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Sexual Revictimization

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SEXUAL REVICTIMIZATION

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ABSTRACT

SEXUAL REVICTIMIZATION

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Based on interviews with six women, this study describes each participant's personal experience of childhood sexual victimization, and revictimization while serving in the military. These traumatic experiences in childhood may have increased their risk of developing Post Traumatic Stress Disorder when exposed to sexual trauma in adulthood. Using a grounded theory approach, the interviewer identified common themes among the stories: early sexual abuse, and subsequent revictimization, poor family support, and poor choice of intimate partners as adults. Moreover, they experienced lessened ability to protect self and low self-esteem and denial. The subjects described a personal culture that included abuse as a normal experience, substance abuse, a need for medical and psychological health care, and poor academic outcomes before military service, and following discharge.

The participants' sexual revictimization was associated with greater psychological distress, and higher levels of psychological symptomology. These women described the military's response to their in-service sexual trauma as severely deficient. The military failed to provide basic medical care or proper counseling for these victims and in no case was the attacker prosecuted.

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I: Introduction

Over the last 15 years, there has been an increase in research documenting the prevalence and effects of childhood sexual abuse. Childhood abuse impacts the victim's psychological, physical, and emotional functioning (Bundrick, 2004). Estimates suggest that women who have experienced at least one incident of sexual abuse in their lives before age 18 range from 1 in 4 to 1 in 2.5 among non-clinical samples (Wyatt, Guthrie, & Notgrass, 1992; www.darkness2light.org, 2008). Research in this area reveals that women who are sexually abused as children are significantly more likely to experience abuse as adults, compared to women who have not had such an experience (Messman & Long, 1996).

Girls are more likely to be abused than boys, although both sexes are approached in equal numbers by potential abusers (Wellman, 1993; West, 1998). Wellman suggested that females are socialized to be warm and nurturing and respond more naively to sexual overtures. Likewise, female victims are more often abused by a close family member. Furthermore, at least one-half of all abusers are known by their victims (Baker & Duncan, 1985). One of the most potentially damaging consequences of sexual assault is sexual revictimization. This occurs when a previously victimized individual is again sexually victimized.

Two out of three individuals reporting sexual assault also report sexual revictimization (Classen, Palesh, & Aggarwal, 2005). Current theories of sexual assault/abuse do not directly address sexual revictimization. Van der Kolk (1989) described revictimization as *re-enactment compulsion*. Van der Kolk wrote, "Many traumatized people expose themselves, seemingly compulsively, to situations reminiscent of the original trauma" (p. 389). J. Herman (1992) theorized that victimized women tend to make poor choices of intimate partners, putting themselves at greater risk of

revictimization. Livingston attributed revictimization to low sexual assertiveness in women who have been sexually abused.

A closer examination of the prevalent literature suggests why little is known about sexual revictimization. Research of revictimization is based upon a small, and perhaps not a representative sample. Study samples include college students, victims who volunteer to participate, and community samples. These participants do not fully cover the wide range of the experience of victimized individuals. In addition, definitions of revictimization focus on the specific nature of the assault, the severity of abuse (Collins, 1998), the age of the victim, (childhood or adulthood) or the number of incidents per victim (Finkelhor, Ormrod, & Turner, 2007). These definitions leave out the emotional experiences of these victims.

Studies reported on sexual revictimization focus on risk factors and correlates (Mayall, & Gold, 1995). Causal theories of revictimization include factors such as acquired beliefs and expectations, learned maladaptive behaviors, and skill deficits on the part of women who were sexually abused as children (Classen, Palesh, & Aggarwal, 2005; Littleton, Breitkopf, & Berenson, 2007; Macy, 2007). The results from these studies indicated that women who had these experiences tended to make poor choices of intimate partners as adults, had a lack of self-protective techniques, experienced low self-worth and denial, and had a personal culture that included abuse as normative. Mainstream research is primarily quantitative in nature and excludes, by design, the voices of the abused.

Aside from risk factors and correlates, the long-term issues that arise are even more profound: physical health and mental health issues, relationship issues, substance

abuse issues and pervasive symptoms of post-traumatic stress. A positive relationship exists between the histories of sexual assault victims, and the need for medical and psychological health care services (Sadler, 2004; Sadler, Booth, Nielson, & Doebbeling, 2000). Victims of sexual trauma, when compared to non-victims, were found to have significantly diminished health, and increased somatic complaints (Frayne, Skinner, Sullivan, & Freund, 2003; Koss, Koss, &Woodruff, 1991; Leserman, Drossman, Li, Toomey, Nachman, & Glogau, 1996; Martin, Rosen, Durand, Knudson, & Stretch, 2000). The topic of diminished health, and increased somatic complaints will be explored in greater depth in chapter two. Other long-term correlates of sexual assault are poor social relationships, poor academic outcomes, substance abuse, higher levels of posttraumatic symptoms, and more high-risk sexual behavior (Filipas, & Ullman, 2006).

Aday and Andersen's (1974) behavioral model of access to care hypothesized that greater severity of violence exposures (rape and repeated military violence) were associated with increased healthcare utilization and poorer health status. A survey of female veterans (Hankin, Miller, & Sullivan, 2000; Skinner, Kressin, Frayne, & Tripp, 2000) revealed that 23% reported being sexually assaulted while serving in the military. The respondents who reported military sexual assault (MSA) scored lower in health status than those respondents who reported no MSA. Sexual assault continues to be under-reported even after victims are discharged from the military. Hankin and Skinner recommend mandatory screening for sexual assault for all female veterans, as repeated trauma creates an elevated traumatic response and subsequent PTSD; women need to be screened during recruitment, and following discharge.

While women from many socio-cultural groups have been victimized and revictimized, the military presents a specific culture of its own that is not exempt from sexual violence against both males and females. Female recruits reported a high prevalence of childhood sexual abuse (CSA) compared to both community and college samples (Merrill, Thomsen, Gold, & Milner, 2001). The high prevalence of rape reported by female recruits reinforces the idea that military recruits comprise a unique group of women, and indicates a need for a study of factors that may have lead to their revictimization. In a survey of 1,887 female Navy recruits, 35% of the recruits had been raped and 57% had experienced childhood physical abuse and/or childhood sexual abuse (Merrill, Newell, Thomsen, Gold, Milner, Koss, & Rosswork, 1999). Merrill, et al. (1999) summarized: "the results of our study and the studies of civilian samples indicate a need for the development of effective sexual assault prevention and treatment programs in both the civilian and military communities" (p. 223).

With a history of CSA, why do these women choose an aggressive, male-dominated workplace where revictimization is a high probability?

Repeated exposure to violence is a relatively common experience among women in the military; this has substantial implications for their mental and physical health. Women in the military who suffered sexual assault, reported severely compromised physical and emotional health status, assault-associated injuries, and diminished educational achievement (Sadler, 2004). Seventy-one percent of the women who asked for Veteran's Administration disability benefits for Post Traumatic Stress Disorder (PTSD) stated that they had been sexually assaulted while in the military (Shapiro, 2005). These studies are important because little data is available on females who are not

attending college and are in the high-risk age range for sexual assault (Kilpatrick, Acino, Resnick, Saunders, & Best, 1997; Koss & Dinero, 1989).

Purpose of the Study

The purpose of this study was to create greater understanding of the phenomenon of women who were sexually victimized as children, choosing a male dominated workplace, such as the military, and then subsequently being revictimized while serving in the military. Using grounded theory research, this author listened to the stories, and heard voices of the participants. She explored themes embedded throughout their personal accounts to understand revictimization.

This study will likely have multiple benefits. It may identify factors that will inform future empirical research. In these interviews, readers may identify commonalities with their own experiences, thereby learning from other's experiences. Clinicians who read this study may discover interventions to reduce the risk of revictimization and come to a deeper understanding of the emotions associated with this phenomenon. Conclusions from this research can be far reaching. Clinicians, health care professionals, and researchers may hear about sexual victimization in a way they generally do not: through the survivor's story. Giving voice to survivors of sexual assault may lead to changes in the way revictimization in the military is treated and responded to in the future.

Researchers have studied college populations, community samples, and female military recruits. Studies vary in sample size, measures used, definitions of child and adult sexual abuse, and data collection methods. The majority of data is collected from college students and members of the community (Arata, 2000; Schaaf & McCanne, 1998; Wyatt, Guthrie, & Notgrass, 1992). While using convenience sampling does make

research easier, that methodological approach does not address the distinct situation and issues faced by women in the military.

This group of military women is unique, because they do not fit the profile of those most commonly studied (college students, clinical samples). This study adds the personal accounts of females who were previously victimized, then revictimized while serving in the military, to the greater academic narrative.

Research Questions

What is the experience of women who were sexually abused in childhood, and then were revictimized while serving in the military?

Classen, Palesh, &Aggarwal, (2005) suggested some questions to explore with study participants: Do the participants mention family support and cohesion, or do they speak to the lack of family support as a factor in revictimization? Do the participants bring up early sexual experiences as a factor in revictimization? Does the content or style of their demeanor demonstrate low self-esteem? Are there demographic differences amongst the participants with regard to the patterns of victimization and revictimization?

While my thinking was influenced by these questions, during the actual interview I did not survey respondents based upon previous research. Rather, I explored the unique meaning in each participant's experience during the analysis phase. The issues generated from these interviews may lead the direction for further research questions.

Definitions

For the purposes of this study, *revictimization* was defined to indicate that there is a high incidence of females who were previously victimized and then revictimized while serving in the military.

Sexual abuse was defined as any form of non-consensual physical contact, inappropriate, unusual, or aggressive sexual behavior.

The Oxford Dictionary of Psychology (2001) defines Childhood Sexual Abuse as, "The subjection of a child or other vulnerable person to sexual activity liable to cause physical or psychological damage. *Childhood sexual abuse* refers to situations when a child is subjected to sexual touch or exposure, genital contact, and/or intercourse" (Oxford Dictionary of Psychology, p. 672). *Military Sexual Trauma* is defined by the Department of Veterans Affairs as sexual trauma experienced while serving on active military duty. Sexual trauma was defined as, "Sexual harassment, Sexual Assault, Rape and other acts of violence." The Department of Veterans Affairs defines sexual harassment as "repeated unsolicited, verbal or physical contact of a sexual nature, which is threatening in nature" (http://www1.va.gov/wvhp/page.cfm?pg=20).

II: A Review of the Literature

Abusive acts and sexual violence, both of children and adults, are serious problems worldwide. Abuse can be physical, emotional, sexual, or take the form of neglect (Finkelhor, 1979; Sgroi, 1982). Sexual abuse is in all cultures: "Culture is about meanings and meanings are different from culture to culture; however, there are no cultures where sexual abuse is accepted" (Arey, 1995, p 203).

A positive relationship exists between victims with history of sexual assault and the need for medical and psychological health services (Arias, 2004; Sadler, 2004; Sadler, Booth, Nielson, & Doebbeling, 2000; Taft, Stern, King, & King, 1999). Arias (2004) noted the long-term consequences of child maltreatment to be an increased likelihood of developing depression, which in turn could lead to self-medication using alcohol and other drugs.

