweany (1987) found that individuals in a multi-couple group BCT experienced significant self-reported improvements in PTSD symptomatology, greater relationship satisfaction, and lower levels of depression compared to a waitlist control group (Dekel & Monson, 2010; Sweany, 1987). Other studies have reported uncontrolled treatment outcome data (Devilly, 2002; Monson, Taft, et al., 2009; Rabin & Nardi, 1991). Across additional explorations of group BCT, studies have found improvements in marital satisfaction and problem-solving communication (Cahoon, 1984; Dekel & Monson, 2010; Rabin & Nardi, 1991). Similarly, Erbes et al. (2008) described the use of integrative behavioural couple therapy (IBCT; Jacobson & Christensen, 1996), a type of BCT, for combat Veterans living with PTSD. It appears that IBCT may be well adapted to the conjoint treatment of PTSD due to the combination of acceptance approaches and standard BCT procedures to reduce both interpersonal conflict and experiential avoidance (Jacobson & Christensen, 1996; Kugler et al., 2019).

Cognitive Behavioral Conjoint Therapy (CBCT) for PTSD

Initially developed by Monson and Fredman (2012), cognitive behavioural conjoint therapy for PTSD (CBCT for PTSD) is an intervention targeted at partners, designed to reduce PTSD and other comorbid-related symptomatology, as well as enhance intimate relationship functioning (Monson & Fredman, 2012). CBCT for PTSD utilizes: a) behavioural interventions to aid with conflict management, improve communication skills, and reduce experiential avoidance of trauma-related cues; and b) dyadic cognitive interventions to highlight and challenge maladaptive trauma-related beliefs surrounding safety, trust, control, and intimacy that are thought to contribute to the development and maintenance of PTSD-related relationship distress (Monson & Fredman, 2012). In uncontrolled trials, CBCT for PTSD has demonstrated efficacy in reducing PTSD and comorbid symptoms (i.e., depression, anxiety, and aggression), as well as improving relationship functioning among service members and Veterans with a trauma history (Macdonald et al., 2016; Monson et al., 2004, 2011; Schumm et al., 2013). Monson et al. (2012) conducted a randomized clinical trial of CBCT, and findings suggested that CBCT is effective in reducing PTSD symptoms and increasing relationship functioning, compared to a waitlist control. These findings support the use of CBCT as a stand-alone treatment for couples affected by PTSD (Monson & Fredman, 2012; Monson et al., 2012). Additionally, a briefer, more scalable iteration of CBCT, known as brief CBCT (bCBCT), demonstrated ongoing effectiveness at reducing PTSD symptoms, reducing functional impairment, and improving relationship satisfaction, in comparison to an active control of PTSD family education when delivered in-person or via telehealth

modalities (Morland et al., 2022). This abbreviated treatment, consisting of eight sessions instead of 15, proved to be more effective at treating PTSD symptoms in either office-based or home-based telehealth formats than PTSD family education. Although preliminary data were promising, more research on the efficacy of bCBCT compared to standard CBCT is needed.

CBCT for PTSD requires an exploration of the person's thoughts and experiences about the traumatic event(s), as well as participation in assignments aimed at overcoming trauma-related avoidance (Pukay-Martin et al., 2017). For differing reasons, some people are unable to confront the memories of the traumatic incident directly, are unwilling to disclose the occurrence to their partner, or are unable to complete therapy (Hembree et al., 2003; Tarrier et al., 2006; Zoellner et al., 2003). The availability of nontrauma-focused therapeutic options enables clinicians to provide treatment to more people who are living with PTSD (Pukay-Martin et al., 2017). The literature proposes two versions of CBCT that circumvent this issue: mindfulness-based CBCT (MB-CBCT; Luedtke et al., 2015) and present-focused CBCT (pf-CBCT; Pukay-Martin et al., 2015).

Mindfulness-based CBCT (MB-CBCT) is an amended version of CBCT that emphasizes mindfulness-based skills such as present moment awareness that reduces both internal (trauma-related thoughts) and external (trauma-related triggers) avoidance behaviours known to be associated with PTSD (Luedtke et al., 2015). Furthermore, MB-CBCT is intended to increase awareness of communication patterns by means of decreasing the incidence of judgement (Kugler et al., 2019; Luedtke et al., 2015). Similarly, present-focused CBCT (pf-CBCT; Pukay-Martin et al., 2015) was developed

as an alternative to trauma-focused therapy that directly targets PTSD symptoms within a couples context and works to improve relationship satisfaction (Pukay-Martin et al., 2017). The treatment focuses on current PTSD-related concerns for the couple, rather than revisiting past traumatic experiences. In the event of trauma disclosures arising during sessions, couples are gently reoriented to discussing how the traumatic event is affecting them presently, thus ensuring the treatment remains nontrauma and present-focused (Pukay-Martin et al., 2017).

