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Stefanie Carreiro
Clinician's Treatment Decisions for
Combat-Related and Military Sexual
Trauma: A Comparative Study

ABSTRACT

Combat-related trauma and military sexual trauma (MST) are two types of trauma one can be exposed to while serving in the military. Although there are some similarities in the two types of trauma there are many more differences. Therefore, this study investigated what factors influence clinicians' treatment decisions for combat-related trauma and military sexual trauma and whether or not clinicians consider the differences in the two types of trauma when determining treatment approaches. A convenience sample of licensed trauma-oriented clinicians (N=108) completed an anonymous, self-administered survey online. Overall, results showed that clinician characteristics (e.g., experience and formal training, theoretical orientation, empirical literature, and supervisor consultation) were significantly more likely to influence treatment decisions then client factors (e.g., client's level of functioning, whether the client endorses suicidal ideation, the client has a traumatic brain injury, client's specific presenting symptoms, etc.). Treatment approaches were likely to be influenced by trauma descriptors that were interpersonal in nature (e.g., client killed a fellow soldier and client was assaulted by fellow soldier, client) and related to military values (e.g., client was unable to trust commanding officers and client was unable to trust fellow soldiers). Finally, clinicians who were randomly assigned to consider either a combat-related trauma vignette or a MST vignette did not differ in their selection of specific therapy techniques (e.g., prolonged exposure therapy vs. psychodynamic therapy). Taken together, these results suggest that psychological treatments for military trauma

are not particularly dependent on the type of trauma but are strongly guided by the clinician's understanding of how to treat trauma in general and to some extent by particular contextual variables connected to the trauma. Future research should determine whether the variables embraced and ignored by trauma-clinicians are appropriate for optimizing trauma treatment outcomes.

Keywords: combat trauma, military sexual trauma, decision-making, patient influence

CLINICIAN'S TREATMENT DECISIONS FOR COMBAT-RELATED TRAUMA AND MILITARY SEXUAL TRAUMA: A COMPARATVE STUDY

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

Introduction

According to the Department of Defense, 1.5 million soldiers have been deployed to Iraq and Afghanistan. Studies show that men and women returning from Iraq and Afghanistan are seeking mental health treatment in unprecedented numbers when compared with those who served in Vietnam (Garske, 2011). According to Castro (2009), military personnel returning from Iraq show rates of Posttraumatic Stress Disorder (PTSD) ranging anywhere from 15-50%. According to the American Psychiatric Associations (APA) *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition- Text Revised* (DSM-IV-TR) (2000), PTSD "is the development of characteristic symptoms (i.e., re-experiencing, avoidance, and hyperarousal) following exposure to an extreme traumatic stressor…" (pp. 463).

Van der Kolk (2003) states that a traumatic event has a "beginning, middle and an end;" however, PTSD is something that can "take on a timeless character" because for some, the experience of PTSD is recurrent (p. 172). The recurrence aspect of PTSD is in part because those diagnosed with PTSD often relive traumatic experiences through visual images, emotional states, and/or nightmares. Those diagnosed with PSTD often struggle with maladaptive behaviors such as avoidance of people who remind them of the trauma, irritability, and inability to concentrate these are also some of the diagnostic criteria. Some additional side effects often seen as associated features are as follows; drug and alcohol abuse, depression, guilt/shame, and the inability to trust others (Van der Kolk, 2003).

Combat-related trauma is one of the leading causing of PTSD in military personnel. According to a study completed by Hoge and colleagues in 2004, 95% of soldiers and Marines who served in Iraq and 89% serving in Afghanistan were exposed to potentially traumatic events. Combat is not the only traumatic stressor that can lead to PTSD for military personnel. Military

sexual trauma (MST) is a term used to represent both the act of sexual assault and a soldiers' response to being sexually assaulted while in the military. Sexual assault reports have steadily increased within the military over the past decade with 3,374 reports being filed in 2012. Men and women who have experienced MST are often at a greater risk of developing PTSD than their counterparts who have engaged in combat (Kimerling, Gima, Smith, Street, Frayne, 2007).

The military has a long standing reputation for hiding the issue of rape, sexual assault and harassment. There are several factors that have contributed to the current state of sexual assault in the military; however, the military environment is its greatest contributor. As Hope and Eriksen (2009) state: "In the armed forces, masculinity codes and macho environments encourage the silencing of women's voices and enable men to behave in certain ways…" (p.116). Hope and Eriksen (2009) add that women who are affected by MST are not only "raped" by the perpetrator but also by the military establishment, as the way in which women are treated after the assault is worse than the assault itself. Women are often subjected to further harassment by the perpetrator and other soldiers; they are frequently blamed for the assault, and not believed when filing a report to their superiors.

The Present Study

With an increasing number of military soldiers returning home from Iraq and Afghanistan, and increasing numbers of MST survivors coming forward, it is likely that thousands or military personnel are going to be in need of mental health services over the coming years. It is important for continued research to take place that determines what social workers, as well as other helping professionals, can do to assist those who are at risk for mental health related disorders. However, it is arguably just as important to develop a greater understanding of

how clinicians are choosing treatment methods for survivors of combat-related trauma and MST in hopes of streamlining the mental health treatment process.

There has been a great deal of research that focuses separately on the treatment of combat-related trauma and MST (Kimerling et al., 2010; Rowe, Gradus, Pineless, Batten, and Davison, 2009; Skinner et al., 2000); however, there are very few studies that look at the differences in treating the two types of trauma. There has been even less research that looks at how clinicians go about determining which treatment approach and/or modality is most appropriate for their clients. Thus, this study will explore the differences in treating combat-related trauma and MST and identify those factors that influence clinicians' thought process when developing a treatment plan.