Childhood victimization was associated with health-risk behaviors such as physical inactivity, and smoking. A correlation between childhood victimization and adverse health in adulthood may be associated with heightened vulnerability to health problems. This stress response may be related to an increase in pituitary-adrenal and autonomic responses to stress as compared to women who were not abused (Arias, 2004). Schaaf & McCanne (1998) suggested that adult females who were sexually victimized as children experienced a variety of long-term negative outcomes including sexual disturbances, depression, anxiety, fear, and suicidal ideas and behaviors. Other long-term outcomes of childhood victimization include poor social relationships, poor academic outcomes, substance abuse, higher levels of posttraumatic symptoms and increased high-risk sexual behavior (Wagner, Wolfe, Rotnitske, Proctor, & Erickson, 2000). These

findings support the theory that psychological responses to stressors affect health outcomes. CSA has a negative impact on adult women's physical and mental health throughout their lives (Arias, 2004).

Women with repeated exposure to violence during military service reported severely compromised physical and emotional health, as well as the assault and the associated injuries (Sadler, 2004). Sadler states that women who were raped or dually victimized were more likely to report chronic health problems, prescription medication use for emotional problems, and significantly lower health-related quality of life. Sexual trauma has been associated with high rates of medical conditions, increased utilization of medical services, and eating disorders (Frayne, Skinner, Sullivan, Tripp, Hankin, & Miller, 1999; Harned & Fitzgerald, 2002). The majority of these studies were conducted upon military discharge.

Powerlessness

Negative experiences from which one is unable to escape or avoid can result in feelings of powerlessness or learned helplessness, potentially leading the victim to believe that it is impossible to avoid or prevent future victimization (Finkelhor, 1987). Past studies of revictimization suggest a re-enactment compulsion is activated, wherein the participant believes that he or she can change the outcome of an experience in a positive way by putting themselves in a risky situation in hopes of attaining a better result (Irwin, 1999; van der Kolk, 1989). Van der Kolk wrote, "War veterans may enlist as mercenaries, victims of incest may become prostitutes, and victims of childhood physical abuse seemingly provoke subsequent abuse in foster families or become self-mutilators" (van der Kolk, 1989, p. 390). In clinical observation, people who have been abused have

a, “sense of apprehension, emptiness, boredom, and anxiety when not involved in activities reminiscent of the trauma” (van der Kolk, 1989, p. 391).

Emotional Regulation

Research has shown that exposure to trauma has the potential to alter brain chemistry affecting the way memories are processed and stored. Victims of abuse are consistently unable to regulate affect. Cloitre (1998) defined affect deregulation as “alternating experiences of emotional flooding and numbing” (p. 280). Abuse can directly contribute to affect regulation problems because it promotes chronic arousal. It may contribute indirectly in that the learning of effective affect regulation skills would likely be impeded because of abuse. Therefore, survivors of abuse often miss external or internal cues, thereby missing a sense of alarm under duress and putting themselves at a greater risk for revictimization.

Decision Making

A study by Arata (2000) demonstrated that CSA can increase the risk of revictimization. Arata stated that it might not be the abuse itself that contributes to revictimization, but the consequential behaviors and emotions associated with the abuse. The mediators in the relationship between revictimization and CSA are increased self-blame, symptoms of posttraumatic stress, and increased sexual activity. The effects are additive, as traumatic sexualization and powerlessness result from circumstances surrounding the child sexual abuse and may contribute to revictimization. The outcomes of Wyatt’s study (1992) were confirmed by Arata’s 2000 study. Wyatt used a quasi-longitudinal research design to examine the scope of sexual revictimization in a multiethnic population. The findings suggested that sexual decision-making was

influenced by "the severity of the abuse, the time in which it occurred over the lifespan and the number of incidences per person" (Wyatt, 1992, p. 170).

Behavioral Difficulties/Sexualized Behaviors

A study by Heberet, Tremblay, Parent, Daignault, & Piche (2006) focused on the correlates of behavior in sexually abused children, attempting to identify individual and situational factors. The study found that children who have been sexually victimized displayed, "greater internalizing and externalizing behavioral difficulties as well as more sexualized behaviors relative to same-age non-abused peers… avoidance coping was found to be linked to poorer outcomes" (p. 290).

Wyatt (1998) presented a longitudinal study examining revictimization in a multi-ethnic, community based population and the findings suggested that the sexual act itself is often perceived in isolation from the consequences of sexual activity. The sexual activity may be more of a function of not knowing how to select partners who desire non-sexual relationships and for selecting partners with whom they can share decision making regarding sexual behaviors. Learning how to perceive themselves as sexual beings and not sexual objects, to communicate these needs and to negotiate with partners the type and frequency of behaviors they wish to participate in, may be central to efforts to prevent revictimization.

Ethnicity

Participants (victims and/or their caretakers) in a longitudinal study (West, Williams, & Siegel, 2000) of CSA were interviewed from 1973-75 and then again in 1990. The sample included African-American girls who ranged in age from 10 months to 12 years. Researchers interviewed 66% of the original sample in 1990 and 30% of the

participants reported that they had been sexually revictimized as adults. The authors found that the presence of physical force in the original abuse experience was the strongest predictor of potential revictimization in adulthood. While this study is documentation that a substantial percentage of women sexually abused in childhood will be sexually abused in adulthood, an understanding of the dynamics that put these women at risk is an important priority for further research. Likewise, this sample is not generalizable to all women, so it is important to collect data from women who represent a broader sampling of ethnicities.

Gender and Sexual Orientation

The pattern of being victimized, and then re-victimized is supported by a study that examined patterns of sexual assault and its correlates among gay men, lesbians, and bisexual men and women (GLB). A community sample of 342 gay men, lesbians, and bisexual men and women indicated that nearly 63% of the participants reported some form of sexual assault and nearly 40% reported sexual revictimization. Sexual revictimization is associated with increased levels of psychological symptomology regardless of gender or sexual orientation (Heidt, Marx, Brian, & Gold, 2005).

Military

One study of 1,887 female Navy recruits indicated that a large number of women with histories of CSA are entering the military (Merrill, Milner, Newell, Thomsen, Gold, Koss, & Rosswork, 1999). In this study, 35% of the recruits had been raped prior to enlistment, and 57% experienced childhood physical abuse and/or childhood sexual abuse. Child sexual abuse was a stronger predictor of adult rape than child physical

abuse. The high prevalence of sexual assault reported in this study suggested that a large number of women with histories of sexual violence are entering the military.

Schnurr (2005) speculated that many women are joining the military to get away from adverse home environments. The implication of such a finding is significant because most research indicates that a person is at greater risk of developing PTSD - or developing more severe PTSD - when he or she has had past traumas. Many female troops are deployed to war zones already suffering from PTSD symptoms related to childhood sexual abuse. Their symptoms are only exacerbated by the intense fear, killing, and loss routinely encountered in combat.

> Women in the military remain vulnerable to violence and discrimination: Women in the military face many issues that are unique to the military environment and that are specifically gender-related. The military, a traditionally male environment, can simultaneously be a source of pride and a source of discouragement for women. Because the military is such a source of power for men, every advance that women make in the military is a significant achievement for the equality of all women. There continues to be a profound lack of equality in the military, both historically and today. (Toth, 2005, p. 329)

Health Outcomes

Seventy-one percent of the women who ask for Veteran's Administration disability benefits for PTSD state that they were sexually assaulted while in the military (Shapiro, 2005). Documents obtained on a website designed for women to speak with each other (www.militarywoman.org/harass6) revealed concerns and complaints regarding sexual assault dating as far back as 1940. Women have served in the United States military since the American Revolution. Women serve in the current military conflicts in Iraq or Afghanistan. Women are serving alongside men in every capacity.

Military Ethos

With the increased number of women in the military, attention to military sexual trauma (MST) has been growing. For many years, the military was a bastion of a good old boys mentality. With an increasing number of females in the military, there has been firm resistance from within the military culture; a female presence is considered a disruption in the system. Traditionally, the military system has been known for developing strong unity and loyalty amongst men, (i.e. male bonding) and intended to enhance cohesion. Women are viewed as "intruders" in this system (Firestone & Harris, 1999). The role and training of a male solider was to be aggressive, forceful and dominant (Terpstra & Baker, 1986). If a woman were to report an incident of sexual abuse, she encountered disbelief and threats of retaliation. Reporting on another soldier is taboo: "The military is a hierarchical structure with a history of patriarchy… individuals of higher status are perceived as having the right to make demands of those of lower status, and individuals of lower status are expected to comply with those demands" (Terpstra & Baker, 1986, p. 20).

Although there have been many calls for change in all branches of the military, findings and recommendations regarding the importance of addressing sexual assault have been largely ignored. The need to implement these recommendations has been recognized by the Department of the Air Force (Lopez, 2004), the veteran medical community (Stoddard, 2005), the Women's Research and Education Institute (2003), as well as the Miles Foundation (2003-2004). A proposal to establish an office to assist victims of sexual assault in the military was rejected by the Department of Defense (Roston, 2006). The Office of Victim Advocacy was reportedly declined because the

Department of Defense states: “it does not tolerate sexual assault of any kind and the department has worked vigorously to implement programs to prevent it.” Currently, all victim support is volunteer-based.

There are few studies on women available in the 18 to 28 age group who are not students or clinical participants (Kilpatrick, Acino, Resnick, Saunders, & Best, 1997; Koss & Dinero, 1989). Female recruits in the military report a high prevalence of pre-military sexual assault compared to both community and college samples (Merrill, et al, 1999). This high prevalence of rape reported by female recruits reinforces the speculation that military recruits comprise a unique group of women. In order to capture the essence of the experiences that have led to their revictimization and the subsequent ramifications, a qualitative study giving voice to the stories of these women is essential to understand their personal accounts of these occurrences. A review of the literature provides no accounts of the voices of the abused.

Dependence on the abuser may delay the victim’s capacity to detect violations of social contracts in a care giving relationship. Over time, the victim may develop more generalized problems detecting violations of social contracts and have an increased risk of revictimization (DePrince, 2005). Additional speculation on revictimization included learned maladaptive behaviors and skill deficits on the part of women sexually abused as children. The results from these studies indicated that women who have had such experiences tend to make poor choices of intimate partners as adults, have a lack of self-protective techniques, experience low self-worth and denial, and have a personal culture that includes abuse as a normative experience. While these results support earlier findings it is noteworthy that this sample is limited to high functioning college

undergraduates with a mean age of 20 years. Further research should include community samples and other possible factors associated with revictimization.

Empirical studies on sexual revictimization focus on risk factors and correlates (Arata, 2000; Filipas & Ullman, 2006; Macy, Nurius, & Norris, 2002). This research is primarily quantitative in nature and these studies exclude, by design, the voices of the abused. Statistics are useful in understanding prevalence, but stories reflect lived experience. It is the intent of this current study to encounter the voices of the abused.

III: Methods and Findings

The frequency of sexual trauma history among military recruits is higher than that seen in the general population (Merrill et al., 1999). In my role as researcher, I explored the processes, activities, and events surrounding the sexual revictimization of women, specifically of women who chose to enter military service. The literature on this topic indicates that repeated victimization is associated with child sexual abuse involving physical contact, intercourse, or penetration. The interviews will help to clarify, support, and add new information to existing thoughts on revictimization.

Throughout this process, I attempted to build theory rather than test it. In order to gain a deeper understanding of the inner workings of these self-referred participants, as well as the motivation behind their choices, a grounded theory approach was used. Grounded theory requires the researcher to derive a theory of a process, action, or interaction, grounded in the view of the participants. Most published research to date is primarily quantitative in nature and excludes, by its design, the voices of the abused. This study is qualitative, and therefore allows these voices to be heard.