Emotionally Focused Couples Therapy (EFCT)

Emotionally focused couples therapy (EFCT) is an empirically-validated treatment for intimate partners that aims to strengthen emotional responsiveness and sense of emotional safety (Baucom, 1998; Johnson, 2002). The main principle of EFCT is rooted in objects relations and attachment theory, and it proposes that PTSD symptoms contribute to a dysfunctional pattern of attachment, which reduces resiliency and fosters insecure attachment to a romantic partner (Johnson, 2002; Kugler et al., 2019; Weissman et al., 2018). EFCT has been proven effective at improving relationship and life satisfaction in Veterans' partners, as well as reducing relationship distress, individual PTSD and depression symptomatology in both Veterans and their partners (Ganz et al., 2022; Weissman et al., 2018).

Structured Approach Therapy (SAT)

Structured approach therapy (SAT), a couple-based treatment for PTSD developed by Sautter et al. (2009), combines psychoeducation about the effects of trauma on relationships, communication training, intimacy enhancement, and partner-assisted in

vivo exposure. Participation in the initial standardized treatment was associated with decreased PTSD symptoms in Veterans of the Vietnam War (Sautter et al., 2009), and has since been adjusted to better fit the needs of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) Veterans due to this cohort being particularly vulnerable to distress and mental health concerns (Sautter et al., 2011). The SAT protocol was amended following the first few sessions through the addition of training in empathic communication and emotion expression (Guerney, 2005), as well as behaviour activation interventions to increase positive affect (Jacobson et al., 2001) and reduce emotional numbing (Sautter et al., 2009). SAT is similar to CBCT as both include significant psychoeducation about PTSD and its impact on relationships, as well as a focus on avoidance patterns, while enhancing couples' communication skills. However, unlike CBCT, which focuses on altering the couple's maladaptive cognitions about trauma, SAT focuses on trauma-related affect that is destructive to relationships by employing a stress inoculation paradigm (Sautter et al., 2014). Initially proposed by Foa et al. (1999), the stress inoculation paradigm teaches the couple emotion regulation skills and then introduces procedures to activate the couple's trauma-related emotions (Foa et al., 1999; Sautter et al., 2014). Research findings have demonstrated that participation in SAT reduces PTSD symptoms in Veterans while also reducing relationship problems and distress in their spouses (Sautter et al., 2014). A randomized clinical trial using SAT supported previous findings, in that it was associated with significant improvements in Veterans' self-reported PSTD symptoms, as well as relationship adjustment, attachment avoidance, and attachment anxiety (Sautter et al., 2015).

Couple Treatment for Alcohol Use Disorder and PTSD (CTAP)

Couple treatment for alcohol use disorder and PTSD (CTAP) is a treatment for comorbid PTSD and alcohol use disorder (AUD) that combines core features of two previously introduced, empirically supported treatment protocols: behavioural couple therapy for AUD (BCT for AUD; Jacobson & Margolin, 1979; O'Farrell & Fals-Stewart, 2000) and CBCT for PTSD (Monson et al., 2004). Given the known associations between alcohol consumption and the maintenance of PTSD symptoms, an aim of BCT for AUD is to achieve abstinence from alcohol and lessen PTSD symptoms (O'Farrell & Fals-Stewart, 2000). To do this, BCT for AUD employs behavioural principles, specifically regular reinforcement from a supportive romantic partner (O'Farrell & Fals-Stewart, 2000). CBCT highlights the bidirectional influence of PTSD and relationship functioning, noting how PTSD symptoms have a negative impact on relationship function, and relationship dysfunction has a negative impact on PTSD symptoms. Monson et al. (2004) suggest that addressing these areas concurrently will result in the most effective transformation. CTAP's main objectives are contingency management and reinforcement of alcohol abstinence, cognitive modification for trauma-related thoughts and avoidance behaviours, and increased communication skills between partners to improve relationship function (Kugler et al., 2019; Schumm et al., 2015).

Strategic Approach Therapy (STRAT)

Strategic approach therapy (STRAT) aims to lessen PTSD symptoms by focusing on avoidance symptoms. PTSD symptoms such as effortful avoidance (i.e., avoidance of outward cues of trauma or of trauma-related thoughts and feelings) have a negative

impact on relationship function, which exacerbates PTSD symptoms (Sautter et al., 2009). STRAT's major change mechanisms include motivational enhancement, coping effectiveness, and improving positive communication between partners to lessen internal emotional avoidance (Sautter et al., 2009). Partner-assisted anxiety reduction approaches are used to reduce avoidance and strengthen bonds within intimate partner relationships. STRAT aims to diminish shared avoidance behaviours in order to repair interpersonal damage and reduce PTSD symptoms among Veteran populations (Kugler et al., 2019; Sautter et al., 2009).

