AN INTRODUCTORY GUIDE

MILITARY SEXUAL TRAUMA

A PRIMER FOR CANADIAN HEALTH CARE PROVIDERS

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ATLAS INSTITUTE FOR VETERANS AND FAMILIES

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INTRODUCTION

The Atlas Institute for Veterans and Families is committed to improving the well-being of Canadian Veterans and their Families. Thank you for your interest in learning more about military sexual trauma (MST) and how you can better care for and support Veterans and Veteran Family members.

This primer aims to provide you, as a Canadian physical, mental health or spiritual care provider, an introduction to MST, how it can impact a Veteran's health care encounters in their life after service and applicable practice tips. Providers across a range of roles may knowingly or unknowingly provide care to Veterans, and the application of this knowledge and these practice tips can make a significant difference for Veteran patients impacted by MST.

Providers who may benefit from this resource include, but are not limited to, the following professionals:

- Chaplains
- Chiropractors
- Counsellors
- Dentists
- Medical imaging professionals
- Nurses
- Nurse practitioners
- Occupational therapists
- Optometrists
- Osteopaths
- Physicians
- Physician assistants
- Physiotherapists
- Psychologists
- Psychotherapists
- Social workers

Administrators and students in these professions may also benefit.

HOW WAS THIS PRIMER DEVELOPED?

The first version of this resource was developed in collaboration with the Atlas Institute's MST resource development advisory committee, who provided feedback and validated the applicability of the resource to the Canadian context. In addition to the contributions from the advisory committee, the information was based on a variety of sources, including an environmental scan of primary research, government publications, policy documents and training videos. The updated version was based on further feedback and reviews from Veterans and service providers and additional primary research. As research on MST is still emerging in Canada, knowledge from other countries is included.

Primer scope and limitations

Building an understanding of the impacts of MST on health care encounters and care provision involves integrating knowledge about MST, the Canadian Veteran/military context, and clinical and service provision knowledge.

Canadian Veteran/military cultural context. This primer provides highlights about the Canadian military cultural context that a) can be relevant to Veterans who have a history of MST and b) would helpful to a range of professional roles across settings that may provide care to Veterans [1,2]. As discussed in subsequent sections, understanding this context enhances assessment and care. There are resources that can provide a more fulsome review of Veteran/military-culture roles and demographics, and readers are encouraged to additionally pursue those resources.

Clinical/service provision. The information provided may build upon or intersect with other clinical/service provider knowledge and practices you may bring within your scope of practice, such as trauma-informed care, sex- and gender- based analysis and expertise-specific knowledge (e.g. sexual trauma). Leveraging this pre-existing knowledge and integrating a Veteran-specific understanding will make a positive impact for Veterans. For those who may have less experience in these areas, readers are encouraged to pursue that training and expertise as is applicable to their role.

AS A HEALTH CARE PROVIDER, WHY DO YOU NEED TO KNOW ABOUT MILITARY SEXUAL TRAUMA?

You may be treating a Veteran or a Veteran Family member without realizing it.

Unknown to many health care providers, and to Canadians more generally, when military members leave military service, their health care transitions from the Canadian Forces Health Services Group to their local provincial or territorial health care system [3]. One out of every 62 Canadians is a Veteran [4,5], so it's not uncommon for health care providers to provide care to Veterans without being aware of it. Actively screening for military service as part of taking a psychosocial history at intake is important.

It is also possible your patient may not be a Veteran, but a Veteran Family member. Family members can be impacted by a Veteran's traumatic experience(s), and, depending on your role, they may share that with you. While the information in this resource is Veteran-centric, because research focused on the impacts of MST on a Veteran Family is limited, this resource is still relevant for health care providers caring for Veteran Families. It can provide an understanding of the nuances of sexual trauma within a military context and offers additional awareness for what a Family member may be experiencing. This knowledge further equips you to respond to possible disclosures from a Veteran Family member in an empathetic and informed way, facilitating trust between you and your patient [6].

Veterans have had unique experiences that influence their health care needs.

Veterans have engaged in, or been exposed to, a wide range of experiences — positive as well as difficult and painful — that can have varying health and life impacts. Additionally, military service happens within a unique cultural context; a context with its own language, values, traditions, social organization and behavioural norms [3,7,8] which can have direct and indirect health care implications. Knowing your patient is a Veteran and better understanding that context [3,9,10] allows you to actively seek information about the range of their experiences to strengthen your assessment, understand their health needs and provide tailored clinical care [11]. It can also help build rapport and trust with the Veteran to whom you are providing care.

Understanding MST can lead to more effective and sensitive care.

When Veterans are not routinely asked about MST when screening for other trauma-related issues, its effects may not be recognized. As a result, presenting health concerns may be misdiagnosed, and physical and mental health needs may not be met with a sensitive, timely and integrated response [12]. A history of MST can affect a Veteran's willingness to undergo certain examinations and procedures [11], leading to poorer health outcomes if those barriers are not understood and addressed. Your increased understanding of military-related traumas, such as MST, can lead to sensitive and effective care and strengthen your relationship with Veteran patients. you are providing care.

YOU DON'T NEED TO BE A MENTAL HEALTH CARE PROVIDER TO PROVIDE SUPPORTIVE CARE TO VETERANS IMPACTED BY MST.

WHAT TERMS ARE IMPORTANT TO KNOW?

Common terminology can allow for shared understanding. The following are definitions for key terms used throughout this document.

Canadian Armed Forces (CAF) is the Canadian military, which consists of the Royal Canadian Navy (RCN), the Canadian Army, the Royal Canadian Air Force (RCAF) and the Canadian Special Operations Forces Command (CANSOFCOM) [13,14].

Military sexual trauma (MST) refers to any sexual or sexualized activity that occurs without the person's consent during their service as a member of the CAF and the physically or psychologically traumatic impacts of this activity on the affected person. The spectrum of MST can vary from a small impact to severe disorders. MST is currently not listed as a diagnosis in the DSM-5-TR or ICD-11 [15]. There are various definitions of MST that exist or are in development, and this language can evolve over time.

People can vary in how they self-identify or refer to those impacted by MST. For providers, using terms such as "patient," "Veteran" or "impacted by MST" helps address potential attitudes or biases that can become barriers to patient-centred care. Your patient may also share their preference over the course of their care.

Reserve Force consists largely of CAF members who have part-time service positions. There are four Reserve Force subcomponents: the Primary Reserve Force, the Canadian Rangers, the Cadet Organizations Administration and Training Service, and the Supplementary Reserve [16].

> **Primary Reserve Force** "mainly consists of part-time soldiers, sailors, airmen and airwomen who work in armouries while they have other full-time civilian employment or attend school [16]."

Trauma-informed approach includes trauma-specific interventions, such as assessment, treatment or recovery supports, in addition to incorporating trauma-informed principles (e.g. safety, empowerment, voice and choice) within an organizational culture [17].

Veteran refers to "any former member of the Canadian Armed Forces who successfully underwent basic training and is honourably discharged [18]." Former Royal Canadian Mounted Police members are also considered Veterans; however, this resource is specific to former serving members of the Canadian Armed Forces.

Veteran Affairs Canada (VAC) is the department of the Canadian federal government working "to provide exemplary, patient-centred services and benefits that respond to the needs of Veterans, our other patients and their Families, in recognition of their services to Canada; and to keep the memory of their achievements and sacrifices alive for all Canadians [18]."

Veteran Family member is defined as a person who is related either biologically, emotionally or legally, taking into account whom the Veteran identifies as significant to their mental well-being.

Evolving language

The language around sexual harassment, discriminatory behaviours and sexual assault in the CAF continues to evolve. In December 2023, the Honourable Bill Blair, Canada's Minister of National Defence, **announced** the implementation of two key recommendations from the **Arbour Report**. These recommendations included changes to key terminology, as well as the elimination of the term "sexual misconduct" from policy as the term lacks clarity. In this resource, we use the term "sexual misconduct" when referring to documents (including reports, resources and statistics) that predate December 2023, where the term was used to measure or report on key outcomes. In other instances, we use the phrasing "sexual and gender-based discrimination, harassment and violence" to include the spectrum of behaviours and actions. This alternate phrasing recognizes that Veterans impacted by MST may use language that differs from formal reports and policy documents. To note, the term "MST" is used within the CAF context specifically. There is no currently agreed-upon terminology to describe sexual trauma related to RCMP service.

VETERANS AND THE MILITARY CONTEXT: SETTING THE STAGE

Developing an understanding of MST requires a preliminary understanding of Veterans and the military context in which they worked and lived, as people can only be truly understood within the context they are embedded [19].

Who is a military Veteran [20]?