> The researcher generates an abstract schema of a phenomenon, a theory that explains some action, interaction or process grounded in the views of the participants in the study. Interviewing is the primary field technique. Interviews have concreteness about them; protocol data from taped interviews, captured on tape and then on paper are available to highlight, cut/paste sorting, and yes, even analyzing or interpreting (Walcott 1994, p.401).

Research Design and Methods

The University's Human Subjects Committee (HSC) assessed this research for potential risk against any possible human rights violations. The committee took into account both American Psychological Association and Washington State codes and laws governing research with human subjects. This study was conducted in accordance with

all applicable Washington State laws and codes governing licensed therapists and researchers. In addition, the American Psychological Association Code of Ethics (2002) was followed closely to maintain the integrity of the study.

Participant confidentiality was ensured by changing any identifiable data in such a way as to minimize the impact on the research results. The use of informed consent, both written and verbal, was used at every step possible to ensure the willingness and understanding of participants.

Paper and pencil, or sorting questionnaire responses provide easy data but often miss the nuances and the richness of the client's experience. The more the questioner can enter into the world of the client, the more lucid and meaningful the report of the experience becomes.

To begin, I contacted a former military woman who founded an organization called Women Organizing Women (WOW), assisting woman survivors of military sexual trauma (Avila-Smith, 2005). This contact maintains a list of persons to whom she agreed to send an e-mail copy of my request for volunteers (see Appendix A). In the e-mail, I briefly described the present study and asked potential participants to respond if interested.

In response to the initial e-mail, twenty-two female veterans and three veteran organizations contacted me. The persons indicating interest in participating were sent a copy of the informed consent (Appendix B). Once this document was signed and returned, an appointment with the respondent was set to conduct a phone interview. The nature of the study, potential benefits and risks, the voluntary nature of the interview and audio taping procedures were discussed. Interested participants were asked if they were currently in therapy or had recently been in therapy and asked to sign a release allowing

the researcher to speak with the treating therapists to verify stability and emotional health. Therapists were asked to agree to make themselves available to persons in the study for any follow-up concerns. Because one requirement to participate in this study was to actively be in or have been in therapy, the findings may be representative only of a certain type of sexually revictimized women—those who have examined the issue in such a way as to be able to discuss it and cope effectively.

When introducing this project to potential participants, I self-identified as a doctoral student in a clinical program and a licensed Marriage and Family Therapist who has practiced privately for 16 years. For the past five years, a large portion of my practice has been dedicated to working with child and adolescent survivors of sexual abuse. As an interviewer, I was positioned as a listener who facilitated the process of unfolding information. Where quantitative research claims objectivity, qualitative research emphasizes the usefulness of self-disclosure and identification of the researchers' experience and background for the study and distinguishes the researcher role versus that of a voyeur.

Self-identification as an abuse survivor was one criterion for inclusion in the present study. The participant's definition of survival and coping was the starting point for the study; therefore, the stories were accepted at face value as the women's phenomenological realities. The primary method of investigation of these realities was grounded theory, a qualitative research method designed to aid in the systematic collection and analysis of data and the construction of a theoretical model (Glaser & Strauss, 1967). Consistent with the qualitative tradition the grounded theory approach is inductive, which allows the researcher to discover categories and themes within the data. The focus of grounded theory is theory generation

(Creswell, 1998). The emerging theory is built up from the data through the coding process where themes are discovered using open, axial, and selective coding of the data. This study was designed to build theory rather than test existing theory. The first step was to allow themes to emerge from the data (Turner, 1981). Next, I listened to and coded experiences that the participants described regarding their sexual victimization and revictimization. Categories originated from an investigative perspective and then derived from statements made by the participants; because reality is a social construction, there are no truths to be discovered. The categories are data driven and inductive. The categories chosen were those that were consistently endorsed among all the participants. The themes from these categories may encourage the development of possible theory. These themes, as revealed by the data, have been addressed in the study.

The data analysis was based on transcriptions of the participant interviews. First, a general review of all the information and notes, looking closely at words and metaphors used by the participants. Following the organization and conversion of the data, the analysis is ongoing.

Each individual interview took two and one half hours to complete, and they were conducted on seven different occasions. One interview required two sessions to complete. I referred to Kvale's (1996) Active Listening Skills to guide the process of recording the interviews. According to Kvale, answers should be spontaneous, rich, specific, and relevant. Questions were short; answers were long. The interviewer clarified the meanings of important material by repeating back what was being said. Interpretation of the participant's descriptive statements occurred throughout the interview as the interviewer checked her interpretation of the participant's answers. The

interviews were self-communicating; they were viewed as complete stories that required little additional description or explanation.

Because qualitative research is subject to researcher bias, it is necessary for the researcher to identify her position within the project and be transparent about the procedures and the rationale supporting various actions at choice points, and even emotional and intellectual responses to the participants. "Investigator-bias and subjectivity are not viewed negatively in qualitative research. They are presumed to be a normal aspect of conducting research where the researcher is the tool of the investigation" (Morrow & Smith, 2000, p.219).

Reviewing the literature on this topic, as well as my previous clinical work with clients, who have a history of sexual abuse and revictimization, influenced my expectations about motivations and outcomes. For example, I have observed that women with sexual abuse histories seem to make decisions based on an apparent motivation to get it right. These women are drawn to recapitulate an event in order to rework it so that they come out with a sense of power. Unfortunately, revictimization often occurs; self-confidence is further diminished and the cycle may be repeated. Throughout the interviews, I found myself listening for the formulation that I had anticipated within my own biases. I never heard that interpretation. I made a journal entry immediately following each interview to capture prevalent thoughts and emotions and again, after the interview and analysis of the tape.

The qualitative researcher is seeking to reflect accurately the stories of her participants with all their complexity and richness. Bias on the part of the researcher might guide the conversation and the analysis in such a way as to be recorded as the

researcher's story rather than the participants (Heppner & Heppner, 2004). I documented self-reflection on a regular basis to discharge and examine emotional responses to the process as well as to serve as a paper trail for potential audit in the future.

Morrow & Smith (2000) reviewed the function of this self reflective journal as follows: 1) To bring to awareness previously unexamined beliefs and assumptions that might introduce bias, 2) To help manage emotional responses to the material, 3) To elicit hunches and questions which will enrich the research, 4) To help the researcher discriminate between the participant' stories and her own. In terms of surfacing and managing such preconceptions based on my extensive clinical experience, I invited two independent readers to assist me by independently completing the first level of coding.

Data Analysis

Data analysis was a continuous process from initial contact through the interview process to the completion of this project. Interpretations and opinions were formulated throughout the research process, while findings were compared to the initial premise of the proposal. After each interview, I utilized Erickson's Analytic Induction Methodology (Morrow & Smith, 2000) which involved writing expanded notes before moving to another activity or interview. In this way, emerging theory was considered when conducting subsequent interviews so that I could deliberately search for disconfirming evidence as the interviews proceeded. This process of analysis included immersing myself in reflection on the conversations. I listened to the interviews and recalled additional data about the conversations with the purpose of generating preliminary hypotheses about the research questions.

It is my belief that a qualitative researcher cannot escape the personal interpretation involved in data analysis. My goal was to view each interview holistically, looking for a description of the individual, the setting, analyzing the data for themes or categories and finally making an interpretation or conclusion about its meaning.

I used a typical grounded theory coding system to analyze the transcripts, field notes and self-reflective memos (Tesch, 1990 as cited in Creswell, 2003). This process included getting a sense of the whole in the individual transcripts, looking for the underlying meanings, clustering similar topics, assigning codes for the themes and grouping topics that relate to each other. I utilized a procedure for developing categories of information (open coding), interconnecting the categories (axial coding), building a story that connected the categories (selective coding) and ended with a set of theoretical presumptions. The purpose of this procedure was to help carry out the steps of theory building.

The strategies for validating findings are seen as the strength of qualitative research, but such strategies take the form of "trustworthiness" and "credibility" (Creswell, 2005). To insure validity, the following verification strategies were employed: 1) The researcher clarified the biases that she brought to the study, 2) The researcher cited negative or discrepant information, 3) The researcher debriefed with a doctoral student and a recent doctoral graduate who agreed to be external auditors, 4) the researcher contacted a person not connected with the study to review the project and provide assessment.

Technology

A voice activated cassette recorder, ctr-122, was used to record the telephone interviews. The quality of the recordings for the first five interviews was excellent. One interview recording did not record and I did not discover this until I began transcribing. When I attempted to reach the participant to arrange another interview, I was unable to locate her and therefore have only my notes to reference. A professional transcriptionist was employed to transcribe the audio tapes to paper. The transcriptionist was asked to provide a verbatim transcription of the interviews, which she did to the best of her ability.

Participants

Participants were recruited in response to an e-mail request for volunteers (Appendix A). There were four requirements to participate in this study: 1) Participants had to presently be or have been in therapy, with their therapist available if needed, 2) participants were sexually victimized before age 14. 3) Participants were then revictimized while serving in the military, and 4) Participants had to be willing to talk openly about their experience.

Responses from potential participants came from throughout the United States, including the West Coast, the Midwest, the East Coast, and the South. Originally, 22 participants responded and due to personal reasons, only six participated in the actual study. Reasons for withdrawal were varied. One participant stated, "Thank you for your patience and tolerance. My Dad just died about three weeks ago… he was the perpetrator and I have been dealing with a lot of mixed feelings... more than I anticipated." Another participant wrote, "I wanted to help you with this issue (abuse in the military) but I don't know what I can do other than tell you my life's story… I did file a VA claim and it was

denied. I refuse to fight it any further because I just cannot deal with the pain it causes me." This participant withdrew. Another respondent stated," I am interested in your project but right now I am trying to get my disability retirement from the IRS after a year and one half, at the same time I am trying to control the pain from agent orange… hopefully I can speak before the New Hampshire task force of the VA hospital. I will send an e-mail tomorrow after I return from the doctors and try to arrange to talk to you" This respondent has been ill, but continues to contact me by e-mail

The researcher interviewed the remaining six women participants who met the criteria. One participant was interviewed in person, while the other five were interviewed over the phone.

The six participants were raised in six different states within five regions of the country. All were raised in rural communities. The participants' approximate ages are between 45 and 60. Three of the participants attended college the remaining three completed high school. All of the participants noted multiple moves while living with their family of origin. One participant had only one sibling; the others had three to nine siblings. One had a military father who died early in her life; others described absent fathers, or fathers who were not engaged. Two of the participants were Native Americans. One participant was in the Air Force, three in the Army, one in the Coast Guard, and one in the Navy. Participant's educational levels ranged from high school completion to college level. Abuse experiences varied from a single incident of sexual abuse to 18 years of ongoing abuse. The age of initial abuse ranged from infancy to 15 years of age. All of the participants had been in counseling or recovery processes.

Brief Biographies of the Participants

Participant (1) grew up in Ohio. She is the youngest of six children and the only female. She described her family as "blue collar" and her mother as a stay-at-home-mom. She was the first to go to college where she joined the ROTC. She enlisted in the US Air Force and served for 9 years. She was married and divorced and is currently single. Her abuse began at the age of two by a family member. She described her father as alcoholic and her mother as a "very independent woman."

Participant (2) grew up wanting to be a Navy fighter pilot (as her father had been). Her father died, and her mother remarried, and then divorced. Following her High School graduation, she attempted unsuccessfully to enlist. She recalled growing up in the military from the time she was born, and moving around a lot. She is the oldest of three children but the only one in her family to choose to go to college. Following graduation, she joined the reserves and eventually went into active duty as a lieutenant in the Coast Guard. She retired from the military, and is an activist for justice in the military.