DISCUSSION

As of current, there exists a paucity in the literature of evidence-based clinical interventions developed specifically for or adapted to couples that are affected by MST. While the model proposed by Goodcase et al. (2015) that can inform the structure of MST treatment is a promising step, it has not been implemented into clinical practice, and is therefore not yet empirically supported. Existing, evidence-based clinical interventions that are available to couples is limited to options that target PTSD symptomatology and relationship functioning. As previously described earlier in this thesis, there is an association between experiences of MST and PTSD. Given this intersection, options that target PTSD symptomatology, irrespective of the precipitating cause, can be considered, however may not be ideal. Couples may benefit from a more tailored intervention given the uniqueness of MST from both civilian sexual trauma and other military-related traumas (i.e., combat trauma). The literature describes how Veterans have worse treatment outcomes from evidence-based psychotherapies than civilians (Straud et al.,

2019) and up to 50% of Veterans do not achieve clinically significant changes (Steenkamp et al., 2015). The literature posits that exposure to different types of trauma, such as MST, which is associated with more severe PTSD than other types of trauma, including combat (Sexton et al., 2017) and civilian sexual trauma (Himmelfarb et al., 2006) may be accountable for these treatment outcome discrepancies (Holliday et al., 2020; Lofgreen et al., 2020; Sripada et al., 2019). Survivors of MST may encounter complicated interactions in attempts to report the incident within existing systems of hierarchy and control in the military (Frankfurt et al., 2018; Monteith et al., 2016), higher rates of other interpersonal trauma than combat Veterans (Lofgreen et al., 2020), and greater challenges with emotion regulation (Lofgreen et al., 2020), all of which may impede treatment outcomes (Khan et al., 2020). Existing therapeutic approaches used with military-connected couples living with MST fail to appreciate how sexual trauma uniquely affects intimate partner relationships compared to other forms of trauma, due to military culture exacerbating the adverse psychological outcomes that already exist for survivors of sexual trauma, as well as how clinical interventions might be more effective if they targeted specific relationship dimensions known to be impacted by MST and MST-related PTSD, such as sexual functioning.

Literature surrounding clinical interventions developed specifically for civilian sexual trauma survivors, or for those who have experienced MST could potentially inform future iterations of clinical interventions that could be tailored to couples. Cognitive processing therapy (CPT) has demonstrated efficacy in treating PTSD symptoms in Veterans and is often deemed as a first line intervention (Charney et al.,

2018). A review study by Boehler (2019) explored the efficacy of CPT in treating MST-related PTSD in Veterans, which found that there was a significant reduction in MST-related PTSD symptoms and negative cognitions. However, Boehler (2019) also warns that results should be interpreted with caution. Among four of the five reviewed studies in the paper by Boehler (2019), the findings were reported within a context of a lack of treatment fidelity, and the authors of the studies noted that participants were not receiving standardized CPT (Boehler, 2019). These claims highlight the need for a formalized, amended version of CPT that can better serve military populations given the unique sociocultural effects (i.e., deindividuation, shared system of values, and an emphasis on obedience) that military members experience.

One study that used CPT for MST survivors reported how reductions in negative posttraumatic cognitions from pre- to post-treatment were associated with reductions in PTSD symptoms (Holliday et al., 2014). Since CPT involves cognitive restructuring, clinicians can help decide which cognitions will be directly targeted in session (Resick et al., 2016). Understanding whether specific negative posttraumatic cognitions are unique to MST survivors could help therapists identify important therapy targets for cognitive-behavioral therapies and facilitate treatment delivery. The study recruited 45 Veterans with a diagnosis of MST-related PTSD, who were randomized to receive either CPT or present centred therapy. Participants who received CPT had statistically significantly lower negative cognition scores post-treatment and at follow-up sessions than participants in the present centered therapy condition. In addition, negative cognitions were positively correlated with PTSD symptom severity. After controlling for present symptom severity,

MST survivors endorsed substantially stronger posttraumatic cognitions related to self-blame than those who did not report an experience of MST. Specifically, MST predicted the following cognitions: "The incident happened to me because of the kind of person I am," "Someone else would have stopped the incident from happening," "Someone else would not have gotten into this situation," and "There is something about me that made the event happen," after controlling for severity of PTSD and depression symptomatology (Carroll et al., 2018).