It's not uncommon to hold various assumptions about who is considered a Veteran, so it can be helpful to have clarity and awareness about what being a Veteran means:

- VAC "considers any former member of the Canadian Armed Forces who releases with an honourable discharge and who successfully underwent basic training to be a Veteran [18]." This includes both Regular Force (full-time) and Reserve Force (part-time) members.
- Not all Veterans were in the Army. Therefore, it is important not to refer generally to Veterans (or serving members) as "soldiers." Each branch of the military has its own mission, services, ranking, uniforms, culture and leaders.
- Veterans may have participated in a range of operations within their military career, whether abroad or in Canada. This could include humanitarian relief and disaster response, search and rescue, and/or wartime service or special duty area service [21].
- There are countless different jobs within the military, and not all Veterans served in the types of roles often portrayed in the media (e.g. in combat gear on the front-line with weapons in a foreign war zone). The military can generally be divided into three areas — land, air and sea — and some examples of jobs across these different areas include, but are not limited to, mechanics, cooks, lawyers, doctors, nurses, engineers and technicians.
- Attachment to the military can vary. When military members become Veterans, the extent to which they identify with the military changes. Some Veterans still very much identify with the military, some less so. This could be due to myriad reasons, both positive and negative (e.g. reason for joining; time in; amount of attachment when they were an active member; circumstances in which they left service; physical, mental or moral injuries; pride). This may affect whether or not they want to be acknowledged as a Veteran by rank or at all.

A historical lens on military demographic norms

The military was historically set up around the norm of the man who is white, heterosexual, Christian and of European origin or a descent member [22,23]. The inclusion of people of other demographics, such as women, racialized groups and those with diverse sexual orientation and gender identity and expression, into military service did not come easily and was met with systemic opposition, targeting and oppression [24,25]. Since then:

- Explicitly discriminatory policies were replaced (e.g. in 1992, non-heterosexual and transgender people were legally allowed to serve in the Canadian military; in 1980, the first woman was admitted to military college; in 2000, the last restriction on women (being allowed to serve in submarines) was removed [26].
- In 2017, the Canadian government "apologized specifically for the historical unjust treatment of 2SLGBTQIA+ federal public servants, including those in the Canadian Armed Forces and the RCMP, and of 2SLGBTQIA+ Indigenous Peoples [27].
- Additional changes have been seen (e.g. women are the largest and fastest growing minority Veteran group in Canada) [28 as cited by 22].
- However, despite the shift in policies, there are ongoing existing biases and/or discrimination that members continue to experience [29,30]. This can manifest in subtle, overt and/or paradoxical ways. For example, one of the remaining challenges members who do not fit the historical male norm can experience is to paradoxically be invisible (e.g. the challenge of women fitting into uniforms and using equipment designed for men) and hyper-visible (e.g. women being targets for discrimination and violence) [22]. Concerted efforts in addressing these biases and discriminatory experiences continue.

A glimpse into military culture

The Canadian military is a distinct Canadian subculture that has its own unique experiences, values, norms and expectations, language and organizational structures [3,8,19]. This can be evidenced in part by Veterans (particularly those in the Regular Force) who describe experiencing "culture shock" in their transition to life after service [19,31]. Examples of engrained core values include teamwork, discipline and unit cohesion [24,26,32]. An example of unique military-specific ethos includes "unlimited liability," which means "CAF personnel can be ordered lawfully into life-threatening situations [33]." Others include the commitment to be available 24-7 and follow directions across life and work domains while on duty (e.g. where to live, what to wear, when/where/what to eat, etc.). A key organizational structure of the military is the "chain of command," where certain ranks have formal and informal power over others [26]. Military members are socialized to be highly sensitive to rank and to show immediate obedience to officers [32].

"FOR SERVICE MEMBERS, MILITARY CULTURE EXISTS AT EVERY LEVEL OF THE SOCIAL ECOLOGY AND OFTEN PROVES TO BE A SALIENT SOCIAL IDENTITY FOR AN INDIVIDUAL[19 P.850]."

These, among many cultural components, are engrained while in service and can continue in life after service; however, the degree to which they are internalized or are part of a Veteran's identity can vary. As providers care for Veterans, being aware of how cultural components influence the health care encounter is key. These components also intersect with the historical and ongoing social identity factors and structures (e.g. sex, gender, race, etc.) at play, and taken together, they can begin to illuminate some of the complex realities Veteran patients impacted by MST navigate.

This overview sets the stage for military-specific factors that have been found to influence both the impacts of MST and barriers to care. However, it can first be helpful to know more about the prevalence of sexual and gender-based discrimination, harassment and violence in the CAF and the health and life impacts of MST.

MST AND UNDERREPORTING

Understanding the prevalence of sexual and gender-based discrimination, harassment and violence in the Canadian Armed Forces has historically been a challenge, as there is evidence of significant underreporting [30]. However, the culmination of historical and recent efforts to bring incidents of sexual and gender-based discrimination, harassment and violence to the forefront across multiple sources (e.g. CAF-DND sexual misconduct class action settlement, external independent reviews of DND and CAF by Deschamps (2015) and Arbour (2022) reports, etc.) have shown that thousands of Canadian Armed Forces members are impacted at some point during their career [34]. For more information about the prevalence of MST in the Canadian Armed Forces, see **Appendix A**.

There are many factors that contribute to the underreporting of MST, including:

- Fears of (based on personal experience of or witnessing experiences of others):
    - negative career repercussions, including career advancement opportunities
    - not being believed
    - lack of confidentiality
- Receiving negative treatment by others
- Being seen as a “troublemaker,” not being trusted and affecting unit cohesion
- Risk of being removed from one’s unit or released from the military
- Lack of disciplinary action for the perpetrator (belief that no change will result from a formal report)
- The experience of others within the military justice system [29]

These examples highlight the role and impacts of systems and structures in reporting. Institutional betrayal and institutional trauma are two aspects that likewise reflect systemic influence on reporting.

Term	Definition	Orientation
Institutional trauma [35]	The failure of a trusted institution on which one depends for safety and support or a response from an institution that exacerbates harm.	Oriented to the response of the institution.
Institutional betrayal [35]	A perceived failure to prevent or appropriately respond to wrongdoings committed by individuals within an institution.	Oriented to the resulting emotional and psychological impacts of the harm on the person impacted.

Observations or experiences of this type of trauma and/or betrayal can decrease the inclination to report one's experience. Sanctuary trauma is closely linked to institutional trauma, as it describes the impact of a health care system providing an unsafe and negative approach to those with a trauma history [36,37]. This can play a role in a Veteran's willingness to disclose their MST history to a provider.

WHAT ARE THE HEALTH AND LIFE IMPACTS OF MST?

Not everyone who is impacted by MST experiences long-term adverse consequences. However, there are many who experience significant, chronic and enduring physical, mental and/or psychosocial impacts, and the range of those impacts can vary [38-40]:

"... The complexity of the aftermath of MST is apparent across a host of co-occurring mental and physical health outcomes as well as in the cumulative impairments in functioning across major life domains. The impact of MST varies widely across survivors, and the cumulative effect of MST can be significantly influenced by known social determinants of health. Given the universe of potential adverse outcomes of MST, there is no clear formula for assessing the impact of MST… and no single intervention can be universally applied for recovery. The complexity of clinical presentations requires personalized approaches to care…[40]"

The variability in the multiple impacts associated with MST [38,41,42] reflects its multi-faceted, multidirectional and complex nature [33,43,44]. This includes recognizing the multiple and dynamic intersection of factors across all levels of a person's social ecology, including:

- *social determinants of health* (e.g. sex, gender, race, education, housing, income, etc.) [40]
- *military-specific factors* [19] (e.g. type of service)
- *psychological and social factors* [19] (e.g. pre-military experiences) [45]
- *trauma-specific factors* [e.g. duration, frequency or severity of MST experiences; pre- and post-military trauma(s)] [46]

Important considerations about MST impacts

SEX- AND/OR GENDER-DISAGGREGATED DATA

While both men and women who experience MST are at risk for experiencing a broad range of impacts, gender may influence the specific impacts that occur and the relative risk for such experiences [47]. The degree of available disaggregated data about the presentation and impacts of MST by sex and/or gender varies. To date, when data is disaggregated, there is more information about women than men [44]. There are ongoing efforts to address that inequity and seek to better understand the experiences of men and gender-specific care provision considerations. Notably, most existing gender-disaggregated research uses the men/women gender binary, and there is more work to be done to understand the experiences and impacts of non-gender conforming and/or Two-Spirit military members and Veterans [22,24].

INTERSECTIONALITY

There are ongoing calls to examine intersections between systemic racism, sexism and heterosexism within trauma, health care and military service, while also highlighting the role of social determinants of health on care access and effectiveness, particularly for racial, ethnic and sexual minority Veterans [19,24,40]. Continued movement toward disaggregated data will only serve to shed light on the complex intersectionality on the many factors involved.

CAUSALITY AND ASSOCIATIONS

Because the majority of studies on MST are cross-sectional, the findings speak to the associations between MST and adverse outcomes. It is not possible to determine the direction of the relationship or make conclusions about causality among factors examined.

Types of impacts

The following is a non-exhaustive snapshot of the co-occuring adverse health and functioning issues that are either associated with a history of MST and/or reflect issues that those with a history of MST may be at increased risk for [45] developing. It's accompanied by examples of disaggregated data that, as noted in the previous section, continue to emerge.