Participant (3) was born on a dairy farm in the mid-west. Her family moved when she was 2 years old. She attended High School and continued on to a University. She is the youngest in the family with one brother 9 years older. She enlisted in the Navy following her graduation from college. She experienced stranger sexual abuse as a child, and sexual abuse while serving in the Navy. She was retired from the Navy with a diagnosis of major depressive disorder, and receives full compensation after serving for 20 years.

Participant (4) is the youngest of 8 children in a blended family. She was abused by a half brother for a number of years. Her father was a minister and the family moved

to many small towns while she was growing up. She describes herself as odd and rejected by her family. Following High School, she went into ranching. She married, divorced, and later joined the Army when she was 23 years old. She married a second time and had a son; divorced and remarried a third time, and a fourth. She is single at present and receiving mental health services from the VA.

Participant (5) is a Native American veteran, the youngest of three children, born on the east coast. Her parents divorced when she was 6 years old. She was assaulted while serving in the military. Now discharged from service, she is married and lives with her husband and two dogs.

Participant (6) is a Native American and an Air Force veteran. She reports growing up in an intact family, religious and idealistic. She is one of five children. She joined the service at 18 years old, following high school completion. Following her discharge, she has enrolled in a college program and is living in the Northwest.

Findings

The authority for creating categories lies with the literature and the interpretation of the researcher. The ground for justification of the categories lies with the empirical evidence. The source of the names used to describe a category is derived from the interpretation by the researcher of the participant's reports and the literature. The data are allowed to "speak for themselves." Heppner (1999) stated that "behavior does not have meaning outside of its context, and understanding the meaning of behavior in context is the essence of qualitative research" (p. 109). According to this view, an understanding of how people behave and the meaning they give to their experience are never understood by isolating some small aspect and examining it alone. I wanted to

explore the emotional experiences of the participants who were victimized in childhood, and revictimized in the military. I looked for emerging themes to support the development of a grounded theory. These themes were selected for inclusion if they contained ideas expressed by multiple participants. There were 11 themes that emerged which I used to organize the findings into categories: each theme name was derived from of the participants' repeated use of these phrases.

1. Early sexual abuse and subsequent revictimization
2. Poor family support
3. Poor choice of intimate partners as adults
4. Lessened ability to protect self
5. Low self-esteem and denial
6. A personal culture that included abuse as a normal experience; prior to military service and within the military.
7. The need for medical and psychological health care
8. Poor academic outcomes before military service and following discharge.
9. Posttraumatic stress symptoms
10. Substance abuse
11. A dismissing military response to disclosure

Listening to the life stories of these six participants, these themes were addressed in the following ways:

Early sexual abuse and revictimization.

Throughout the interview process, I observed that early sexual abuse appeared as a correlate to revictimization for the participants. However, none of the participants acknowledged this phenomenon. The participants seemed to view themselves as victims to the abuse and did not remark on the factors that influenced their revictimization. The limited perspective in the participants' comments evidences this. It is important to note here that early sexual abuse and engagement in therapy were requirements to participate in this study, yet still the connection between early sexual experiences and revictimization did not present throughout the interview.

As one participant (6) recounted her long-term sexual abuse history, it was evident that she vacillated between being a victim, feeling empowered, and then again not trusting herself. Instead of seeing things on a continuum and noticing her resiliency, she just gives up on relationship altogether. There is a loss of trust of self, of the military, and of men.

> I was sexually violated by my step-father from about age 5 until I put it to a stop when I was 15 years old. He was also in the air force. I again was raped as a teenager… When I went into the military, I met a sergeant I thought I could talk to, and he sexually abused me and beat me up because I told him 'No.' At this point in my life I can't stay in a serious relationship because I cannot trust men.

Another respondent recounted her abuse history without emotion; she simply stated the facts. After being abused repeatedly, she seemed to be disconnected from her feelings. This disconnect may have been a precursor to her revictimization. She continues, "I was sexually abused from about 3 years to about 7 by a maternal uncle and

my father. I was sexually abused by my mother's boyfriend when I was 14 or 15; I was raped in the service when I was 18."

A potential pre-curser to victimization and revictimization for participant (1) was recurrent traumatization, including sexual abuse, growing up in a household where women were devalued, and witnessing domestic violence:

> The women in the house were being blamed and told we were stupid. There was domestic violence…My sexual abuse started when I was 2 years old and continued until I was 12 years old. My eldest brother, who was 7 years older than me, was the abuser. I never told anyone…I was molested by a female cousin at age 14, then sexually assaulted by a stranger…at 14 or 15. I got drunk and was date-raped by an 18 year old… alcohol was involved… it was never reported.

This participant's story illustrates the extent of her child and adolescent abuse. Her military revictimization echoes her early experiences. "I was raped by a colonel during my OB-GYN entrance exam…I was broken but not destroyed."

Later in her military career, after being accepted into a third lieutenant's program, this participant described the following incident:

> I do really believe my mind had gotten very used to compartmentalizing things. There was a rather salty army colonel who was the doctor, and I have to go through an OB-GYN exam. Now mind you, by this time I have had 23 OB-GYN exams, and I knew exactly what to expect. This guy digitally assaulted me. It was rough.

She stated another occurrence with a different military OB-GYN doctor:

> I had another assault by another doctor, I think I was either a first lieutenant or captain, and I had another mandatory OB-GYN appointment. I had gone to this doctor multiple times, and he always told me what he was going to do. And this time, totally out of sequence, he rectally examined me without saying anything. I again disassociated.

Participant (3) described abuse during a medical exam. Her early sexual abuse was not ongoing, but her abuse included inappropriate touching and genital exposure by a neighbor. She was naive and unprepared, both emotionally and physically,

for the harassment she endured during boot camp. She earned the privilege of going to communication school, but dropped out because of the harassment she endured there, "All the male classmates harassed me so bad I couldn't stand it."

She seemed to have had no coping skills to protect her against revictimization.

> I was a virgin when I graduated from high school; I was a virgin when I graduated from college; and I was a virgin when I went into the navy…I was constantly getting hit on, so finally I just gave in; I gave up my humanity…During boot camp they treated us like sluts. My first pelvic exam, nobody explained what was going to happen. He shoved something up me with full force. I felt like I had been gang-raped. It felt like a physical assault more like a medical exam.

Participant (4) has had many emotional breakdowns, resulting in hospitalization during her service in the military. She reported always trusting, and then being continually betrayed. Her early sexual abuse may have set her up for an expectation of betrayal:

> My half-brother began molesting me. I felt like I was the dirty one…After high school I went to a cattle ranch, I left with a guy, and actually we got married. He was alcoholic. We broke up. Then I entered the military…I was sexually harassed from the moment I entered basic. There was no place to go with reporting it.

The long term effects of childhood sexual abuse on adult functioning includes self-destructive behaviors and poor interpersonal relationships. Early sexual abuse can create an inability to be assertive in sexual matters, learned helplessness, and powerlessness. Guilt and shame can be manifestations of the sexual abuse and could be later manifestations of the powerlessness experienced; this could be seen by potential abusers as "incapable of effective resistance" and have contributed to the revictimization, (Draucker, 1995).

Poor family support.

While the lack of family support is hard on many children, those who have been sexually abused during childhood tend to feel more isolated when family support is lacking. With no one to share their pain, victims of childhood sexual abuse can internalize their shame. Four of the participants in this study had been betrayed by a family member, therefore taught not to trust, and learned to devalue themselves. Participant (4) described her family as blended…she was the youngest of the eight children. Her half-brother sexually abused her. Her father was a minister and well regarded in the community but absent from the family. At the time, she had no words to describe what was happening to her. This quote shows how the victim was stigmatized in her family and how that stigma contributed to her guilt.

> Ours was a blended family, we moved around a lot. Over the years what has hurt me the most was the lack of roots and family…You know, staying cohesive I couldn't disclose [the sexual abuse] because I didn't want to tear the family apart, it was already falling apart. My half brother molested me, and you know, I still thought I was the dirty one… A couple of [my siblings] rejected me because of the problems I've had as a result of the childhood sexual abuse.

The families of the participants were described as struggling, unsettled, and when the abuse occurred, it went un-accounted for. All the participants described lack of family support and difficulties with communication.

When a family system is disturbed, the tendency is to pick the most vulnerable family member to be the identified problem, typically the one with the least protection.

Children often lack the words to express what has happened and tend to internalize the feelings around the abuse. Behavioral changes can be the first symptoms that are identifiable by an adult. Participant (3) noted:

> Our neighbors were hillbillies, they were ignorant and oversexed, and being an outsider we were not accepted that well…I learned to keep to myself…One time I was walking home from visiting a friend, I guess I was about 11. An elderly gentleman, who was very prominent in our local community and was a grandparent of one of my neighbors stopped and offered to give me a ride the rest of the way home in his pick-up truck. Then he started stroking my thigh. I jumped out of his truck, and he said 'Well, you won't tell your parents about this, will ya?' and you know, I never did tell my parents. I never did tell my dad, and by the time I told my mom she was in a nursing home. Maybe it's a good thing I never told them, because, you know, who would have believed a kid who had a reputation for being odd anyway?

When the abuser is a member of the family, the secret nature of the abuse can cause a lot of anguish for the victim and add a lot of stress to the family functioning. Participant (1) stated:

> My sexual abuse started when I was 2 years old and continued until I was 12 years old. Pretty much on regular basis I was abused sexually and then of course emotionally, from 2 to 12 by my oldest brother. There wasn't the language or understanding of it, or even the social understanding of it. I never told anyone.

For this participant, there was an acceptance of abuse as natural to the family culture. Consequently, she was revictimized on numerous occasions throughout adolescence and adulthood. It was not until much later in her life that she was able to see how dysfunctional her family was.

> My father came from a highly abusive background…I can always remember him being drunk throughout my life…he was verbally abusive to everybody. He was physically abusive to some of my brothers who would overstep boundaries, typically into legal issues...it was the women in our house who were being blamed and told we were stupid. My grandmother was sexually abused at the hands of her abusive husband.

Other participants described family dysfunction: "I felt isolated and alone as I grew up….I was naïve."

"When my father died the family spiraled down."

One participant (3) reported disclosing her victimization to her parents and shortly after the abuser's father was reportedly assaulted and subsequently died; the participant suspected that her father had taken the law in his own hands and punished the abuser's father, but she cited this as speculation never confirmed.

It is understood that family variables, such as disturbed interaction patterns and poor communication, early in a child's life can produce vulnerability and later, distress. All of the participants sought security in the military. Presumably, the military would act as a functioning family; unfortunately, they had a repeat of an even more dysfunctional system with no means of disclosure.

Poor choice of intimate partners as adults.

For those who have endured early childhood sexual abuse and repeated victimization, choosing an intimate partner in adulthood can present many challenges. Survivors of abuse and revictimization often have lowered expectations for loving partnerships. Participants in this study seemed to view marriage as a convenience rather than as collaborative; and perhaps as a protective measure while in the military. With abuse considered as part of the fabric of their lives, participants reported tolerance of ongoing abuse in their relationships.

Lasting intimate relationships proved rare for many participants. Frequent moving around while in the military was one potential reason for the brevity of relationships. However, lack of post-military relationships suggests reasons linked to early childhood experiences (i.e. moving around, alcoholic parents, early sexualization, etc.). One participant explains, "My first duty station was good… I met my second

husband there and my son was born there, and that was pretty happy. But then of course I was transferred; no relationship has ever lasted with me, you know?"