An understanding of military culture is necessary in contextualizing these findings related to heightened PTSD severity among Veterans and a tendency toward negative cognitions orienting around self-blame. Military personnel are trained to be self-reliant and capable of protecting themselves from the "enemy," and military culture is known for endorsing values of strength, self-sufficiency, and personal responsibility (Castro et al., 2015). Experiencing MST may undermine one's sense of self-sufficiency and engender beliefs that others, having received the same military training, would not be victimized, subsequently leading survivors to view victimization as a personal failure (Carroll et al., 2018). Military culture may further exacerbate the pervasive "rape culture" that exists within society that contributes to perceptions of self-blame. Considerations that are unique to military culture include barriers to reporting sexual trauma, strengthened group cohesion and de-individuation, which contributes to the propagation of negative sexual and gender beliefs, as well as a strong sense of trust and reliance on fellow service members and commanding officers. These unique cultural considerations contribute to feelings of betrayal that is almost incestual in nature, given the all-encompassing

perception of the military as a family (Goodcase et al., 2015). These findings underscore the need for cultural change surrounding attitudes toward sexual assault within the military, which appear to increase the likelihood of developing negative posttraumatic cognitions for many survivors (Carroll et al., 2018). However, a sole emphasis on the awareness of differences that exist within the military is insufficient; this awareness must be supplemented with a desire to implement changes, in order to address the inadequacy of current interventions and enact meaningful change for survivors.

Several couple-based support services are available for actively serving military members and Veterans and their partners. The Veteran Couples Integrative Intensive Retreat (VCIIR) is a week-long, retreat-style intervention that aims to reduce PTSD symptoms and ameliorate relationship distress. VCIIR utilizes conjoint psychoeducation to reduce stigma surrounding PTSD symptoms and increase help-seeking, as well as emphasizes building emotion regulation skills and rebuilding partner attachment through empathic communication (Monk et al., 2016). Thus, VCIIR seeks to reduce PTSD symptoms through the use of therapeutic techniques and repair damaged relationships through increasing communication skills and shared positive experiences (Kugler et al., 2019). Another program, Couple HOPES (Helping Overcome PTSD and Enhance Satisfaction), is a guided, online intervention for couples adapted from CBCT for PTSD. Among a series involving 10 couples, participants with PTSD experienced statistically significant pre- to post-intervention effect size improvements in PTSD symptoms and perceived health. These individuals also exhibited other small to medium effect size improvements in quality of life, depression, argumentativeness, anger, and anxiety,

however they were not statistically significant (Fitzpatrick et al., 2021). Partners experienced moderate pre- to post-intervention effect size improvements in relationship satisfaction that were statistically significant (Fitzpatrick et al., 2021). Within a Canadian context, Wounded Warriors Canada provides a peer-based couple program, called Couples Overcoming PTSD Everyday (COPE). Targeting Veteran couples who have experienced an operational stress injury, phase one of the program involves a five-day retreat with five couples who spend support time together to work on their relationships as a group. Phase two of the program provides ongoing family coaching, involving three telephone-based sessions per month over six months to ensure that the skills learned during the initial phase are maintained (Tam-Seto et al., 2016; Wounded Warriors Canada, 2015). These conjoint support services show promise in meeting the needs of military and Veteran couples who are living with service-related PTSD. Regarding future directions, this body of work could benefit from a focus on more specific types of trauma, such as MST, as well as more formalized clinical research that can provide evidence on outcomes and efficacy.

Furthermore, the literature highlights the effect of MST as a salient issue on specific relationship dimensions within intimate partnerships, such as sexual functioning. Research consistently identifies lower sexual satisfaction and function as mediating the association between MST and relationship satisfaction among service members and Veterans and their partners (i.e. Blais, 2020). The literature also notes that specific PTSD symptom clusters mediate the association of MST severity and sexual function and satisfaction in women service members/Veterans (i.e. Blais et al., 2018). Extant couple

therapies used among service members and Veterans (i.e., CBCT and EFT, as aforementioned), could be amended to explore and treat sexual issues. To address sexual trauma, relationship satisfaction, sexual dysfunction, and sexual dissatisfaction, it may be of worth to explore interventions that prioritize a focus on processing the trauma, assisting individuals to see themselves as survivors rather than as victims, reaffirming a survivor's perspectives that sexual experiences are safe and consensual, and cultivating a belief that healing is a combined effort between the survivor and their partner (Blais, 2020; Meston et al., 2013; Nasim & Nadan, 2013). This would be valuable given that current PTSD treatments for individuals do not seek to improve sexual functioning (O'Driscoll & Flanagan, 2016). In addition, findings from Blais et al. (2020) discuss how interventions that target improving sexual functioning among MST survivors may be most effective if they target depression symptoms and PTSD-related anhedonia (Blais et al., 2020).

Limitations

Acknowledging the limitations of this narrative review, only peer-reviewed publications were considered. Future research may benefit from the inclusion of grey literature, such as dissertations and book publications, which could add to the clinical understanding of novel treatment interventions. In addition, it is important to acknowledge how countries differentially define the status of 'Veteran.' The literature does not always specify the kind of Veteran that is being referred to. Given different language use across studies, this will impact how the literature can be understood. Furthermore, with respect to next steps for this field of research, it may be beneficial to

conduct a more rigorous review that is scoping or systematic in nature. Lastly, this search only discussed the experiences of heterosexual couples, and vastly underappreciates the experience of non-heteronormative couples. Future research would greatly benefit from additional exploration around how sexual trauma affects 2SLGBTQIA+ intimate partners.