MENTAL HEALTH CONDITIONS AND SYMPTOMS

- Women and men impacted by MST are more likely to receive a mental health diagnosis compared to those who were not impacted [39,48,49]. This can include explicitly trauma-linked conditions, such as posttraumatic stress disorder (PTSD), but also mood disorders, anxiety disorders, psychotic disorders, substance use disorders, eating disorders, sleep disorders or others [38,41]. Experiences of MST can also exacerbate pre-existing mental health conditions and/or increase their severity [40].
    - Female Veterans with a history of military sexual assault have been found to demonstrate negative consequences above and beyond the effects of civilian sexual assault [50 as cited in 51].
    - Men and women with a positive MST screen were found to have comparable risk for a depression diagnosis [48]. Perinatal depression is also an important consideration for women [39].
- PTSD and suicidal behaviours are the strongest and most consistently associated mental health issues across men and women with MST [40,49].
    - Compared to women without a history of MST, women with a history of MST are more likely to develop PTSD [40,52].
    - While the risk for PTSD may be higher for women who experience MST, research has also shown that PTSD symptoms may be more severe for men who have experienced MST than for women [40].

  - For 2SLGBTQIA+ individuals, the consequences of sexual assault “may be compounded by exposure to stigmatization and discrimination related to sexual minority status. Of particular concern among the 2SLGBTQIA+ population is the increased risk of suicide. American 2SLGBTQIA+ service members have demonstrated a tenfold increase in past-year suicide attempts compared with non-2SLGBTQIA+ military peers, an effect that is likely amplified by the experience of sexual assault [42 as cited by 53,54].”
- There is noted co-occurrence between MST and risky, self-destructive and health-compromising behaviours. A systematic review found MST was consistently associated with suicidal behaviours (i.e. ideation, attempts, mortality) and an eating disorder diagnosis. Many studies found significant relations between MST and alcohol, drugs, smoking and substance use disorders, but findings were mixed, and more research is needed [55].
- Other examples of co-occurring symptoms and problems associated with a history of MST include inattention to safety and difficulty with attention, concentration or memory; dysregulated emotions (e.g. physical agitation, impulsivity, outbursts); emotional disengagement/flatness [11].

Veterans reporting a history of MST should be screened for PTSD and suicidal behaviours in addition to commonly co-occurring mental health conditions [40,53], with the ongoing monitoring of their conditions, symptom severity and suicidality [56].

DID YOU KNOW?

“Not all traumas are created equal; research has shown that sexual assault is more likely to result in symptoms of PTSD than most other types of trauma including combat [1,11].”

THE ROLE OF MORAL INJURY ON MENTAL HEALTH IMPACTS

Providers working with Veterans with histories of MST should consider issues related to organizational mistrust, betrayal and moral injury [43]. Moral injury refers to the psychological, social and spiritual impact of events or acts that a person performs, witnesses or fails to prevent which conflict with one's own deeply held moral beliefs and values [57,58]. Witnessing or experiencing incidents of sexual and gender-based discrimination, harassment and violence can be potentially morally injurious events (PMIE) [35]. PMIEs can be accompanied by institutional betrayal (IB), a perceived failure of the institution to provide protection or respond appropriately [41]. IB can compound with experiences of interpersonal betrayal [40], and IB has been associated with extreme stress reactions and symptomatology in military cohorts [35,40].

Impacts can be independent of the type of incident

Veterans may have witnessed or experienced incident(s) of sexual and gender-based discrimination, harassment and violence across "the continuum of potential harm" by one or multiple perpetrators. The potential impacts of the incidents can be considerable, independent of where these incidents lie on the continuum, including whether or not they meet a criminal threshold [59 as cited by 60].

For more information about moral injury:
atlasveterans.ca/moral-injury

PHYSICAL HEALTH PROBLEMS

Like with mental health, there are a broad class of physical conditions and clinical signs and symptoms commonly associated with, or the result of, the experience of MST [38]:

- Physical impacts can be consistent with sexual assault(s). These include both acute injuries and their long-term chronic impacts [38].
    - Examples include pelvic or rectal pain, sexually transmitted infections, etc.
- Medical conditions can be caused or exacerbated by physiological reactions to traumatic stress.
    - Examples include headaches or chronic neurological or musculoskeletal pain; gastrointestinal problems such as irritable bowel syndrome; sexual dysfunction; sleep disorders [38].
- Medical conditions caused or exacerbated by a patient's behavioural reactions to or attempts to cope with traumatic stress.
    - Examples include conditions associated with problematic substance use, such as liver disease; conditions associated with nicotine use, such as chronic obstructive pulmonary disease or cardiovascular disorders; conditions associated with disordered eating behaviours, such as obesity or severe weight loss; conditions associated with risky sexual behaviour, such as AIDS [38,49].
    - Research on women Veterans with a history of MST showed associations with various chronic medical illnesses, including increased risk for diabetes mellitus, hypertension, obesity and cardiovascular risk factors [61 as cited by 40].
- Extensive research has shown that a history of sexual assault often leads to sexual dysfunction [62 as cited by 50]. For men and women Veterans, it is more common to have a formal diagnosis of sexual dysfunction compared to those without histories of MST. [41]
    - To date, male-specific research suggests MST is associated with higher erectile dysfunction and sexual compulsivity [63].
    - Based on the limited literature focusing on sexual functioning in women Veterans, there appears to be a relationship between PTSD and sexual dysfunction, including sexual disinterest, fear of sex, arousal problems, orgasm problems and painful vaginal intercourse [50].
    - For women, there can be impaired reproductive health [40,53] and infertility, and unplanned pregnancies, and/or miscarriages have been associated with an MST history [46].
    - These physical consequences can also be further complicated by negative mental health consequences, as comorbid mental health disorders can complicate receipt of medical care. This can additionally amplify the negative effects on physical health [64 as cited by 40]. It may be beneficial to include mental health services as part of addressing physical health issues [49].

COMMON CHALLENGES IN CORE AREAS OF FUNCTIONING AND WELL-BEING

Physical and mental health impacts can affect core areas of functioning and well-being after military service and vice versa. Examples of challenges research shows are associated with a history of MST include, but are not limited to [65 as cited by 40]:

- **Relationships:** Challenges with Family, romantic relationships, interpersonal violence, social isolation
- **Identity:** Including impacts of self-esteem, meaning-making
- **Managing health (physical/mental):** Can have possible implications on a person's ability to maintain life responsibilities and manage stressors
- **Career/job/education:** Loss of military career; difficulty keeping a job or with school
    - For women Veterans in particular, satisfaction with employment post-service has been found to be affected.
- **Housing:** Homelessness found to be a risk for male and female Veterans, but stronger risk reported for men [66]

HOLDING MULTIPLE REALITIES ON MST IMPACTS ACROSS GENDER

The gender-disaggregated data that continues to emerge can shed light on new nuances, and yet these nuances may also initially seem confusing or contradictory. Appreciating that multiple realities, such as the following, can co-exist can help bring some cohesion to seemingly confusing or contradictory information:

Women and men can present/respond similarly to MST(s). They can share common reactions and types of problems, such as contending with gender identity issues [46]. These commonalities, however, are also worth exploring, as they can reflect different underlying issues and concerns [2,46,51]. For women, their response may reflect navigating the expectation to demonstrate they are equally competent to their male peers. For men, their response may reflect navigating feeling "less of a man [46]." Thus, a similar presenting core issue may have differing underlying concerns that can intersect with gender norms.

Women and men can present/respond differently to MST(s). Differences can likewise reflect the influence of gender norms, such as how members and Veterans express their distress and their help-seeking approaches [2]. For example, some research suggests men are more likely to delay seeking medical and mental health care, reflecting knowledge and stigma-related barriers [46,67], whereas women can demonstrate a greater willingness to seek help from authorities and pursue treatment [46]. These differences in approaches can have subsequent downstream impacts on the nature and severity of issues that emerge, and providers may see a wide range of presentations.

Presentation and response profiles across men and women Veterans can be complex and non-specific [49]. Knowing there is no clear and consistently defined presentation reflecting a history of MST makes it all the more important for providers to screen for sexual trauma(s) (military and otherwise) [2]. The possible diagnostic and treatment implications can be significant. As appropriate to your role and setting, include screening about sexual trauma in intake interviews [2] (see "**How can you help?**" for more about screening). If endorsed, appropriately integrate it as part of the case conceptualization, assessments and plan of care.

The impacts of a history of MST can also occur at anytime in a Veteran's life and even surface years or decades after they served [11,12,68]. Therefore, no matter the patient's age or how long it has been since they have served, it is important to screen for MST when taking a Veteran's trauma exposure history.

WHAT SPECIFIC MILITARY FACTORS INFLUENCE THE IMPACTS OF MST?

For Veterans, the nature of these impacts on their mental and physical well-being are also influenced by military-specific factors that reflect military organizational and cultural components. While there are a range of military-specific factors, a few key ones are identified.

The military environment is often all-encompassing, and those impacted by MST can continue to be exposed to the perpetrator(s).

While those impacted by sexual trauma in a civilian setting can also have ongoing exposure to the perpetrator(s), military service life has the potential to be all-encompassing, particularly for Regular Force members. For those living on a base or on deployment, all areas of life — from work to health care to socializing — are integrated and take place within a “closed system.” As a result, those impacted by MST may have regular, if not continuous, interactions or exposure to the perpetrator(s), or they may actually be required to interact with the perpetrator(s) in multiple areas of life or in an isolated location. This all-encompassing nature can increase the risk of trauma re-exposure (even when off duty) and leave those impacted feeling even more trapped and helpless, and increase their physical and mental distress [2,44,53,69].