Another participant (4) spoke to the difficulties of maintaining a committed relationship while in the military. When reflecting on her problems with relationships, she stated that she realized that her early sexual abuse has influenced her choice in partners.

> [My first husband] was alcoholic. We broke up and then I entered the military…I met my second husband and had my son. My husband was not in the military, and we were separated because I was [sent away]. It is very difficult to stay in the military when your husband is not…but that was not the problem, I think that I would choose too quickly and not believe that I had standards that could be met, and I had no knowledge about addiction or anything…[I was at a different station] when I reported abuse from my third husband…physical violence. The other two were abusive, but this was physical violence.

It seems though her intuition was numbed, and she did not perceive the subtle cues that each partner was an alcoholic and an abuser. The continuity in the men she chose may be an indicator that she was attracted to someone because the abuse was familiar, rather than her protective recourses keeping her from acknowledging the toxicity that was evident. Her familiarity with abuse began in early childhood, and continued in her relationships. She went on to describe her third husband:

> He was sensitive, he would talk about things. He was goal oriented. He was promoted well before his time; all the star stuff, typical of many abusive men. He had a dark side, the closest thing to evil. He delighted in seeing people get upset, even with his own children and me; he delighted in seeing us torn apart. He beat his first wife and he beat his daughters. And he drank in such a manner that it was alcoholic.

For another participant (3), the constant harassment from the men in the military diminished her self-esteem. Being degraded in boot camp and communication school caused her to conform to the military culture. This participant grew up in a small town

and was not prepared with a self-assuredness that could have protected her from the unspoken rules of the military. She explains, "I had not had intercourse when I entered the military and I was constantly getting hit on, so finally...I gave up my humanity. I finally gave up and just spread my legs; I figured I wasn't worth [expletive deleted] anyway."

Another participant described a volatile relationship with an intimate partner who was also a superior officer. "I had a five year affair with an Air Force pilot who was physically and verbally abusive… I tolerated this abuse"

Of all the participants interviewed, there was one (5) who described a long-term, satisfying relationship with a man. She described meeting her husband in the military, and they are still married after 18 years. "Although I was abused in the military, I am grateful for meeting my husband there."

Wyatt, Guthrie & Notgrass (1992) generalized that there is a link between women who have experienced sexual abuse and subsequent choices of intimate partners as adults. For example, sexually victimized women, in both childhood and adulthood are more likely to have brief sexual encounters, and experience numerous short-term relationships. A study by Judith Herman (1992) of women who have been sexually abused as children supported the theme that victimized women tended to make poor choices of intimate partners as adults. The study participants disclosed making intimate partner choices without allowing time for discovery but rather for convenience.

Lessened ability to protect self.

All of the participants enlisted in the military believing they had coping skills and personal authority that would protect them or serve them in the violent environment of the military.

Participant (4) spoke of her ability to protect herself and say "No" in regards to a drill sergeant. She explains, "There's still one of my suitcases out there because I wouldn't have sex with a drill sergeant or send him a picture of me in a bikini."

Participant (4) also stated that she had no qualms about protecting herself against men in the military: "I had no problem tellin' 'em, 'Turn around and take a walk, buddy. You are going to get yourself in trouble.' I had no problem telling them to get walking."

One participant spoke to the lewd comments she heard the men in her squadron say about her. She pretended not to notice, but she felt devalued and objectified. I played the dumb blond thing a lot…it was the 70s… I didn't get it. The guys seemed to snicker about it under their breath."

Another participant (1) spoke highly of her status amongst the men in her ROTC training course. She thought she had the respect of her peers until she was assigned to duty. "I had a lot of interesting things because even among my male peers I was well-respected… just because I didn't put up with any of their crap."

However, after assigned to duty, this participant described being given lesser jobs, harassed more, and subsequently revictimized.

Participant (2) who spoke to her ability to protect herself, talked about an officer who came in to the office and massaged her shoulders. Even though she communicated

clearly her request for him to stop, stating that she wanted to work and not be touched. He presumed that a man had abused her as a child.

> I didn't want to be touched in that way, in terms of projecting that kind of image. So I said 'can I talk to you for a minute?' He was okay with that, and he sat down and I said, 'Hey, you know, I just have something I want to tell you. I'm not speaking for anybody else, but I would really appreciate it if you would not come in and massage my shoulders when I'm trying to work because I can't really do my work while you're doing that…I'm just letting you know I prefer you don't do it.'

The study participants entered the military believing they could protect themselves, but the sexual harassment they endured was a set-up for further victimization. Individuality and personal authority is chipped away while serving in the military.

Participant (2) continues, "The military is looking for bodies and young people with energy, people that are pliable, willing to follow orders without questioning anything or authority. People who are poor, you know?"

It is evidenced in the conversations that, saying no to a soldier or colleague can be hard enough, but saying no to an officer, or supervisor is much more problematic. Saying no also breaks group cohesion, and the victim is ostracized, and even targeted for retribution.

Early sexual abuse stimulates the fight or flight response, and repeated traumatization keeps this response elevated when in other distressful events (van der Kolk, 2003). Even though a physiological response occurs, it does not seem to create an aversion to dangerous situations. Throughout the interviews, the participants described how they continued to put themselves into situations where they were vulnerable. The

ability to identify and assess dangerous situations appeared to be missing for all six of the women interviewed in this study.

One participant (1) stated how wanting to be included as one of the boys affected her judgment. This allowed her to make a decision of convenience rather than choosing to take care of herself. In this excerpt, it is also evident that drinking removed the ability to protect one's self.

> I never had the policy of drinking with my troops. But after training, we all went out to a local pub. I just wanted to be one of the boys. That night, one of the boys, a staff sergeant who was also one of my supervisors pulled me into a bathroom, pinned me down and raped me.

Another participant (3) spoke about the harassment she was subjected to upon entrance into the military.

> I was already terrified of boot-camp. I hated being yelled at, screamed at, and, you know, like, where you see these movies, Marine Corps boot camp. They call the recruits things like 'Maggot.' Stuff like that. Well, in this boot camp they called us 'Ladies.' They made it sound derogatory. They treated us like sluts.

Another participant brought up this marginalization of women in the military. Participant (2) Women are outsiders in this environment, reinforcing their feelings of being different and not having a voice. Drill instructors have long attempted to degrade and thus motivate male recruits by calling them Ladies. "The first three years were like a good old boys' club, I could not believe it. These people were alcoholics. Most of them were men. They were drunk all the time…They didn't take anything very seriously."

Another participant (1) speaks to a similar experience of the military where women are demeaned and objectified; and the Good Old Boy mentality prevails.

"[The environment] was extraordinarily vindictive; mean-spirited…It was amazing the things that they would say to each other. And this is part of a mentality of the military especially of academy grads…They'd call each other 'pussy' and 'fag.'"

Putting one's self in dangerous predicaments and not avoiding dangerous social situations (drinking with the boys) can be an example of coping strategies predicated on early abuse where they were restricted from running away to flee danger. If the early abuse is traumatic, personally invasive, death threatening, or threatening to family, the result is that sensitivity to similar situations becomes diminished and they find themselves in similar situations that recapitulate that early childhood experience. These people are perceived as compliant victims, when in actuality this behavior is an adaptation to the primary traumatic event.

In a study of sexual revictimization, Catherine Clausen (2005) found that people who were revictimized showed difficulty in interpersonal relationships, coping, self-representations, affect regulation, and greater self-blame and shame. Insight and intuition seemed to be replaced by victimhood. Early childhood sexual abuse shapes a child's sexuality and influences subsequent behavior. Many young women who express interest in joining the military reported to have been preyed upon sexually by their recruiters (Mendoza, 2006). Mendoza wrote. "Women were raped on recruiting office couches, assaulted in government cars and groped en route to entrance exams."

Low self-esteem and denial

Self-esteem can be defined as a reflection of a person's self-appraisal of their own worth. Beliefs about one's self, emotions, and behaviors may all be an indication of a person's self-esteem. Denial can be a defense mechanism, where a person represses an event, thought, or feeling that evokes too much discomfort to tolerate. Instead, the person insists it is not true or ignores it despite potentially overwhelming evidence.

All of the participants entered the military with some sense of self-esteem and confidence. The abusive situations endured by the participants diminished their ability to trust or protect themselves, causing diminished self-esteem and denial of their vulnerability. There was an expectation of fairness and equality when they enlisted; however, they were competing against the overwhelming ethos of the military that marginalizes women in service. The participants denied being marginalized, thinking it would be different at a new location or a different assignment.

Many participants described assignments of lowly jobs, one step above making coffee. While this certainly contributed to diminished self-esteem, not being acknowledged or supported by the military in respectful ways was also indicated as a contributor to feeling bad about one's self. One participant recalls, "I have a hard time trying not to come across as you know, just being a whiner or complainer, you know what I mean? There are times I just want [life] over with."

Throughout the participant's descriptions, there appears to be an undercurrent of low-self worth. An example of a participant's (2) own assessment of her loss of confidence and self worth is described in the following excerpt from her transcription.

> There are no limits on your mind other than what people tell you when you're growing up. So I never considered the possibility that I might not be able to be a fighter pilot…When you run up against a wall that you can't penetrate you go around it.

After reporting abuse/harassment to her Commanding Officer, they spoke to him about the incident. When he repeated the offense, they charged *her* with sexual harassment. She explains, "The revictimization, to sum it up, happens when you report because they turn it around on you. If they're even remotely successful it's time for you to go. And who wants to be punished and revictimized?"

Another participant (1) described her loss of self-esteem. In the initial part of her interview, she reported being acknowledged with grants and awards. During her military service, depression replaced self-worth. "I got two scholarships…from the Daughters of the American Revolution who wanted me to go to law school and who also gave me a leadership award because of all the things I was accomplishing."

Further into the interview, she described her experience in the military. "Part of the other aspect of what this system does is it breaks your spirit… [We were] just treated like we didn't have a brain, like we didn't matter."

After reportedly being drugged and raped by the First Sergeant, this participant describes having an eating disorder, being institutionalized, and wanting to kill herself, "[There] was an inability to deal with my own hurt."

Experiences of denial were not admitted overtly within the stories offered by the participants. Here is one example of how denial was a coping mechanism to move forward and work in an environment that was clearly abusive. This example also illustrates diminished self-esteem and PTSD.

> They tried to make me look like a loser from day one. When I reported the abuse, from that day forward they tried to make me look like a loser. And I wasn't. So my way of coping was to buck-up and be even better until I got out. And when I got out I tried to go to school and I couldn't finish….And then I just had a breakdown.

Throughout her interview, participant (2) described ways that she manipulated her environment by being seductive. When describing her attempts to locate her ex-step-father to find missing pieces of her life's puzzle, she described the information-gathering process as successful. "I'm pretty charming… I got everything I needed to know. and frankly, he was a man, and I was a young woman. I am a woman, you know. It wasn't

difficult to get information out of him. You know, we had a good time" This elevated self-esteem was actually this participant's downfall. When she reported ongoing sexual harassment in the military, she was charged with harassment herself. After talking to her supervisor about the incident, he responded by saying, "Well, he's just trying to make you feel welcome in the unit." She says, "If he doesn't stop, I'll have to go to the CO." The next thing she learned was that he was spoken to about this situation, "When it happened again, he turned around and charged me with sexual harassment…This is when I learned you never show your hand before you play it. You can't talk about what you're going to do; you just have to do it. You have to document it and do it." After this, she decided to leave the military.