CONCLUSION

Incorporating conjoint clinical treatments for couples impacted by sexual trauma is both timely and powerful. The inclusion of an intimate partner engenders an opportunity for healing on a more meaningful relational level, which is particularly salient given previously highlighted associations between perceived social support and PTSD symptoms among trauma survivors. The development and implementation of tailored treatments for couples who have been affected by MST that address specific relationship dimensions known to be affected, such as sexual functioning, PTSD-related symptomatology that affects conflict behaviour, communication, and intimacy, all while leveraging an understanding of the underlying contextualizing factors of military involvement, would be a valuable contribution to clinical practice. Through constructing a clinical intervention informed by these elements, clinicians can begin to implement highly meaningful and effective changes in those affected by sexual trauma and MST-related PTSD, as well as the wellbeing of one's partner, and the functioning of the intimate partner relationship as a whole.

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Chapter 5

Conclusion

Couples where one individual has experienced MST can face numerous relationship issues, including difficulties understanding the assault, commitment and attachment issues (Goodcase et al., 2015), poor communication patterns (Miller et al., 1982), sexual dysfunction (Blais et al., 2022; Blais, 2020; van Berlo & Ensink, 2000), and challenges with intimacy more broadly (Georgia et al., 2018). While a number of studies discuss the effect of trauma experienced by the serving member on the intimate partner relationship (Dekel & Monson, 2010; Ghahramanlou-Holloway et al., 2011; Sayers, 2011), there are a limited number of studies that illuminate the effect of sexual trauma on the intimate relationship itself (Goodcase et al., 2015), and it is rare to find an article that focuses exclusively on the impact of MST on couples (Goodcase et al., 2015). Yet, research has consistently reported the unique challenges that can potentially exacerbate the effects of MST on couples where one or both partners are in the military. Military couples face unique stressors by nature of being affiliated with the military, including combat exposure, heightened risk for PTSD development, frequent deployments, reintegration, long-distance relationships, and balancing family life (Ghahramanlou-Holloway et al., 2011).

The present thesis sought to explore the dimensions and impacts of MST that affect intimate partner relationships. These phenomena were examined across three chapters. The first study, a scoping review, sought to explore how the literature

conceptualized and described the intersection between MST, PTSD, and intimate partner relationships. Upon the analysis of various themes that came out of the scoping review, a narrative review was undertaken to identify and synthesize knowledge of the relationship between sexual trauma and moral injury, within a military context. Findings from the first two chapters highlighted a focus on clinical interventions and created space to learn more about clinical interventions available to intimate partners. The final phase of the present thesis consisted of a second narrative review that explored the clinical interventions available to military couples whereby one or more partners has experienced trauma and potentially lives with trauma-related PTSD. This work highlighted a lack of clinical interventions suited to meet the needs of couples impacted by MST specifically. Findings from the literature are supported by current qualitative research, which echoes the underlying impacts of MST on intimate partner relationships, as discussed below.

SUPPLEMENTAL PRIMARY DATA COLLECTION

Findings from the literature reviews discussed in previous chapters are reflective of themes coming out of current primary data. As part of a broader qualitative study being undertaken within Canada, supported by the Canadian Institute for Military and Veteran Health Research (CIMVHR), interview data were collected from survivors regarding how MST has impacted various domains of their lives and wellbeing. A subset of the interview guide was dedicated to exploring the effects of MST on survivors' intimate partner relationships. A constructivist approach was taken with this research. Constructivist researchers seek to understand the individual meaning and context of participants, noting the way participants see the world and how their experiences shape

reality (Tracy, 2013). The results were organized on the basis of iterative thematic analysis into the following subthemes: issues around disclosure and communication, challenges with intimacy, navigating trauma-related symptoms, and challenges with trust and attachment.

Issues Around Disclosure and Communication

Numerous participants discussed their inability to disclose their MST experiences, as well as their struggles in the aftermath of the incident to their intimate partners. Even after many years, survivors do not disclose the details of their MST and prefer not to talk about it. For example, this participant shared:

> I never, ever told my partners. Like my husband, we're divorced now, but I mean, I never told him. My common law husband now, he knows something went on and that something happened, but I've never told him what exactly. We've been together eighteen years and I've never told him exactly what. I just, I don't, I just don't talk about it.