Military workplace culture has often been known to tolerate or accept sexual and gender-based discrimination, harassment and violence.

Sexual and gender-based discrimination, harassment and violence can be accepted or tolerated in a workplace culture [70 as cited in 21]. In the Canadian military, incidents of sexual and gender-based discrimination, harassment and violence have been recognized as a significant occupational hazard, as evidenced, in part, through the Federal Court’s certification of class-action lawsuits (e.g. Heyder and Beattie class actions against the Government of Canada) [72]. Efforts are currently underway to address this. The combination of being a predominantly male workplace [53], that often promotes and idealizes “hypermasculinity,” can lead to a widespread tolerance, if not acceptance, of sexual and gender-based discrimination, harassment and violence. This widespread tolerance is conducive to more serious incidents [29].

MST can resemble the violence and abuse that can happen within Family relationships.

Given the Family-like structures and values in the military, sexual and gender-based discrimination, harassment and violence by a commanding officer, comrade-in-arms or other military personnel in other roles (e.g. chaplain, health care professional, legal officer, etc.) can be experienced as if it were perpetrated by a caregiver or a sibling. This overlaps with a degree of familiarity those impacted may already have with the perpetrator(s). The profound violation and betrayal of experiencing harm at the hands of someone who is meant to ensure your well-being can result in significant conflicting emotions, dissonance and self-blame [8,73 as cited in 53].

MST(s) may occur in addition to other traumas.

Individuals who join the military can have higher rates of exposure to adverse experiences in childhood and adolescence compared to the general population (e.g. it's not uncommon for some to join the military as a way of escaping their home environment) [44,73 as cited in 53]. Further, the nature of military service itself brings increased risk for additional trauma, particularly in operations. The cumulative effect of various traumas can have a significant negative impact on well-being [20].

The young age at which many Veterans entered the military can have an impact on their coping skills.

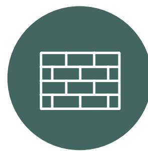
Military training that instills physical and mental toughness often takes place during formative years in young adulthood. The emphasis on toughness can lead to a reliance on emotional suppression and a narrower set of coping skills [2,74 as cited in 53]. With fewer opportunities to learn and engage in a wider range of adaptive coping skills, chronic stressors can result in increased difficulty in coping. This, combined with the fact that young adults are at a higher risk of sexual assault, even in civilian populations [69], lends itself to an increased risk of negative impacts and challenges in recovery.

HOW DO MILITARY EXPERIENCES CONTRIBUTE TO BARRIERS TO CARE AND DISCLOSURE?

Trauma can generally influence if, and how, a patient accesses services [75]. Military-specific factors can intersect with common trauma responses, along with social and psychological factors, in complex and nuanced ways and contribute to barriers in seeking care and disclosure in life after service:

Asking for help and accessing care can be countercultural for a Veteran, as self-sufficiency is highly reinforced throughout military training and military life

A Veteran has a heightened experience of power and authority dynamics. This can impact your engagement with them.



Veterans impacted by MST can be cautious about trauma-specific or general health disclosures.

Veterans may feel betrayed by the military, affecting their capacity to trust other institutions outside the military, such as the civilian health care system.

Veterans may have limited experience accessing the civilian health care system, which can have implications on how they pursue health care once they leave the military.

Asking for help and accessing care can be countercultural for a Veteran, as self-sufficiency is highly reinforced throughout military training and military life.

Given the unique survival and endurance demands of the military, the military promotes toughness, self-sufficiency and the ability to "soldier on." This includes suppressing physical and emotional needs and putting the mission and other comrades before oneself. Even when there is an opportunity to rely on social support, members may be reluctant to do so, as they feel it reflects their inability to soldier on and, instead, fear being stigmatized as weak. Veterans who are marginalized and/or racialized may have a heightened need to demonstrate their self-sufficiency or navigate additional stigma of being perceived as "weak" because they don't fit the historical masculine or gender norm. For example, Veteran women have reported needing to "prove themselves" equal to their male peers and "work twice as hard… to be considered half as good [22 p.37]."

In addition to engraining the need for self-sufficiency, military life can also be highly insular, making it particularly challenging to reach out to important and needed social supports. While those who experienced sexual trauma in a civilian context can similarly experience separation from needed supports, there can be an increased sense of isolation for military members, particularly for those stationed abroad and/or in enclosed spaces (e.g. submarines).

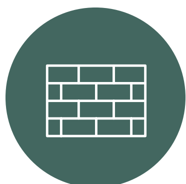
Between being deeply engrained with a sense of self-sufficiency and having fewer opportunities to reach out for support, many Veterans have learned to not seek support on their own. This approach can extend into all areas of life, including health care.

A Veteran has a heightened experience of power and authority dynamics. This can impact your engagement with them.

"A PRIVATE SALUTES ANYTHING THAT MOVES."
— VETERAN IMPACTED BY MST

The strict hierarchy and chain of command in the military extends beyond what is experienced in the civilian contexts. Additionally, the military's oversight of a member can extend to their actions off duty. For example, a member's actions while on or off duty have the potential to be a chargeable offence if it affects the military or the member's role. The strict hierarchy and chain of command has the potential for significant abuses of power and distinct threats. Abuses of power can also occur with perceived authorities, even if they don't have actual authority [2]. While those impacted by sexual trauma can struggle with issues related to power and control, those impacted by MST may have particular difficulties with hierarchies, systems and interpersonal interactions where someone has power over the other [2]. There can also be power differentials between Veterans who are racialized/marginalized and those in the majority. For example, lesbian women Veterans who are in higher positions of power have reported being targeted by lower-ranked service members, "despite strong military customs about the treatment of those in higher ranks [24 p.66]."

As a health care provider, your knowledge and role afford you a certain sense of power and authority, including as a potential gatekeeper to supports and treatment. This, along with the following other factors, may augment a Veteran's reluctance to disclose an MST history. But emphasizing a collaborative approach and proactively addressing concerns they may have (e.g. confidentiality) can be a way by which Veterans feel more open to considering disclosure.



Veterans impacted by MST can be cautious about trauma-specific or general health disclosures.

Building and maintaining trust with those impacted by MST can take additional time and effort [39,68,76,77 cited in 69].

This can be reflective of:

- *Caution around disclosing their health care needs/minimizing symptoms* [78]. Disclosures while in service could have military career implications, and some Veterans may have learned to limit or downplay their symptoms.
- *Military leaders may have previously aligned with the perpetrator(s)*. An authority figure can show alignment with the perpetrator by failing to use their power and authority to enforce the safety of the impacted individual. One example is how specialized military skills can complicate a sense of due process and justice. The specialized military skills of the perpetrator may have led authorities to prioritize them over a sense of due process for the impacted person. Authorities may choose to move the person impacted by MST to another posting, while the perpetrator continues in their current position because their skills are harder to replace and/or are more critical to defence needs. Not only can this make those impacted feel as if they're receiving unjust consequences compared to the perpetrator, but also it can lead to decreased reporting.
- *Negative/poor previous provider-specific experiences*. Health care providers may have dismissed disclosures regarding MST and/or potentially have been perpetrators themselves. Veterans may be cautious, anxious or distrusting of you as an individual provider, not based on their experiences with you, but as an extension of their previous experiences.

Veterans may feel betrayed by the military, affecting their capacity to trust other institutions outside the military, such as the civilian health care system.

"VETERANS WON'T WILLINGLY PUT THEMSELVES IN THE POSITION NOT TO BE TAKEN SERIOUSLY AGAIN."
— VETERAN IMPACTED BY MST

For Veterans, institutional betrayals, such as negative responses from the military following a disclosure of MST, can be another source of broken trust. Members make unique and significant commitments as part of their service (e.g. being available 24 hours a day, seven days a week; accepting unlimited liability, etc.), and it's recognized that there is a "moral obligation on military leaders to assure the well-being of members who accept the obligations of unlimited liability [79 as cited in 26, 80]." Failure to appropriately address accounts of MST and hold perpetrators accountable are breaches of this moral obligation, and those impacted by MST have expressed feeling deeply betrayed by the institution and their peers [22]. Negative military responses can include skepticism, blame, judgment [81 as cited in 45], minimizing or denying incidents, those impacted receiving subsequent poor performance evaluations, being overlooked for promotions or being downgraded in duty assignments.

As Veterans' health care transitions to the civilian health care system, the distrust stemming from military institutional betrayal, which may possibly include military health care providers, can continue with non-military institutions. However, some research shows that positive institutional responses, such as believing, validating and refraining from judgment, are related to greater emotional well-being and hope for those impacted by sexual traumas when compared to poor institutional responses [81 as cited in 45].

Veterans may have limited experience accessing the civilian health care system, which can have implications on how they pursue health care once they leave the military.