The systematic demoralization of women in the military contributed to loss of self-esteem and denial. The participants entered the military confident that they could be successful. Having compartmentalized their early childhood sexual abuse, their experiences in the military and subsequent revictimization left them psychological vulnerability.

A personal culture that includes abuse as a normal experience.

In each participant's description, early abuse was stated as matter of fact. There was no expression of outrage at the offender, disappointment over lack of protection, nor any remorse or anger. They were not surprised by being harassed or marginalized. They expressed knowledge that they would be confronted by a culture that would be discriminating. Positive self-regard created thoughts that they could manage this environment and use the military for their stated purposes (i.e., education, travel, learning

of new skills) but they were unprepared for the degree of abuse and harassment that they received.

Many of the participants did not disclose their childhood abuse to a close family member, nor did they receive treatment for early abuse. While recounting their personal histories, the matter-of-fact tone illustrated an expectation that this is how the world is.

Participant (1) stated, "I was pretty much, on a regular basis, abused sexually and then, of course emotionally, from 2-12 by my oldest brother. I never told anyone; there wasn't the language or understanding of sexual abuse." She continued, "I was molested by a female cousin at 14 years and actually sexually assaulted by a stranger and date raped while vacationing with a girl friend and her parents when I was fourteen."

One participant had experienced sexual harassment from a military Veteran at a early age, "At the age of 13, I was groped and grabbed by a Vietnam Vet, as well as numerous other young girls in my age group. He would offer drugs and alcohol to a bunch of us, and he actually had sex with a very good friend of mine."

Another participant (4) had insight into sexual predators present in the military, "The half brother that molested me had been molested by an Army Colonel."

Intellectualizing their experiences rather than emotionally describing them is one way the participants coped with trauma. In order to survive in this world, the participants came to normalize this abusive culture. This also served them in coping with their revictimization in the military.

> Well I finally just gave in. I figured when I signed on the dotted line I gave up my humanity. I started drinking heavily, and I just more or less spread my legs for the first good-looking guy. I figured I wasn't worth [expletive deleted] anyway. It was a pretty dehumanizing environment.

Participant (6) illustrated how abuse is a normal part of the military culture.

Over time, being devalued and disrespected is integrated into thoughts and emotions, consequently lowering self-esteem.

> I learned how every military female, regardless of what Ivy League school they went to or career they had, were treated like crap, especially at the squadron officer school where sexual harassment and inappropriate treatment and cheating were allowed to happen. And they had no qualms about it. We were told we were not speaking up enough, and when we did we were too bossy.

This same participant described another experience at squadron officer's school.

> Somebody asked a question about a Navy admiral who was sitting in a dental chair and he groped the breast of the technician." When asked what he thought of this behavior, the General replied by saying, "The admiral has been in service for 26 years, and we certainly don't want to throw his career away for something that minor." "That was the whole thing, time and time again, treatment like we didn't have a brain, like we didn't matter."

Another participant who was aware of ongoing harassment in the military inquired about action to take. At this meeting with commissioned officers, she asked, "'what do we do if we're at these different locations if we're harassed or anything?' And no one said anything. No one would even address it."

Participant (1) described her experience of the sexualization and marginalization of women on a military base. Her commanding officer set the tone for the atmosphere.

> While there, I got to hang around with a bunch of male captains in military police where I learned one was a really big predator…He said, 'Hey, you can use a pen'…and in his glove box was nude photos of himself fully erect. This was the captain in the military police. And on this same base, in the Officer's Club…there was a mixed group of third Lieutenants attending. Um, in the Officer's Club was a topless dancer who was clearly bruised and battered and this was reprehensible. I mean, I'm not a prude, but it was really quite demeaning for any of us women and I actually sat there with my back to her.

The dissociation from the trauma is evidenced by a participant's description of listening to a lecture on rape and prostitution. She stated:

> As she was explaining sexual favors for money, it triggered me and I remembered my sexual abuse as a kid. I can tell you now, I absolutely

> dissociated. I remember standing in the middle of campus after class and having no idea where I was." She later heard from her professor that "98% of the women who were sexually abused as children had gone on to be prostitutes, not because that's what they wanted to be, but because they thought they had no choice.

Since child-victims are more likely to be victimized as adults, the belief that abuse is a normal experience of life is an important theme. Schultz (2000) explained:

> A combination of acquired beliefs and expectations, learned maladaptive behaviors, and skill deficits on the part of women sexually abused as children who are thought to result in their poor choices of intimate partners as adults, a lack of self protective techniques, low self worth and denial, and a personal culture that includes abuse as a normal experience" (Schulz, p.397)

All of the participants reported childhood sexual abuse; however, disclosure and treatment at the time of abuse was absent.

The need for psychological and medical health care.

The need for medical and mental health care for the "fall-out" from revictimization while serving in the military is evident in the stories below. Women who have been sexually victimized and revictimized were more likely to describe chronic health problems and use prescription medication for emotional problems (Sadler, Booth, Nielson, & Doebbeling, 2000). "Sexual trauma has also been associated with high rates of medical conditions, increased utilization of medical services, and eating disorders" (Harned & Fitzgerald, 2002 p.1170) All of the participants required follow-up health care and many had difficulty accessing to services. For many, the attempts to get services through the VA were as traumatizing to the participants as were the assaults.

Participant (1) who needed follow-up physical and mental health care was denied treatment with no explanation.

> There was no reason that my disability claim had been refused…They won't show you the documentation that they are looking at…They won't share that with you. They won't help you write about what's going on…All you know is that they are

> refusing you any kind of help, both through medical rehabilitation as far as a job or mental health treatment.

Participant (6) had a challenging time receiving help to apply for services. Her documents were lost in the system and she had to re-file several times.

> I went to one VA after another. I had the sense that no one seemed to care. I went to some folks to have help writing my claim…They're supposed to help veterans write up the claim without prejudice or biases…The standard answer was 'I'm sorry, I can't help you.'

At another attempt at receiving services, this participant faced another barrier: "I went to this guy who was supposed to help me at the VA. He pretty much yelled at me and told me he didn't care if I'd been raped in the military. He wasn't gonna help me even though that was his job."

After being placated, she finally found a doctor who acknowledged her symptoms. "Anyway, one of the V.A. doctors was very nice and he showed me that all the previous doctors I'd seen, or counselors, pretty much agreed that I had PTSD."

Participant (1) who was in desperate need for services had to pay for her own treatment because they disavowed the abuse she experienced during her military service.

> I was going through these aspects of inability to deal with my own hurt. I was self abusing. I mean, by this point I'd already been in [an alcohol treatment center]. I literally wanted to kill myself…like putting a gun against my head. I was bulimic and anorexic. I was a 5'3 woman and you could see my ribs and jaw and everything. I was self abusing with alcohol. I had to pay for it, the professional fees and the psychiatrist.

One participant commented that she was not interested in military assistance for her post-traumatic stress. "I did not seek help from the VA because I didn't trust them."

Another participant stated that her treatment was only helpful because it included

monetary support. “I went [to a different state] and got involved in the mental health system and mainly what was the most helpful for me was helping me get my social security, get a place to live, that sort of thing.”

After a vivid description of her childhood and military abuse, one participant described that she had been receiving services for many years. “I have been service connected through the VA 100% for PTSD.”

A study (Sadler, Booth, Nielson, and Doebbeling, 2000) found:

> Women who were raped or dually victimized were more likely to report chronic health problems, prescription medication for emotional problems, failure to complete college, and annual incomes less than $25,000….impairments comparable to women with chronic illness (p. 473).

All of the participants reported requiring follow-up health care and many with difficult access to services. Additional research on psychiatric and physical complications from sexual victimization specifically for military women is needed.

Poor academic outcomes.

The academic outcomes for the participants of this study varied. Some aspired to officer’s training, while others never did well in school. For those participants with poor academic outcomes, childhood abuse, multiple moves, and dysfunctional families all contributed to their academic achievements.

Continuous relocation contributed to difficulties in school and problems with learning for participant (4). “With all the moves I got put in the dumb class when I was in fifth grade…where I lived there was one other white kid in the dumb class and all the others were Hispanic American…you know, from Mexico. I went from making straight A’s to D’s.”

Participant (3) had a challenging time while taking an exam for an officer's training school.

"I couldn't even pass OCS written exam, which was heavily skewed toward engineering, so I enlisted and went to the Naval training center."

For one participant (4), her revictimization and subsequent posttraumatic stress caused her to have poor academic outcomes in college, "When I got out [of the military] I tried to go to school and I couldn't finish classes. I would drop a class and it would get to the point where I didn't even drop the class, I just stayed home."

Participant (2) has exhibited resiliency, used alcohol as a coping mechanism, yet still succeeded in school and went on to the Coast Guard:

> In the eighth grade I could tell you that every weekend, the cool kids, if you will, because I was an athlete, we'd get our hands on Mad Dog and get drunk together. I was drunk a lot. I understand in hindsight that was for numbing…I did pretty well with grades.

Participant (1) was offered a college scholarship, then dropped out of college for financial reasons:

> It was my dream and intention to go to college, get my criminal justice degree, go to law school, get into the U.S. Senate, and become the first female president…I had a rather nice scholarship sitting for me. I did go to college, but I had to work three or four jobs…So a friend who was in the military, in the Air Force, came and said, 'Why don't you consider going the officer route?'

Another participant (3) successfully completed college prior to entrance in the military. This served her well throughout her service:

> I was the youngest and only daughter of six males in a middle class family and the first to go to college. I got a college education before I went into the military. Those who do not are the most vulnerable…They're malleable; they're still susceptible; they're extremely vulnerable and there's no one to protect them. That could be considered child abuse if you ask me.

Children who have been traumatized have difficulty focusing and tend to exhibit erratic behavior in school. A longitudinal study (Perez & Widom, 1994), conducted over a 20 year period with over 1500 participants, cited the long-term consequences of childhood sexual abuse on academic outcomes. The IQ and reading ability scores for those who were abused were considerably below average when compared with those who had no history of abuse. Also, 41% of the abused and/or neglected group repeated a grade, and 53% had been suspended or expelled. The study concluded that, "The effects of childhood victimization on intellectual and academic outcomes extend into adulthood" (p.617-633).

For some participants in this study, the longitudinal results parallel the findings for academic outcome. These participants varied in their responses, some exhibited resiliency and focus in succeeding in school and others lacked the ability to complete their academic education.

Posttraumatic stress symptoms (PTSD).

The women in this study did not speak about being traumatized by the country being at war or violence witnessed while serving in the military; however, they did speak to the trauma of the sexual assault, lack of avenues for reporting, and the absence of legal support provided by the military. Evidence of posttraumatic stress presents in these participants as fragmentation, over sexualization, lack of healthy functioning, and repetitive or circular thought patterns.

For many participants, having this conversation about their revictimization in the military was challenging and difficult to report. With the difficult subject matter being delivered to a stranger who is simply recording rather than offering support, initially

some participants withdrew due to feelings of being re-traumatized. Simply thinking of describing their abuse was overwhelming.

One participant, who dropped out early on, stated that her sexual assault claim was denied, and having to prove herself seemed to be re-traumatizing, "I filed a VA claim [regarding the military assault], and it was denied. I refuse to fight it any further because I just can not deal with the pain it causes me."