Another participant noted unwillingness to tell their intimate partner about the psychological difficulties they are experiencing as a result of MST, highlighting the need for secrecy and the perceived taboo nature of disclosing this type of information:

> I've looked at programs but again, that presumes that I'm willing to tell my husband, 'Look honey I'm having a hell of a time, I need to leave and go get some therapy.' He's part of the problem. I've identified him as part of this problem, I'm going blow up my whole life to go get some help. I don't know if I can do that. It's bad enough I hide away in here to talk to you, and he doesn't know what the hell's wrong with me. So, it's very secretive.

This participant expressed challenges communicating with their partner, particularly in periods where they feel as though their mental health is struggling:

> Even in my current relationship, there have been times where I've gone– especially when I'm really depressed, I get very emotionless, and I kind of forget that he's there and he'll feel very rejected by me. I have to remember that I'm in a

> relationship and I have to maintain that relationship. I need to talk to him if I'm not feeling very good or anything like that. I have to have communication with him.

Challenges with Intimacy

Nearly all participants expressed not wanting to be touched following their experience of MST. Across interviews, participants reported feelings of disgust when intimate partners initiated any type of touch, would intentionally avoid dating situations that got to a point where physical touch was involved, and demonstrated startle responses when touched:

> I became more isolated within myself, I didn't want to be touched, I was very– I had a huge startle response […] It was hard to uh, to be with him and let him touch me and even though I loved him, it took a long time.

Other participants highlighted the challenges in communicating theses hesitations around intimacy with their partner, noting the repercussions of these feelings on their partners' perceptions. This participant shared:

> I was unable to speak to my partner in saying that, you know, I'm feeling uncomfortable here. I really don't want to have sex with you because I don't feel like I'm wanting of that. So, a lot of times in relationships they would tell me that I'm being cold, that I'm not being affectionate, because I couldn't even like, I wasn't really a big cuddler.

Despite challenges with intimacy, participants consistently highlighted their appreciation for their current partners' patience, understanding, and support. For example, this participant stated:

> Being intimate has been painful, actually, in the past few years. We've sought counselling, we sleep in separate bedrooms, but he's super supportive and we're just close in other ways. Thankfully I've got him as a partner but it's certainly– I find it very difficult to be intimate at this stage of my life.

Navigating Trauma-Related Symptoms

A number of participants expressed difficulties in situations that they were not in control of following their MST experience. This participant described their emotional volatility, and shared:

> It's made me volatile with anything that I'm not immediately in control of. If it's not following a pattern, if it's not following the script that I think it should be following, I tend to find it quite stressful and quite aggravating.

One participant highlighted an inability to date due to an intolerance of the physical symptoms that the experience may entail, and stated:

> I can't date because I can't handle anything that causes adrenaline. My body can no longer handle being around someone maybe that I'm attracted to and going on a date and stuff. My mental health is not good enough to ever entertain dating because it's taken me, you know, five years just to get to the point where I'm not throwing up all the time and I'm not having constant anxiety attacks. I can't add anything to my life that has any stress.

Another participant described the effects of hyperarousal and subsequent aggression on their intimate partnership, and indicated the following:

> Within our first year of marriage, we were fighting at least two to three times a week and that had a lot to do with not having treatment for posttraumatic stress disorder… You don't realize the problem until someone points out 'hey, you know, that's not normal.' With PTSD, if you're in that mindset of everything's about to get you and anything out of your control is a danger, you don't notice how much you're isolating yourself. Well, for twenty years I've created a life for myself where I can hermit quite comfortably and no one really notices because that's the pattern I set up.

One participant reported the effects of avoidance and numbing symptoms, also common with a diagnosis of PTSD, to describe their detachment from romantic relationships and said:

> If I was in like a relationship with somebody, I was very closed off, like I just didn't have a ton of emotions at all. They would say things to me, and they'd be

> like, 'do you even love me?' and I'd be like 'it's debatable.' Did I really put that much effort into actually loving you, I'm not sure, because I was again so very– I was detached from relationships.

Challenges with Trust and Attachment

Echoed in the aforementioned subthemes, challenges with trust and attachment appeared to be a prevailing issue for intimate partner relationships whereby one partner had experienced MST. One participant expressed an unwillingness to pursue a romantic relationship out of fear of judgement from their potential partner, sharing:

> You're kind of moping around and you're just like yeah, it'd be really nice if I could talk to somebody about these feelings without worrying that they're going to go running off like, 'oh my god your head is really messed up in there,' because that's the way it feels.

Relationship Avoidance

Within the subtheme of challenges with trust and attachment is the intentional avoidance of romantic relationships from individuals who have experienced MST. One participant, having appreciated the pervasive and deleterious nature of the impact of MST on previous relationships, expressed a strong desire against pursuing a romantic relationship:

> I have no hope or no wish for any type of romantic relationship and it really affected the ones that I had earlier on in my career when these things started happening.