The Canadian military is legally mandated to oversee and provide health care services to its members. As such, while in service, military members only see military providers or military-approved civilian providers. Which providers can be seen can be further limited by circumstances, such as deployment overseas (note: military Family members access health care through the civilian health care system). Military (and approved civilian) service providers have access to a military member's complete health record while they're active members, which can facilitate good communication among health professionals; however, it can also risk perpetuating biases and assumptions in care. Given the young adult age at which many members enlist, after leaving military service may be one of the first times Veterans access civilian health care system as adults.

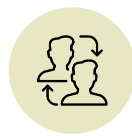
If Veterans apply to VAC to provide supports or cover treatments, they require documentation of diagnosis. If the diagnosis was not made while the member was still in the CAF, Veterans must pursue it in the civilian health care system. For Veterans seeking a diagnostic assessment, the need to recount their experiences once again, especially their traumatic ones, to new providers can be difficult and retraumatizing. In addition, given that their access to supports and treatment coverage is often dependent on these assessments, Veterans may be anxious when they meet with you and disclose their experiences. This anxiety can be heightened if they have had previous negative experiences with health care providers, military or civilian, including having MST or other symptoms and conditions dismissed.

Last, navigating the nuances of civilian health care, including supplemental insurance, requests and payment for reports and less integrated communication among a new range of health care providers, can be disorienting and stressful for Veterans. This system-navigation stress, layered on any trauma-based conditions, can contribute to increased exhaustion and a sense of helplessness, affecting their capacity to access care.

HOW CAN YOU HELP?

This contextual understanding of MST and the ways in which military-specific factors can influence health impacts and affect health care encounters post-service highlight the importance of providers implementing practices that sensitively and effectively meet the needs of Veteran patients with an MST history.

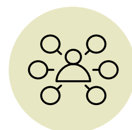
The following practice tips integrate trauma-informed principles with military literacy and an understanding of sexual trauma to provide sensitive, tailored and effective care to Veterans impacted by MST. These tips are meant to be practical and yet broad enough that they can be applied by a range of providers caring for Veterans:



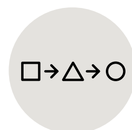
Build trust and strengthen the patient-provider relationship

Foster a Veteran's sense of personal control and choice in their health care

Screen for MST (as part of trauma screening)



Understand how unexpected behaviours may reflect trauma responses



Prepare for clinical practice adaptations in response to gender/sex issues

Facilitate integrated and holistic care

Practice tips across the trauma-informed continuum

Being trauma-informed is "a profound paradigm shift in knowledge, perspective, attitudes and skills that continues to deepen and unfold over time [82]." A developmental approach of trauma-informed care highlights that the approach is a continuum that providers and organizations move through. This continuum begins with being trauma-aware, then trauma-sensitive, followed by trauma-responsive and then being fully trauma-informed [82].

Trauma-informed principles can be implemented across the continuum, and while there can be variation in principles across sources, common themes include trauma acknowledgement and understanding; fostering safety, trustworthiness and transparency; promoting empowerment and choice; responsiveness to cultural, historical and gender issues; and collaboration [17,21,75].

Build trust and strengthen the patient-provider relationship

"MST-RELATED DISCLOSURE AND CARE OFTEN INVOLVES LINES OF QUESTIONING AND PROCEDURES THAT REQUIRE SUBSTANTIAL TRUST [45]."

Recognizing that a strong provider-patient relationship can have positive impacts across all aspects of care provision (e.g. informed assessments, accurate diagnoses, effective treatment planning, confidence in decision making, patient treatment fidelity, treatment outcomes)[8] for building and maintaining trusting relationships with those impacted by MST [68,76 as cited in 83] can take additional time and effort.

Whether the care being provided does or does not pertain directly to experiences of sexual trauma(s), fostering trust in the provision of care can facilitate the ability of a Veteran with a history of MST to honestly discuss their needs, continue to seek care, trust the recommendations providers give and follow through with them.

The following provides some concrete practice shifts you can make to create a safe environment and build trust [2,8,12,75,77,84 as cited in 21, 85 as cited in 9]:

CLEARLY EXPLAIN ROLES AND APPOINTMENT EXPECTATIONS (INCLUDING PRIVACY AND CONFIDENTIALITY)

- Introduce yourself and explain your role and any involved colleagues.
- Explain how much time you have to spend with them and negotiate how best to use it (e.g. “We have X amount of time. What would you like to focus on?”).
- Before asking questions, clearly convey existing ethical and legal limits on confidentiality, address any questions they have and provide your reasoning and responsibilities.
- Ask the Veteran if there are details that they do not want disclosed and respect those wishes according to the limits of confidentiality.
- Be prepared to explain any release forms you ask the Veteran to sign.

PROVIDE SUPPORT OPTIONS

- Offer for a friend or Family member of the Veteran’s choosing to be present during interviews.
- Ask about whether they would want Family members (biological or chosen)/friends to provide health care information or support in care.
- Offer written resources or ask if the Veteran would like to take notes.

LISTEN CAREFULLY AND ENGAGE THE VETERAN

- Address questions and comments to the Veteran, even if Family members are present.
- Acknowledge the Veteran’s statements with small verbal encouragements and restate what the Veteran tells you.
- Ask questions and avoid making assumptions.
- Respect the Veteran’s subjective experience.

PROVIDE CONSISTENCY AND PREDICTABILITY WHERE POSSIBLE

- Tell the Veteran what you are going to do and then do what you say.
- Do not mislead the Veteran. It is better to be forthright and potentially receive a strong reaction — however uncomfortable that may be — than to misguide the Veteran and be regarded as untrustworthy.

INCORPORATE A STRENGTH-BASED APPROACH

- Explore a Veteran's presenting concern with questions about what has been helpful for the Veteran so far.
- Identify supportive factors in their lives and reflecting those statements back to them can offer a more strength-based perspective. This can in turn provide increased hope.

ACKNOWLEDGE YOUR MISSTEPS OR ERRORS AND APOLOGIZE AS NEEDED

- You are human and won't always get things right. What matters more than getting it right is acknowledging when you don't have the answer or have got something wrong. Acknowledging your mistakes and apologizing goes a long way in strengthening the relationship.

The subsequent practice tips build upon this relational and trauma-informed foundation.

Foster a Veteran's sense of personal control and choice in their health care

By recognizing Veterans may have less familiarity with the civilian health care system, may not be as aware of or as comfortable with taking initiative for their own health care and/or may be less familiar with prioritizing their own needs, you have an opportunity to educate and encourage Veterans to be active participants in their care.

Some practical ways to do so include [8,12,20,77,86]:

LOOK TO REDUCE THE POWER DIFFERENTIAL BETWEEN YOU AND THE VETERAN

- Sit at the same level as the Veteran and make eye contact.
- Ask the Veteran if they would like to be addressed by their rank.
- As applicable, start and end appointments with patients when they are fully clothed. While this may take a few extra minutes, it allows the patient to "leave on equal footing [12]."

GIVE THE VETERAN AS MUCH CONTROL AS POSSIBLE

- Ask the Veteran if they would like a third person to be in the room during the interaction.
- Give the Veteran options and choices whenever possible. Remind or educate patients about having choices regarding their treatment, care and providers.

VIEW THE VETERAN AS AN EXPERT ON THEIR OWN EXPERIENCES

- Take complaints of pain or vague symptoms seriously.
- Do not argue with a Veteran about their feelings or level of discomfort. Never dismiss symptoms as “all in their head.”

PROVIDE VETERANS WITH REMINDERS THAT THEY ARE ACTIVE PARTICIPANTS IN THEIR CARE

- Discuss the following, to foster a Veteran’s agency and participation in their care:
    - The full range of their treatment options (sometimes they can be different options than those offered while in service).
    - The option all patients have to seek out second opinions.
    - The freedom all patients have to seek out care providers who may be a better fit for them, if they are experiencing challenges with other current providers.

Screen for MST (as part of trauma screening)

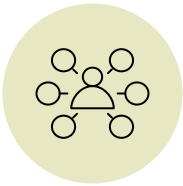
Veterans may be hesitant to disclose a possible history of MST or any sexual trauma. Including screening for MST(s) as part of trauma screening can:

- Mitigate any impact your biases or assumptions may have about who may be impacted by sexual trauma (i.e. recognizing the duality that it's prevalence is higher with women and other minority groups with the fact that it's not "just a woman's issue" [1] and men are also impacted).
- Create space for those impacted who might not otherwise disclose their history.
- Demonstrate that you are aware of and sensitive to these types of experiences and that you can help [2,20].

Keep in mind that you are asking if the trauma happened, and how you might adapt your care or facilitate additional supports, rather than asking for details about the trauma. If there are needs for support that are outside your scope, make the appropriate referrals.

You may be hesitant to ask about possible MST because you are afraid of how the patient will react when you ask or feel unprepared/unqualified to support the patient if they say yes. Research has shown that, if done sensitively, most individuals who have experienced sexual trauma are open to being asked about their trauma histories within a health care context [1,20,87]. Even if Veterans don't endorse a history of sexual trauma (military or otherwise), following trauma-informed principles can make a significant difference in care provision, as there may be other trauma histories you're not aware of or are not disclosed at that time.