Another participant who dropped out of this study stated that the re-traumatization she experienced while talking about her past was too much. She is currently under treatment for PTSD through the VA.

One participant canceled and rescheduled the interview four times. Eventually, she dropped out of the study, "I hate this, but I think I need to reschedule our interview…I have been throwing up all day thinking about this interview."

Throughout another interview, one participant (5) exhibited affect deregulation. This happens "when traumatized people go immediately from stimulus to response, without first figuring out what makes them upset. They tend to experience intense fear, anxiety, anger, and panic in response to even minor stimuli; this makes them either over react and intimidate others or shut down and freeze" (van der Kolk, 1996, p. 422). She seemed to react to stress in a more acute way. Participant (5) continues, "It was a troubling time for me, and once you have questions like 'Is there something wrong with me?' and a question about boundaries, you can be traumatized in a lot of different ways." After discharge, she stated, "Financial concerns were just overwhelming all the time… Just having food, clothing, and shelter was a major concern. Because it was always, you

know, with PTSD you have a hard time completing things, pulling things together." She didn't try to get help from the VA because she "didn't trust them."

Many persons with the diagnosis of PTSD have difficulty with emotional regulation. The following participant (3) described an incident of over-reacting to concerns with military injustice. Her PTSD was misdiagnosed as a personality disorder, and she was taken off anti-depressants. The participant was struggling with the recent death of her husband, and the following excerpt is her explanation of her experience in the hospital:

> I'm very afraid of hospitals because of what happened to me there [regarding being sexually abused during an OB-GYN exam]…When I get upset I don't normally crawl into the fetal position and sob or whatever. I lash out in a way that can be very frightening, I guess….I was upset, very angry, and you know what the bastard put in my darn progress note?...That I had a rather severe personality disorder. I'm still drafting a letter to write to my senator about that one...They don't offer military sexual trauma counseling because they claim that nothing I went through during the military qualifies.

Another participant (4) reported similar treatment by her treating medical professionals. "I was so upset with the way I'd been treated. And of course I'm still going to therapy at the Vet center….When I went to the psychiatrist, she wrote in my progress notes that I was clearly mentally ill with no insight into my condition."

Posttraumatic stress is open for misdiagnosis because it looks like a variety of other diagnosis. It can present in the same manner as an anxiety disorder, mood disorder with psychotic features, substance induced disorders, and psychotic disorders due to a general medical condition (DSM-IV-TR, p. 467). The following participant was misdiagnosed as having a mood disorder rather than PTSD. "I could not go on and on, mainly not being believed…I knew I wasn't bipolar…I know I have post traumatic stress disorder."

Because it is nearly impossible to be compensated for military sexual assault, the related posttraumatic stress is often misdiagnosed, "What I actually got my compensation for was major depressive disorder."

A participant was refused access her documentation verifying she had a service related disorder. One of the VA doctors showed that there was consensus among all of her previous treating physicians that she had PTSD. "All of the doctors previous that I had seen, or counselors, pretty much agree that I had PTSD. There was no reason why my disability claim had been absolutely refused."

For many survivors, "sexual victimization is very frightening, harmful, and psychologically destructive…and therefore may produce chronic or delayed post traumatic stress" (Dolan, 1991, p.6). A study on secondary victimization of female veterans asked women to give a detailed description of one assault incident (Campbell & Raja, 2005). The researchers used multiple assessment techniques to measure revictimization. The study concluded secondary victimization was, "significantly positively correlated with posttraumatic stress symptomology" (p.97-106). Furthermore, retraumatization from the experience of reporting the abuse was present in 70% of the participants. These participants were told not to report the incident; they were refused the right to report the abuse, and/or were told that their experience was "not serious enough to pursue further." Understandably, this discouragement of reporting caused many women to cease seeking medical and mental health assistance related to the incident.

Substance abuse.

The use of substances, particularly alcohol, was described by only two participants as either a major factor contributing to their early sexual abuse or a factor present in their lives during their military service.

One participant (1) who came from an alcoholic background, and who drank a lot during high school, had many experiences with alcohol during her time in service to the military. She accounted for her alcohol use in adolescence.

> My cousin and I went driving around with some guys she knew and got drunk and I was raped…I was raped at 14-15- by an 18 year old boy and again alcohol was involved…Without failure, every weekend we would be drunk together, so at the beginning of 8th grade I was pretty much drunk a lot.

Again, in the military, alcohol played a role in her sexual trauma.

> These people were alcoholics, most of them men. They were drunk all the time. They went out as groups on Saturday nights and had large dinners. The commanding officer was an alcoholic, and when you have that kind of leadership, it's a wild atmosphere…We were playing volleyball and someone pulls out some Tequilla and I said, sure…I'll have a couple, no big deal. I knew exactly how much I could take. And what I didn't want. All I want is water…and the first sergeant says 'Here captain, it has no alcohol or anything in it.' I take a huge swig and halfway down my throat I realize there is something in it. By the end of the game I could not stand on my two feet. 'I will take care of her,' one of the guys says and he opens the male bathroom and I am throwing up. The next thing I remember is passing out. When I woke up the sergeant is on top of me and no one is in the room.

Another participant (3), who had lived a fairly moderate lifestyle prior to entrance into the military, stated that after being in the "dehumanizing environment" of the military she began to self-medicate with alcohol, "I started drinking very heavily. I hadn't had hardly any alcohol before I joined the military, not even in college. I never smoked pot."

It has been suggested that there is an association between a history of physical or sexual abuse and substance abuse. In a case study of a 37 year-old woman who had suffered from childhood sexual abuse, self-medication with drugs and alcohol enabled the participant to: "Maintain dissociation of memories of abuse and facilitate interpersonal functioning... it became evident that her substance abuse symbolically repeated her traumatization" (Teusch, 2001, pp 1530-1532).

A study of over 3,500 women VA patients found that 23% of the participants reported sexual assault while serving in the military (Hankin, Skinner, Sullivan, Miller, Frayne, & Tripp, 1999). It indicated that sexual assault experienced while in the military contributed to elevated depression (three times higher) and increased alcohol abuse (two times higher), than participants who had not been assaulted in the military.

The participants described their abuse with corresponding participation in risky situations with accompanying use of substances. Because alcohol was involved in some of the attacks, their superior officers did not take the participants seriously.

Military response.

Recently, there was story about a Eugene, OR woman (Corbett, 2007; http://www.kval.com/x56846.xml, 2006) who served in Iraq and is now in jail, facing desertion charges. This soldier failed to report for a second tour duty in Iraq due to Post Traumatic Stress symptoms. The solider reported being, "sexually harassed repeatedly by three of her supervisors throughout her military service." The military's response was to send her back to duty under these same assaulters/supervisors. After being abused and humiliated, her response was to hide-out for a year.

A common theme that emerged throughout the study participant's descriptions was the absence of military response to their reports of sexual abuse.

After reporting abuse from her third husband, participant (4) described the military's response:

> I was taken out of my job and placed in the basement of the hospital in the mail room, a dark little corner in the mail room in the middle of winter in Korea, and he was given a job in the first Sergeant's office. I was schlepping boxes in the snow and driving by and seeing him running and happy and talking to people.

Another participant declared she "gave up her humanity" when she entered the military:

> I was sexually harassed from the moment I entered basic…and there was no place to go with reporting…I never discussed [my sexual assault] with my VA therapist 'cuz they just don't want to hear it. They just don't want to talk about any of my military experience. What I actually got my compensation for was major depressive disorder.

When another participant (6) reported abuse from her military husband, she requested to be transferred. When her transfer came through, she was sent to an all-male post with no support, and within driving distance of her abuser. "I had to go through an investigation to prove him wrong… the chaplains won't come forward. Those guys are trying to keep everything hush-hush."

Another participant (4) described how the lack of military response affected her during and after her military service:

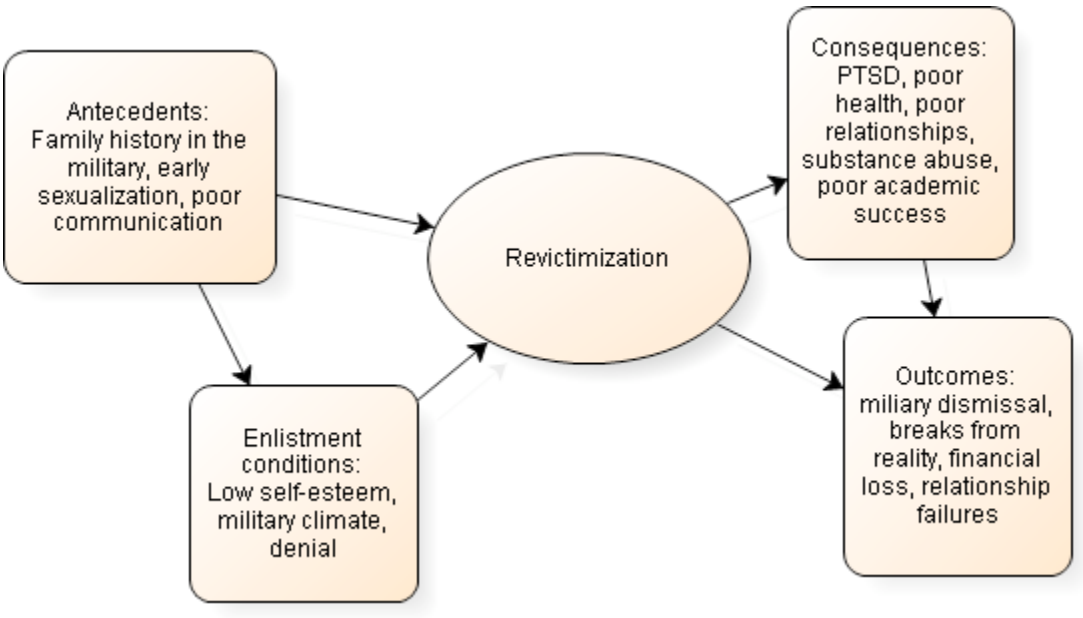
> When I reported the abuse, from that day forward they tried to make me look like a loser, and I wasn't. So my way of coping was to buck up and be even better until I got out. I tried to go to school, but I couldn't even finish a class. I would drop a class, but it got to the point when I wouldn't even drop a class I would just stay home…It took me almost a year before I felt safe to even cry about it, and then I just broke down.

One participant described being treated poorly when she tried to report her assault, “Women are treated like [expletive deleted] when they report it.”

Another participant stated, “I saw things time and time again that told me this system is not just, it’s not fair.”

Military response continues to be lacking, with no process for sexual assault to be considered seriously. The McDowell checklist is the system currently used to determine if sexual assault reports are valid; however, the tests creator, Lt. Col. Charles McDowell, stated that “women who make rape allegations fall into three categories: ‘narcissists, socio-paths, and immature, impulsive, inadequate types,’” (Lydersen, 2008). With surveys indicating that 78% of women in the military have encountered sexual harassment, and up to 50% having experienced sexual assault, an adequate response for victimized women is needed.

Figure 1: Grounded theory of revictimization for six women military veterans



IV: Summary, Conclusions, and Recommendations

Limitations of this Study

This study used a purposeful sampling procedure, (Creswell, 2003) surveying females who were sexually abused as children, and then revictimized during their service in the military. The participants self referred. This is a small group of women, who chose to report the abuse, engage in treatment, and discuss their experience with a stranger. Participation was limited to those few who were willing to discuss this very personal issue with a stranger. It is understandable that some would not wish to participate in this research, as sexual victimization is both personal and traumatic. The fear of reprisal from the military and from their home communities may have influenced their decision to decline the interview.