Another participant described dating as burdensome, both with respect to feeling as though it was an added weight on their lives, as well as wanting to avoid being perceived as a burden by future potential partners. They stated:

> I ended the relationships really quickly because I got to a point where I didn't even like pursue dating anybody anymore. Even guys I seemed to like, I would turn them down and stuff because I just didn't want it anymore. I didn't want to

> go. I don't know, I almost consider like dating now and then for the last several years is just like a burden that I don't want, and I'm sure I'm a burden they don't want to take on.

MILITARY CULTURE AND THE INTIMATE PARTNER RELATIONSHIP

Sociocultural factors relative to the military have been discussed throughout the course of the present thesis. Findings of this work highlight how knowledge around military culture is important in understanding MST and informing clinical practice. Individuals who have experienced MST function within military cultural norms that exacerbate the psychological hardship that follow sexual assault, including issues with power and control, deindividuation, an emphasis on duty and obedience, and the all-encompassing nature of military life (Goodcase et al., 2015; Turchik & Wilson, 2010). However, with respect to intimate partner relationships specifically, one important facet of military culture that is underappreciated is the perception of the family unit, and more specifically, the intimate partner relationship.

In 2008, the CAF unveiled the *Canadian Forces Family Covenant*, a commitment pledging support to military families. It formally acknowledges the epitomal role that military partners and families play in supporting service members. The Covenant emphasizes the key contributions that partners and families make in allowing for an operationally effective and sustainable military force. The Covenant recognizes the extraordinary levels of sacrifice required of military families and reinforces the CAF's commitment to ameliorate the many burdens that service life imposes on partners and families. The Covenant is as follows:

> "We recognize the important role families play in enabling the operational effectiveness of the Canadian Armed Forces and we acknowledge the unique nature of military life. We honour the inherent resilience of families, and we pay tribute to the sacrifices of families made in support of Canada. We pledge to work in partnership with the families and the communities in which they live. We commit to enhancing military life." (Canadian Armed Forces, 2008)

Unlike with civilian professions, the military requires a level of commitment and identification of partners and families more broadly. Military spouses are inherently woven into an individual's military identity, and are undoubtedly affected by military-related traumas, especially MST. The sacrifice made by those who serve requires a related sacrifice by their entire family, thus imparting a set of values and norms unique to military families. The consistent relocations of military life result in a constant flux of support structures, which might include schools, friends, and routines (Meyer et al., 2015). Military communities are prepared to quickly accept new members. As such, departing from the military can be challenging (Ray & Heaslip, 2011) given that the family not only loses its military identity, but also its greater military community (Holmes et al., 2013). The military culture, of the service member and their respective partners and families, as well as the bidirectional impact of military events with the family unit are all salient considerations when providing care to military members and their families (Meyer et al., 2015). These findings underscore the relevance and need for work to better understand the dimensions and impacts of MST on intimate partner relationships. The present thesis aims to serve as an early step in this direction, while also highlighting identifiable gaps in the literature. The inclusion of GBA+ as foundational to this work shone light on a paucity of attention surrounding the MST experiences of individuals in LGBTQ+ relationships, which will be discussed below.

A SPOTLIGHT ON LGBTQ+ RELATIONSHIPS

Prioritizing a sex and gender-based lens for research underscores the need to understand the experiences of non-heteronormative couples. Given that a GBA+ lens was taken with the present thesis, findings clearly highlighted an absence of representation for queer relationships within the current literature. Therefore, there exists a need for future research in this area given the differential stressors known to affect this population.

Lesbian, gay, and bisexual (LGB) Veterans report higher levels of emotional distress, trauma exposure, and PTSD symptomatology than both non-LGB Veterans and LGB civilians (Rashkovsky et al., 2022). Traumatic experiences, including MST, affect intimate partner relationships and put LGB Veterans at higher risk of relationship dysfunction (Rashkovsky et al., 2022). Research findings on MST in lesbian and bisexual (LB) women Veterans is mixed. One study reported rates that are similar to heterosexual women (Lehavot & Simpson, 2014), while another study, published at a similar time, reported higher rates of MST among LB women (Mattocks et al., 2013). In accordance with LGB individuals' increased exposure to trauma, this population experiences higher rates of PTSD relative to their non-LGB counterparts (Roberts et al., 2010). The literature posits that this may be due to increased traumatic experiences, discrimination on the basis of one's sexual orientation, and a lack of support from families and government systems (Rashkovsky et al., 2022).

In spite of the deleterious effects of minority stress and increased trauma exposure, LGB individuals have successful and supportive intimate partner relationships, which may serve as a source of resilience within the wider context of trauma risk

(Rashkovsky et al., 2022). Those in same-gender relationships report equally high or higher relationship quality relative to heterosexual relationships (Balsam et al., 2008). Study findings demonstrate that relationship satisfaction is higher among lesbian-identifying women Veterans receiving PTSD treatment compared to heterosexual women (Blount et al., 2017).