In **Appendix A**, you will find a resource, adapted from a training delivered by Margret Bell, PhD [20] (the U.S. Department of Veteran Affairs National Deputy Director for MST), that provides a detailed example of how to ask about MST and ways to respond with sensitivity and empathy. Tools like this can help you feel more confident incorporating MST screening into your standard interview practice.



Understand how unexpected behaviours may reflect trauma responses

You may observe behaviours from Veterans that may initially surprise or confuse you. Using a trauma-informed lens helps to understand these behaviours can be protective adaptations people may use to keep themselves safe (e.g. avoidance to provide immediate escape from pain or something difficult) [11]. They might also reflect dilemmas that those impacted by MST are navigating (e.g. “I want to trust others, but others can severely hurt me.”) [11].

Examples include:

- A strong hypervigilance to your non-verbal language, including carefully monitoring your facial reactions, body language and tone.
- Difficulty being in small spaces with closed doors.
- Demonstrating extremely high levels of engagement in activities, such as excessive exercise or workaholism.
- The use of inappropriate humour.
- Aggressive or angry outbursts.
- Noticeable difficulties in monitoring or identifying their emotions [2].
- Difficulty acknowledging the impact of MST on them [2].
- Physical agitation [11].

For those impacted by MST, trauma and coping responses may be more pronounced [39].

If there are strong “fight/flight/fawn/freeze” responses while in appointments, working with a present Family member to support the Veteran can be helpful. Remembering these responses have been adaptive or survival based helps not to take them personally or to misunderstand them. This way, when a Veteran directs behaviours at you, you can provide calm, validating and supportive responses with healthy boundaries. While recognizing this is not always easy, your calm and validating feedback can help a Veteran feel safe, understood and better able to manage their responses. As appropriate in the moment, provide some education about trauma responses, so Veterans better understand their own responses.

Prepare for clinical practice adaptations in response to gender/sex issues

BIOLOGY, SEX AND GENDER ARE IMPORTANT PSYCHOPHYSICAL SAFETY CONSIDERATIONS.

“Given the sexual and gendered nature of sexual misconduct and trauma [11,67], specific consideration to sex and gender across all facets pertaining to understanding MST is critical.” The physical, sexual and interpersonal nature of sexual misconduct/trauma(s) has implications on a person’s sense of safety as they interact with others. Some people impacted may find it stressful to interact with a provider, particularly when they are physically and/or emotionally vulnerable in the health care encounter (e.g. being disrobed). All types of physical touch, regardless of the type of provider, can provoke anxiety [12]. Those impacted may be acutely aware of a provider’s gender and/or sex, and because of their traumatic experience, this can lead a person impacted to feel unsafe. A provider’s awareness and understanding of this unintentional impact and offering choices about how the impacted person receives care are important in fostering psychophysical safety.

RESPECT A VETERAN’S REQUEST FOR A HEALTH CARE PROVIDER OF A SPECIFIC SEX AND/OR GENDER.

As a result, providers can acknowledge the impact sex/gender has on a Veteran’s sense of safety or vulnerability. You can discuss whether there are health care provider or organizational resources to accommodate these requests, or what alternatives could help foster a sense of safety. There may also be opportunities to discuss possible benefits to both single- and mixed-gender approaches, depending on the Veteran’s readiness [88 as cited in 1].

Gender considerations apply both to the provider and to treatments, such as mixed-gender therapy groups. Gender considerations are applicable whether you provide one-time or ongoing care, and they may differ at various points throughout the Veteran’s care journey.

PHYSICAL EXAM AND MEDICAL PROCEDURE ADAPTATIONS.

Certain health exams and procedures can be difficult for Veterans impacted by MST, as they recreate sensations a Veteran may have experienced during their trauma(s). Examples of sensations include being in physical pain, feeling a lack of control (e.g. for procedures requiring anaesthesia) and physical exposure and touching (including, but not limited to, intimate body parts) [10]. Veterans impacted by MST "may be more likely to avoid procedures and treatment(s) where they anticipate their trust or safety could be betrayed again (e.g. a woman Veteran having a vaginal examination by a male provider could fear being raped again) [89 as cited in 45,90]." Exams that could cause increased distress include, but are not limited to [11]:

- Breast exams and mammograms
- Dental exams
- Endoscopies and other invasive procedures
- Exams that involve standing behind the patient or leaning over them
- Eye exams
- Fertility treatments
- Labour and delivery
- Pelvic exams and pap smears
- Procedures that require physical restraint, confinement or sedation
- Rectal exams and colonoscopies
- Urological exams

There are simple modifications that can help increase a Veteran's sense of control and safety. While recognizing that no single approach will fit every Veteran or situation, explaining processes and rationales, obtaining consent, monitoring for signs of distress and offering running commentary as needed are all general practices that can make a significant difference to patients [12]. Here are some suggested practices:

- Begin by describing the typical order in which an examination or treatment will be undertaken. Ask about any potential difficulties and whether they need it adapted in any way [12].
- As needed, engage the patient to come up with potential coping strategies [11]. These can include:
    - Seeing the procedure room in advance
    - Having a chaperone or Family member present
    - Sedation or pain medication, if appropriate
    - Distraction (e.g. headphones, focused breathing, discussion of a pleasant event) and
    - Other practices that have worked in the past
- Ask the patient if it would be helpful to narrate out loud what you are doing as you conduct the exam/procedure.
- Periodically check in with the patient about how they are doing during the exam/procedure. Tune into non-verbal signs of distress, such as tense muscles, flinching, "spacing out," facial flushing, tears or stuttering [12].

Facilitate integrated and holistic care

EACH PATIENT IS UNIQUE IN THEIR REACTIONS TO AND RECOVERY FROM MST — HONOUR THEIR DIVERSITY [80,92].

There can be quite a diversity in how Veterans impacted by MST process their experiences and respond to treatment and services. This reflects how the sociological, cultural and historical contexts in which MST occurs intersect in complex ways with varying military, social and psychological factors (including subsequent personal and institutional responses to disclosures) [19]. Respecting and attending to a patient's diversity is critical to clinical and ethical care [1,91 as cited in 68].

KEEP IDENTITY INTERSECTIONS AND DIVERSITY OF EXPERIENCES TOP OF MIND.

In addressing their current health needs, keep in mind the range of intersecting social identities of the Veteran patient (e.g. sex/gender, race, ethnicity, age, etc.), what their military roles and experiences have been (e.g. Navy, Air Force, Army, operational, administrative, etc.), the range of supports and resources they may have and the military and societal messaging they may be navigating. For example, men may face unique challenges in recovering from MST in light of persistent myths about men and sexual trauma (e.g. men should always be strong and able to protect themselves) [93 as cited by 94]. The recovery of historically marginalized groups can be further complicated by identity-based stress and trauma before or after MST. Considering the intersections of the Veteran's dimensions of identity is integral to recognizing the most appropriate care for them [95].

HOLD A BIOPSYCHOSOCIAL-SPIRITUAL PERSPECTIVE OF CARE AND COLLABORATE INTERPROFESSIONALLY AS NEEDED.

While your point of contact with a Veteran may be within one domain (e.g. reproductive health), using a biopsychosocial-spiritual perspective to screen across all domains can help you monitor symptoms and risk factors. This includes recognizing how the psychosocial components can include suicidality and homelessness, and the spiritual component can also include factors regarding meaning, purpose, sense-making and identity. As is within your scope of practice, provide resources and educate Veterans about mind-body connections, such as how physical symptoms such as chronic pain can be related to trauma history [39]. Additionally, recognize the challenging reality that a Veteran with an MST history may present with non-specific physical and/or mental health impacts., Making referrals or working with other health care providers who can provide assessment and treatment clarity (with patient consent) can ultimately contribute to positive treatment outcomes.

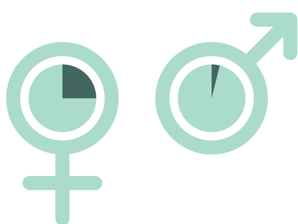
THANK YOU

We recognize the commitment you have, as service providers, to deliver the best care to your patients. As the demand on Canadian mental health services ever increases, we also know that finding the time to advance your learning can be difficult. The application of the knowledge and practice tips you learned through this primer can make a significant difference for Veteran patients impacted by MST, and we thank you for your ongoing commitment to enhancing the care you provide.

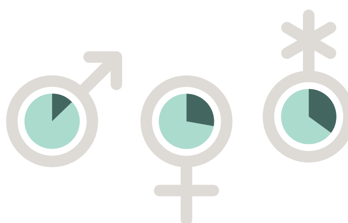
APPENDIX A: HOW COMMON IS SEXUAL AND GENDER-BASED DISCRIMINATION, HARASSMENT AND VIOLENCE IN THE CANADIAN ARMED FORCES?

In 2016, 2018 and 2022, Statistics Canada conducted the *Survey on Sexual Misconduct in the Canadian Armed Forces*, which was a voluntary survey of all active CAF members (Regular Force and Primary Reserve). This survey defines and categorizes sexual misconduct into three main categories reflecting a spectrum of behaviours: sexual assault, sexualized behaviour and/or discriminatory behaviours on the basis of sex, (and as added in 2018) sexual orientation or gender identity [96]. The survey provided the following snapshots of members' experiences within the past year of completing the survey (data regarding Primary Reserve is available; however, the following data is specific to Regular Force members).