Another limitation was the availability of participants to donate some time to this interview (estimates were 1 ½ to 3 hours; actual interviews to 2 ½ hours). The agreement to audiotaping discouraged some inquiring participants.

The participants all served prior to the current conflicts in Iraq and Afghanistan. Until recently, women were banned from training in many military operations because they were not allowed to put these types of training into practice because they were forbidden from serving in combat zones. Consequently, the participants in this study were serving in "lesser" positions in the military which re-enforced their lack of authority.

Suggestions for further research would include a larger sample of women, and women who are currently serving in combat positions in Iraq and Afghanistan. Women and men are serving side-by-side in these conflicts, and it is worth noting if this is a predictor of a more cohesive unit with less misogyny.

Strengths of this study are the consistency of participant reports and complaints, range of time of military service, and the diverse backgrounds of the interviewees.

Summary of Findings

The six women that I interviewed for this project were at once similar and dissimilar in several areas. All the participants qualified themselves based on their self-identification of having been sexually abused as a child and revictimized as an adult while serving in the military. All had sought therapy in an attempt to resolve their abuse. All have been treated with disrespect when reporting their abuse, and abusers to military superiors, and many found it difficult to get medical attention for the resulting physical and mental health problems. All of the participants joined the military voluntarily. This is particularly interesting given that many women join the service despite the military's intolerance of them.

All of the participants cited dysfunction in their family of origin and with the exception of one participant. Moreover, the quality of adult partnerships was compromised. This lack of functional relationships was partially due to their experiences in the military, including relocation to different military bases, and of course, their sexual harassment. All participants described substance abuse by military personnel; however, only one participant expressed serious alcohol consumption and the need for treatment.

While all of the participants exhibited symptoms of posttraumatic stress related to their sexual abuse, the constant threat of sexual victimization, and the lack of process to report, not all of these women were diagnosed with PTSD. Since the posttraumatic stress disorder (PTSD) did not appear to be related to warfare, the PTSD was not an acceptable

diagnosis for treatment by and with military resources. There were diagnosis of psychosis, mood disorders, anxiety, and personality disorders.

Some participants joined the military to escape the civilian world, while others were attracted to the positive aspects of the military. Some were "joining the family business," for service in the military was expected.

The attitudes that, "the organization must be protected at the cost of the individual" has contributed to the military response to sexual assault since women were first allowed to serve. This same attitude engenders the suppression of reports by the VA, ignoring the presence of sexual abuse, and denying treatment to those reporting. Disclosure of sexual abuse within military ranks threatens to tarnish the reputation of the military on a larger scale. Therefore, evidence of abuse is overlooked and those calling attention to it are discouraged and punished.

This dynamic is familiar to victims of abuse. In their respective families of origin there was an unspoken rule, "If you tell anyone what happened, the whole family will suffer and it will be your fault." The military mimics this statement with their discounting of female soldiers reporting sexual harassment and sexual abuse in order to protect their reputation and male military personnel.

The absence of emotions in the participants' descriptions was most likely their favored coping mechanism. The study participants seemed to be directing their anger to the lack of services available to them and the difficulties they are experiencing trying to secure these services. It is of interest that each one of the participants began their stories with emotionally neutral descriptions. It is only evident as they approached the conclusions of their stories that they began to deregulate emotionally.

Conclusions

Many female soldiers have lived through the violence of war. Still others have experienced a combination of sexual assault and violence in war. Those who have experienced both have found themselves struggling to cope with their personal lives.

Given the serious health consequences of rape and sexual violence toward military women consistent across all areas of service, it remains a serious public health concern. The women reporting here are fighters. They signed up for service and even when under extreme abusive circumstances, they survived. Many continue to fight the injustices they suffered in the military culture.

The participants reported competency in their fields while in the service. Most were technically trained, but given routine office jobs, training jobs and support services. In addition, some were trained to participate in a war zone and were threatened by our actual enemies; in addition, they have had to cope with the fear of being sexually assaulted by their captains, lieutenants and fellow soldiers. When the culture outside the military devalues women in uniform, rape and sexual harassment within culture of misogyny in the military is prescriptive of conflict.

The participants' comments suggested that pre-military victimization was associated with revictimization for them. The emotional and behavioral effects of early child abuse led to increased vulnerability for adult sexual assaults.

Experiencing childhood trauma was predictive of these women losing their self-protective instincts. When women who have been sexually abused join the military, they may have unclear boundaries and unhealed traumas that set them up for further victimization. In my clinical experience, the survivor of sexual abuse often is quite adept

at taking care of others, and may often feel more comfortable putting her own needs aside.

The role that drugs and alcohol played as a risk factor for sexual assault was notable given the frequency with which the assaults described were alcohol related. The participants often reported their assailants being under the influence at the time of the rape. Throughout the interviews, there are many references and descriptions of an alcoholic environment. In order to be one of the boys, participants were encouraged to join the drinking. Early on, I assumed that alcohol use would be a coping mechanism employed by the participants. To my surprise, this was not often the case.

Recommendations

Women are entering the military at younger ages, are more likely to be of enlisted rank, and are less likely to have completed college. Similarly, the requirements for males to enter the military have been lowered, including persons with felony convictions and high school dropouts. While screening for vulnerable females is important in reducing incidences of sexual assault, the over-arching program of sexual violence prevention in the military must include attention to the reduction of potential perpetrators and shifting the cultural ethos of misogyny and homophobia pervading the military.

With greater understanding, society may be challenged to acknowledge the impact systems can have on the extent of the problem of sexual violence. The degree to which sexual abuse takes place is greatly influenced by how abuse is viewed by leaders. Leadership or supervisory behavior contributed to an environment for these women that tolerates or even encouraged behaviors that directly or indirectly resulted in sexual violence toward them. There were units in which the leaders of the military did not come

to the aid of the victims, but encourage abusers or even took part in the abuse. Anyone who reports abuse is likely to be punished or ignored. Participants described officers making sexually demeaning comments or gestures, creating an implicit sexualized environment. It was noted by the participants that if military males perceived that officers were unwilling to deal seriously with sexual harassment complaints, the harassment will continue.

Sexually demeaning conduct must not be tolerated, and the occurrence of such behavior should result in disciplinary action. The women interviewed reported that they did not know how to report a rape formally. It is clear that primary prevention interventions are necessary; it is also necessary to develop new channels for reporting sexual assault without fear of retribution. A proposal to establish an office to assist victims of sexual assault in the military was recently rejected by the Department of Defense citing that, "The Department does not tolerate sexual assault of any kind and the department has worked vigorously to implement programs to prevent it." (DoD Directive #1030.1 certified 4-23-07). This refusal to create a centralized system to respond to victim's needs comes at a time when reports of sexual abuse continue to rise.

Sexual assault issues need to be treated directly and early on. Many of the participants who sought treatment were unable to receive services. Effective treatment needs to be delivered close to the time of the assault.

These participants evidence the problem of sexual abuse in the military. The transcripts represent an accumulation of 15 years of reports of this abusive situation that has gone nowhere. The women interviewed for this project have stepped forward to discuss openly their early childhood abuse, and subsequent revictimization with the intent

of addressing family violence and violence in the military. The unanimous recommendation of the participants was to establish a military environment that does not tolerate sexual abuse, that holds abusers accountable for their actions, and that provides victims of abuse with the services they need.

The results of these interviews make evident the need for a cultural shift in the values held toward women and women in the workplace. Women currently comprise almost half of the U.S. workforce, yet gender bias persists. The Department of Defense must create a military culture that does not tolerate sexual abuse, hold offenders accountable, and punishes criminal behavior. Victims must be provided with the services they need while ensuring confidentiality. Training of commanding officers, law enforcement, and others on how to respond to reports of violence must be mandatory.

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Appendix A

Selection of Volunteers – e-mail

Revictimization

Your e-mail address has been given to me by Susan Avila-Smith, director of Women Organizing Women.

As a student in a doctoral study program and a practicing therapist for 16 years, I am interested in the issue of revictimization of women. I have observed that a large number of women serving in the military have experienced revictimization while serving in the military. I also noted in my practice that many of my clients who experienced childhood sexual abuse were revictimized as adults. In my readings I note that there are theories of why this occurs, but the voices of the abused are not heard. I am requesting volunteers to speak to me of their experiences in order to better understand the emotions associated with this phenomenon.

Please respond to this e-mail if you are interested in participating in this doctoral study of women who have been sexually victimized before age 14 years and revictimized while serving in the military.

Volunteers will be privately interviewed and selected on the basis of availability, willingness to speak of your experience and agreement to be audio-taped.

The purpose of this study is to make the voices of the abused **heard.** It will guide efforts to identify issues that will inform future research, while informing women of the issues that increase their risk of being victimized, and possibly, reduce the risk of further revictimization.

Appendix B

Interview Informed Consent

Antioch University Seattle
Informed Consent Form

The Clinical Psychology Program supports the practice of protection for human subjects participating in research and related activities. The following information is provided so that you can decide whether you wish to participate in the present study. Please be aware that even if you agree to participate, you are free to withdraw at any time, and that if you do withdraw from the study, you will not be subjected to reprimand or any other form of reproach.

Procedures to be followed in the study, identification of any procedures that are experimental and approximate time it will take to participate:

You will be partaking in an in-depth interview process. You will be asked to talk about your experience of childhood sexual abuse and sexual abuse occurring in adulthood. You will also be asked to describe your experience and to talk about the types of things you have done to help yourself through your experience. The interview process will ask you to talk about your experiences in the military regarding sexual revictimization. The interview process will be audio-taped. The audio tape will be later transcribed and used in the analysis. The interview will take approximately 1 ½ to 2 hours. You will have the opportunity to review the transcript for accuracy.

Description of any attendant discomforts or other forms of risk involved for subjects taking part in the study:

As you talk about your experience, you may feel distressed. If you become distressed and wish to discontinue the interview, please let me know. You do not have to answer any question you do not wish to and you may terminate the interview at any time with out penalty.

Description of benefits to be expected from the study or research:

This study may benefit psychotherapists, clinicians, health care professionals and military officials. The military has expressed interest in setting new guidelines pertaining to sexual assault, but to date there are few implemented. It is possible

that you will not receive any immediate personal benefit by participating in the interview, however, by sharing your reflections you may assist in the design of improved military accommodations and broader awareness of the effects of sexual assault and revictimization. If you would like a summary report at the end of the project, one will be provided.

Appropriate alternative procedures that would be advantageous for the subject:

You may choose not to participate in the study/research. Resources in the community will be made available to you, i.e. The Veteran Administration Support Groups, an individual treatment session with your former therapist or contact with a volunteer therapist.

Subject Rights:

I have read the above statement and have been fully informed of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I have concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I also understand that I can withdraw from the study at any time without being subject to reproach. I understand that I can contact Janyce Vick (206-789-2200) should I have any further questions. I may contact the Human Subjects Committee at Antioch University for any concerns regarding this project (206-441-5352).

Signatures:

The nature of the demands, risks and benefits of this project have been explained to me.
I understand what my participation involves and I am choosing to participate in this project. A copy of this form will be given to me.

Signature_____ Date_____
Subject

Signature_____ Date_____
Researcher

I give my permission to be re-contacted at a later date for possible follow-up:
Yes_____ No_____