Despite the known association between elevated PTSD symptoms among Veteran populations, LGB Veterans and their partners reported positive relationship and sexual functioning, healthy conflict tactics, low levels of aggression, and high levels of constructive negotiation (Scheer & Poteat, 2021). This finding differs from results among heterosexual couples, which typically report a correlation between increased PTSD symptom severity and declining relationship and sexual functioning (Campbell & Renshaw, 2018).

THE NEED FOR TAILORED CLINICAL INTERVENTIONS

Partnered service members and Veterans experience a variety of unique stressors that have the potential to place additional strain on their intimate partner relationships, emphasizing the importance and need for conjoint interventions for this cohort (Kugler et al., 2019). These stressors include extended periods of separation during deployment, higher psychological distress resulting from the inherent dangers of deployment (Gimbel & Booth, 1994), frequent relocations (Erbes et al., 2008), post-deployment adjustment difficulties (Hoge & Cotting, 2004; Kline et al., 2010), PTSD (Kline et al., 2010), depression (Maguen et al., 2011), sexual dysfunction (Blais et al., 2018), reduced sexual satisfaction (Blais et al., 2019), reduced perceptions of social support (Brancu et al., 2014;

King et al., 2006), and notably, military sexual trauma (Blais et al., 2019; Ilies et al., 2003). These stressors are risk factors for relationship distress and decreased relationship function, independent of PTSD symptomatology (Martin & Sherman, 2012). Indeed, the presence of PTSD symptoms is theorized to interact with relationship distress in a cyclical fashion, such that more severe PTSD symptoms are associated with higher relationship distress, and contrarily, higher relationship distress is associated with increased PTSD symptoms (Monson et al., 2004). In addition, extant research describes how greater relationship difficulties are associated with more severe PTSD symptoms (Kugler et al., 2019; Taft et al., 2011). The unique experience of military couples, supplemented by the heightened risk for developing service-related PTSD, particularly following experiences of MST, necessitate attention towards the development of interventions that can meet the needs of intimate partner relationships that are in distress following the impacts of MST.

CONCLUSIONS: THE NEED FOR MILITARY CULTURAL COMPETENCY

Underlying the findings across all three chapters of the present thesis is the need for military cultural competency. Extant research on cultural competence consistently demonstrates the failure of mental health care providers to acknowledge, understand, and manage sociocultural differences in their patients. As a result, effective communication may be hindered, there may be a lack of therapeutic alliance formation, and patients may leave dissatisfied, thus contributing to worse health outcomes overall (Betancourt & Green, 2010).

Immersion in military culture can be so ineffaceable that Veterans may identify with it more than any other cultural influence, even many years after service has concluded. Although, for some individuals, military culture can be a source of tension. Currently serving military and Veteran women have described military culture as negatively affecting their experience and recovery from MST (Bell et al., 2014). For better or worse, military culture indoctrination is so powerful that it can fundamentally change an individual's worldview, often hindering the military to civilian transition (Brewin et al., 2011). Some scholars have gone as far as arguing that military culture may be the real patient when providers are treating military-related trauma (Jones, 2011). Eloquently stated by Hall (2011), "Unless we understand their language, their structure, why they join, their commitment to the mission, and the role of honor and sacrifice in military service, we will not be able to adequately intervene and offer care to these families" (Hall, 2011, p. 4).

Until recently, recognition that the military was a culture and required culturally competent care, just as other cultures do, was not existing in the literature. Now, professionals from various disciplines around the world have unanimously avowed that military cultural competence is an epitomal component of care provision for military members and their families (Meyer et al., 2015). Historically, poor treatment outcomes may be attributed, in part, to inadequate cultural competence of providers and non-culturally informed approaches to the care of military personnel, Veterans, and their partners. Following these assertions, efforts have been spent to improve military cultural competency of health care providers (Meyer et al., 2015). However, there continues to

exist opportunities for improvement. Indeed, there is a way forward in better serving the needs of military members, Veterans, and their intimate partners. Such efforts may involve a continued paradigm shift in providers' fundamental appreciation that military service is a tangible culture. If duly understood, this awareness can be rightfully harnessed to yield better health outcomes for service members and Veterans, the ones who risk their lives for the world, as well as for intimate partners, who in this context, risk their worlds themselves.

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Appendix

Appendix 1. PRISMA-ScR Checklist

Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	13
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	14
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	16
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	19
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	N/A
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	20
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	20
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	20
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	20
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	21
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	21
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	N/A
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	22

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.	22
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	22
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	N/A
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	22
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	24
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	32
Limitations	20	Discuss the limitations of the scoping review process.	38
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	38
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	N/A

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.
* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.
† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).
‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.
§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

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