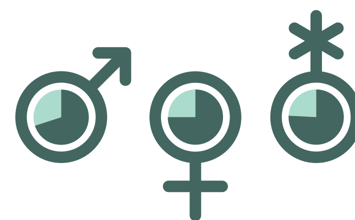
WHO IS AFFECTED [34,96]



Since joining the CAF, approximately **25% of women and 4% of men** who are Regular Force members have experienced sexual assault at least once.

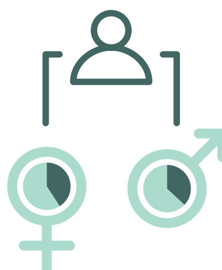


Over a 12-month period, **approximately 13% of men, 28% of women, and 35% of gender diverse people** who are CAF Regular Force members experienced targeted sexualized or discriminatory behaviour*.



Over a 12-month period, **approximately 70% of men, 75% of women, and 76% of gender diverse people** who are CAF Regular Force members witnessed or experienced sexualized or discriminatory behaviour*.

BY WHOM [97]



Just over half (52%) of all CAF Regular Force members who were sexually assaulted stated that the **person responsible was a peer**.

Similar proportions of women and men in the CAF Regular Force stated that a **supervisor or someone of higher rank was the perpetrator** (41% and 37%, respectively).

WHERE [96,97]

In total, **86% of CAF Regular Force members** who had been sexually assaulted in the past 12 months stated that at least **one incident took place in the military workplace**.

Almost 40% impacted by MST stated that at least incident of sexual assault took place **outside of the military workplace**, but involved other military members.

**Data is from Cotter (2019), given gender diverse Regular Force member estimates were not provided in Cotter (2022) due to the sample size.*

While any member can be impacted by incidents of sexual and gender-based discrimination, harassment and violence, the Canadian survey data is consistent with research which identifies there can be increased targeting by perpetrators [98] for those who are women, single persons, younger than 39 years old, persons with disabilities, 2SLGBTQIA+ persons, Black, First Nations, Inuit and Métis Peoples, and racialized persons [53,67,80,99cited in 51].

Sexual assault in the Canadian military was reported at higher rates among women compared to men [34]. This is notable given that women make up 20% of current serving Canadian military personnel, and nearly 17% of Veterans are women [100]. While the rates are higher for women than men, as seen in other countries [101 as cited in 95], the absolute number of cases may be comparable due to the higher number of men versus women who serve. There is also a broad misconception that sexual assault is only committed against women by men.

In addition to differences between women and men, sexual assault was found to be more prevalent among First Nations, Métis or Inuit members, persons with disabilities and younger members [34]. More than one in four of transgender or gender diverse Regular Force members were targeted by sexualized or discriminatory behaviour over a 12-month period [96]. Of significance is that transgender or gender diverse members were about three times more likely to have experienced discrimination compared to cisgender, heterosexual Regular Force members (15% versus 4%)[96]. These various differences in prevalence align with what is seen within the general population [60].

Taken together, this data reflects the way in which social categories (e.g. sex and gender, ethnicity, age, class, geography) interact with systems and structures of power (e.g. sexism, racism, ableism, ageism) [102-107 as cited in 17]. The breakdown of prevalence and impacts of incidents of sexual and gender-based discrimination, harassment and violence according to various intersectional factors in the Canadian context continues to emerge and reflects evolving research practices (e.g. examining sex *and* gender).

Notably, the snapshot provided by the above-mentioned survey sits within a long-standing history of sexual and gender-based discrimination, harassment and violence within the CAF (see the "**Resources for health care providers**" section to learn more). As such, while there are currently efforts underway to facilitate change, it's nonetheless important to recognize that behind these numbers are generations of members who may have been impacted in years prior and whom health care providers could currently be seeing as Veterans in their care.

APPENDIX B: SCREENING FOR MST

Significant portions of this appendix have been adapted from a training delivered by Margret Bell, PhD [20] and a sensitive practice handbook developed by Candice L. Schachter, PhD and colleagues [12].

If appropriate for your professional role, screening for MST can be part of history-taking, particularly as part of assessing a patient's sexual or trauma history. There is no one correct way to ask about sexual trauma history, including MST. Direct approaches can be a relief to some and may be too intrusive to others. What's more important than the screening tool is the provider-patient relationship [12]. In asking about a sexual trauma history, here are some considerations.

Preparing to ask the questions [11,20]

These preparatory practices are applicable for all questions. However, they are particularly relevant for those of a sensitive nature:

- Make sure the environment is comfortable and private.
- Demonstrate you are paying attention by making eye contact and ensure you are facing the Veteran (i.e. not your computer).
- Be comfortable with the language. Practise saying it out loud beforehand to find a way that feels natural for you.
- Avoid negative questioning. For example: "Nothing's ever happened to you, right?"

Asking sexual health and/or trauma questions [12,20,39]:

- You can introduce the questions in a way that provides context and rationale about how past traumatic experiences can impact health and health care experiences. Use a normalizing statement, which can demonstrate these are questions you ask everyone.
- Clarify confidentiality, even if previously discussed, as that is a critical concern for those impacted by sexual trauma(s).
- Clarify that you are simply asking them if it happened or not, and they are not expected to share details. The purpose of disclosure is to help inform your provision of care.
- If in your role you'd begin by asking about sexual activity in general, you could ask: "How many sexual encounters have you had? Have those all been consensual?"
    - Asking about "encounters" rather than "partners" takes into account that patients may not identify those perpetrating non-consensual sexual activities as "partners."
- When asking about sexual trauma(s), including witnessing or experiencing incidents of sexual and gender-based discrimination, harassment and violence, ask using behaviourally based questions. Avoid terms such as "rape," "sexual assault" or "sexual harassment," as they can be unclear and may generate stigma. And you don't know how someone may react to them.

    You could say something such as: "Patients I have worked with have had upsetting experiences in their lives that may still bother them today. Some of these are sexual in nature and can include things such as advances or verbal abuse of a sexual nature, being touched in a sexual way that made them uncomfortable or being forced or pressured into having sex. Have experiences like these ever happened to you, either during your military service or in your life after service?"

After you ask the question [12,20]

IF THEY HESITATE OR SEEM RELUCTANT TO RESPOND:

- You could acknowledge that, "I know these things can be hard to talk about. I think it is important to ask because there is growing evidence that violence and abuse can affect a person's health and create difficulties when they see health care (providers). You don't have to discuss this with me if you don't want to. If you do, I can work with you to ensure you are comfortable when you see me and to get the support or assistance you need [12]."

IF THEY SAY NO [12,20]:

- Pause after they say no to show this topic is important and deserves space.
- Avoid responding with a sigh of relief or anything that might convey you didn't want to hear yes.
- You could say something such as: "I ask because some patients do have these kinds of experiences. There are services available to help though, so I wanted to make sure to talk to you about these resources, if they were relevant."
- Be sensitive to the reasons a Veteran might not want to disclose trauma(s). There isn't harm in asking about it, so long as providers respect the wishes of those who prefer not to disclose [12].

IF THEY SAY YES [12,20]:

- Supportive responses to disclosures are a critical part of effective treatment. Show them you heard what they said, that it matters to you and ask what it means to them, to their health and what it might mean for their care.
- You could say something such as: "I'm sorry that happened to you. Are there ways that experience continues to affect you today? Is there anything in particular you want me to know or take into account as your health care provider that would help you feel comfortable/safer in our appointment? Is there anything else you want me to know as your provider?"
- Remember, your role is not to fix the fact that it happened, but to respond empathetically, take the disclosure seriously and ask what you can do to help. That in and of itself is powerful.

AFTER A DISCLOSURE HAS HAPPENED [12,20]:

- Given this resource is intended for health care providers from a number of professions, it is difficult to get too specific about how an MST disclosure will impact your work with the Veteran patient. If you aren't a mental health professional, be aware of supports and services available to your patients and discuss a referral with them if you feel it is necessary.
- Recognize that action is not always required. Those impacted may simply want their providers to have the information.
- Ask if it's their first disclosure, as that can help shape your response and understand what supports may be in place and what they need. This may include sharing support resources (including those provided in the "**Resources for Veterans and Veteran Family members**" section).
- If those impacted show or indicate some level of distress after their disclosure, collaborate to develop an immediate self-care plan with them. Monitor for mental health and life risks (e.g. suicide, including access to a weapon), be aware of available supports and make referrals where necessary.

RESOURCES FOR VETERANS AND VETERAN FAMILY MEMBERS

Following your interaction with your patient, you may want to provide them with additional supports or resources. The following are reliable options. The resources are both military and non-military, and many offer immediate supports that are available 24-7.

MILITARY-SPECIFIC RESOURCES

website or phone

Sexual Misconduct Support and Resource Centre (SMSRC)

Support services are available for currently serving and former CAF members, DND public service employees, Cadets, Junior Canadian Rangers, and Family members of the wider defence community. Services are currently available to those who are 16 years and older and are either directly impacted by sexual misconduct or are supporting a loved one who is directly impacted. In addition, services are offered for leaders and management seeking guidance and support on addressing sexual misconduct and best ways to support those who are directly impacted. Services include supportive counselling, information and referrals to resources and services, advocacy to help you meet your needs, accompaniment to your appointments, meetings and proceedings, assistance with workplace arrangements and other practical assistance. You can reach the SMSRC 24-7 by phone. You can remain anonymous while accessing the SMSRC's services. If you wish, SMSRC counsellors can refer you to a civilian or military health care provider, they can do so without passing on any personal information you have shared with them. Any information you share with them cannot be accessed by the CAF chain of command or anyone else outside of the SMSRC.

Languages: English, French

Phone number: 1-844-750-1648

Link: **canada.ca/en/department-national-defence/services/benefits-military/health-support/sexual-misconduct-response/get-support**

Hours of operation: 24 hours a day, 7 days a week

website

Sexual misconduct support resources search tool

A list of resources, CAF-specific and provincial and community-based, searchable by location. The list provides only basic information for each resource such as location, website links and contact information.

Link: canada.ca/en/department-national-defence/services/benefits-military/health-support/sexual-misconduct-response/resources-search-tool

website or phone

Canadian Forces Morale and Welfare Services

Provides a host of programs and services to enhance mental, social, physical and financial well-being. A particular resource to be aware of is the Family Information Line, which is a confidential, personal and bilingual service offering information, support, referrals reassurance and crisis management.

Available to: CAF members, Veterans and their Families — immediate and extended

Languages: English, French

Phone number: 1-800-866-4546

Link: cfmws.ca

Hours of operation: 24 hours a day, 7 days a week

website or phone

Veteran Affairs Canada

Veterans Affairs Canada (VAC) provides services for current or Veteran members of the CAF or RCMP or a Family member. VAC provides various services and benefits, and specifically for those impacted by MST, this includes the VAC Assistance Service and information about applying for VAC benefits. Veterans may be eligible for VAC benefits related to injury/illness from MST, even if they have been previously denied in past.

Available to: CAF or RCMP members, Veterans and their Families

Languages: English, French

Phone number: 1-866-522-2122; TDD/TTY: 1-833-921-0071

Link: veterans.gc.ca/eng/health-support/mental-health-and-wellness/understanding-mental-health/military-sexual-trauma

Hours of operation: Monday to Friday, 8 a.m. – 5 p.m., Eastern time

website

Military sexual trauma

This webpage offers information related to incidents of sexual and gender-based discrimination, harassment and violence, as well as the associated harms (MST). Developed by the Atlas Institute.

Available to: Veterans and their Families, health care providers and the general public

Languages: English, French

Link: atlasveterans.ca/mst

website

Military sexual misconduct and military sexual trauma fact sheet

This fact sheet offers information about MST and where to get support in Canada. Developed by the Atlas Institute.

Available to: Veterans and their Families, health care providers and the general public

Languages: English, French

Link: atlasveterans.ca/mst-fact-sheet

website

Beyond MST mobile app

This free secure trauma-sensitive app was created by the U.S. Department of Veterans Affairs to support those impacted by MST.

Available to: Military and Veteran mobile app users

Language: English

Link: mobile.va.gov/app/beyond-mst

NON-MILITARY-SPECIFIC RESOURCES

website or phone

9-8-8 Suicide Crisis Helpline

The 9-8-8 Suicide Crisis Helpline offers bilingual, trauma-informed and culturally appropriate support available to anyone in Canada.

Available to: Anyone in Canada

Languages: English, French

Phone number: 9-8-8

Link: 988.ca

Hours of operation: 24 hours a day, 7 days a week

website or phone

Hope for Wellness Helpline for all Indigenous Peoples

A crisis intervention and counselling line offering immediate help to all Indigenous Peoples across Canada.

Available to: Indigenous Peoples across Canada

Languages: English, French. Telephone counselling is also available in Cree, Ojibway and Inuktitut by request

Phone number: 1-855-242-3310

Link: hopeforwellness.ca

Hours of operation: 24 hours a day, 7 days a week

RESOURCES FOR HEALTH CARE PROVIDERS

Here are additional resources that may support you in learning more about MST, Veteran-specific care, the Canadian government and MST, personal Veteran accounts and trauma-informed care.

MILITARY SEXUAL TRAUMA LEARNING

website

The Trauma and Recovery Lab

The Trauma and Recovery Lab "focuses on reducing the deleterious impact of trauma on individuals and Families, and on fostering scientifically informed approaches to recovery and posttraumatic growth." The website contains resources that may provide additional context and information about MST.

Link: **thetraumaandrecoverylab.com**

website

CAF-DND sexual misconduct class action settlement

(claims closed as of November 2021)

Outlines information about the Heyder and Beattie Class Action lawsuits against the Government of Canada. These class actions were certified as class proceedings and approved a settlement agreement that provides compensation to current and former members of the Canadian Armed Forces and current and former members of the Department of National Defence and/or Staff of the Non-Public Funds.

Link: **caf-dndsexualmisconductclassaction.ca**

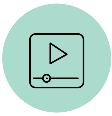
publication

Report of the Independent External Comprehensive Review of the Department of National Defence and Canadian Armed Forces

The Honourable Louise Arbour, C.C., G.O.Q. (May 2022)

Provides a comprehensive examination into sexual misconduct within the CAF, with a number of key recommendations to address the problem.

Link: **canada.ca/en/department-national-defence/corporate/reports-publications/report-of-the-independent-external-comprehensive-review**



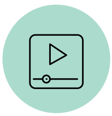
video

DND/CAF sexual misconduct apology

Canadian Armed Forces (December 2021)

The Minister of National Defence, Chief of Defence Staff and Deputy Minister of National Defence deliver an apology to all current and former Defence Team members and Veterans who have been affected by military sexual misconduct.

Link: **youtu.be/lfghqwVWn0U**



video

Military secrets: Soldiers speak out on sexual misconduct

W5 (November 2021)

W5 investigates sexual misconduct in the military and interviews Canadian soldiers who disclose they were sexually abused while serving their country.

Link: **youtu.be/tI84PYsEad4**

virtual training

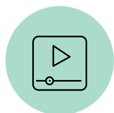
Military sexual trauma (United States)

PsychArmor (2015)

A training course hosted by PsychArmor, featuring Margret Bell, PhD, who provides an overview of MST for health care providers. While this is an American training course, much of the content is applicable more broadly. Please note: You need to create an account to watch the video, but there is no associated cost.

Link: **learn.psycharmor.org/courses/Military-Sexual-Trauma**

INFORMATION ABOUT CARING FOR VETERANS



virtual training

Introduction to trauma-exposed professionals: TExP1

Wounded Warriors Canada, in partnership with the Atlas Institute (2023)

This course was developed to help mental health service providers better understand the experiences of trauma-exposed professionals (TExPs) including their unique work environments and military culture. Upon completion of this course, service providers will be better equipped to assist TExPs who may not understand the potential impacts of their service on their mental health and well-being. The course provides culturally specific clinical approaches to support the mental health needs of those who serve.

Link: atlasveterans.ca/texp1

publication

Best Advice guide: Resources and considerations in providing care to Veterans, 2nd edition

The College of Family Physicians of Canada (2023)

This guide highlights special considerations for family physicians and other primary care providers in providing care of Veterans. This includes common themes to address the health needs of Veteran patients, providing key factors and context, practical tips and rewards related to caring for Veterans.

Link: patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-caring-for-veterans

website

TRAIN Learning Network (United States)

TRAIN is a national learning network that provides thousands of quality training opportunities to professionals in the health workforce. TRAIN offers various courses specific to Veteran and Family care, including but not limited to, “Institutional betrayal & courage in addressing Veteran exposure concerns”; “Transgender: Care for the gender non-binary Veteran”; “Community care provider ù A perspective for Veteran care”; “Military and Veteran caregivers: Health, wellbeing and phenotypes for suicidal ideation.”

Link: train.org

MILITARY CONTEXT

website

Ranks and appointment

Department of National Defence (2023)

Throughout this document, there are discussions of the importance the military rank system can have on experiences of MST. This webpage is a quick reference where you can learn more about the hierarchical and formal rank structure.

Link: canada.ca/en/services/defence/caf/military-identity-system/rank-appointment-insignia

TRAUMA-INFORMED CARE RESOURCES

publication

The Missouri Model: A developmental framework for trauma-informed approaches

Missouri Department of Mental Health (2014, revised 2019)

This seven-page document provides a practical developmental framework, complete with definitions, processes, indicators and resources across the trauma-informed spectrum (e.g. trauma-aware, trauma-sensitive, trauma-responsive and trauma-informed care), for organizations looking to implement a trauma-informed approach. This resource is American; however, its components can be applied within the Canadian context.

Link: **dmh.mo.gov/media/pdf/missouri-model-developmental-framework-trauma-informed-approaches**

publication

SAMHSA'S concept of trauma and guidance for a trauma-informed approach (United States)

Substance Abuse and Mental Health Services Administration (July 2014)

This 27-page document provides an overview of trauma, trauma-informed approach and guidance in implementing this approach within an organization. This resource is American; however, the clinical and organizational components can be applied within the Canadian context.

Link: **ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf**

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