The research question I propose to answer is "How does the treatment of combat-related trauma differ from the treatment of Military Sexual Trauma (MST)?" The aims of this study are: 1) to determine what factors contribute to a clinician's decision when choosing which treatment method(s) to use with trauma survivors (i.e., training, theoretical orientation, type of trauma, clients' wishes for treatment, years of experience, professional degree, literature etc.), 2) to determine if clinicians select different trauma interventions when treating combat-related trauma and military sexual trauma and, 3) to develop a greater understanding of which elements in combat-related versus MST inform a clinician's intervention choice.

CHAPTER II

Literature Review

Introduction

There has been a great deal of research on effective treatments for PTSD; some of the more notable options are Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE) and Eye Movement Desensitization and Reprocessing Therapy (EMDR). This paper will start off by describing combat-related trauma and MST followed by a discussion of how they are different from one another. Then there will be an overview of the various types of therapies offered for PTSD followed by a brief discussion about the need for more research that examines how clinicians choose treatment approaches.

Definition of Trauma

The American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition- Text Revised* (DSM-IV-TR) (2000), states that in order for an event to be considered traumatic it must involve "actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person…" (p. 463). The DSM–IV also states that traumatic events can be directly experienced (e.g. military combat, rape/sexual assault, violent personal assault, being kidnapped, natural or man made disasters) or indirectly experienced (e.g. observing serious injury or death of another person and/or witnessing or handling the remains of a dead body or body parts).

It has been reported that when people are exposed to any one of the above listed traumatic events they are at increased risk for developing acute emotional difficulties and/or long-term relational and health problems (Acosta, Albus, Reynolds, Spriggs, & Weist, 2001;

Madsen & Abell, 2010; Wolfe, Crooks. Lee, McIntyre-Smith, & Jaffe, 2003). However, most people who are exposed to the above list of traumatic events will not develop PTSD and/or other mental health diagnoses. In military populations the number of soldiers and Marines who develop PTSD typically depends on the intensity of their combat experience. For instance, in a study by Hoge et al. (2004), 12.9 percent of soldiers and Marines (N=1,709) who were exposed to high intensity combat in Iraq developed PTSD. Although it is difficult to pin point the reasons why only some trauma survivors develop psychopathology, one could say that the person who does not develop psychological distress benefits from resilience and/or protective factors (Hutchinson, 2011).

Clinicians have the ability to choose from any number of therapy modalities when working with survivors of trauma who have developed PTSD such as Acceptance and Commitment Therapy (ACT), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), Interpersonal Psychotherapy (IPT), Mindfulness Meditation (MM), Prolonged Exposure Therapy (PE), Psychodynamic Psychotherapy (PDT), Somatic Experiencing (SE), Stress Inoculation Therapy (SIT), and Supportive Counseling (SC). All of these modes of therapy will be discussed in greater detail later in this paper.

Types of Trauma

Combat-related trauma. Combat-related trauma can come from any number of exposures or types of events. The following are some of the more common events that soldiers are exposed to: being attacked or ambushed, being exposed to incoming artillery, rocket or mortar fire, seeing dead bodies or human remains, being responsible for the death of the enemy or fellow soldier, and knowing someone who was seriously injured or killed (Bernhardt, 2009). In a study completed with 1709 Soldiers and Marines, Hoge et al., (2004) found that 95% of

Marines serving in Iraq reported being ambushed, 75% had seen dead or seriously injured Americans, 57% reported having to handle the remains of the fallen, and 65% were responsible for the death of an enemy.

Garske (2011) sums up the feelings many have about combat and its impact in this way: "War is a disease that kills and maims, not just by tearing apart soldiers' bodies, but also by ravaging their minds" (pp. 31). With nearly 50,000 troops returning home with visible wounds, one must consider the probability that many more may have emotional and psychological wounds. In a *Newsweek* article, Shalev and Miller (2004) speak to the invisibility of the psychological effects of war:

> We can count the dead. We can see the physical injuries. But in soldiers returning home, it's hard to see the psychological damage among those who have witnessed the blood, heard the screaming, felt the shattering blast, and smelled the burning flesh. Unless they make some sense of what they saw and felt under fire, they'll continue to relive the experiences of war (pp. 70).

Armistead-Jehle, Johnston, Wade, and Ecklund (2011) point out that the number of veterans reporting mental health concerns is anywhere from 19% to 44% depending on the source. A variety of different factors could increase the likelihood of mental health problems in returning veterans: intensity of combat exposure, being unmarried, being in a junior rank, seeing a friend get injured or killed, being responsible for killing the enemy or bystander and handling the remains of the fallen (Armistead-Jehle et al., 2011; Garske, 2011; Lapiere, Schwegler & LaBauve, 2007). Unfortunately, it is estimated that only 10% of male and 26% of female soldiers actually seek services after deployment (Corso, Bryan, Morrow, Appolino, Dodendorf, & Baker, 2009).

Military sexual trauma (MST). *Military Sexual Trauma* (MST) can be defined as "sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurs during military service" (Rowe, Gradus, Pineless, Batten & Davidson, 2009, p. 388). It is important to note that MST can occur if the victim is not a service member. For instance, the wife and/or child of a service member could be victims if the perpetrator was a military service member. There are also cases where civilian workers have been assaulted by military service members. This shows that the definition of MST often changes and is dependent on the individual whom experienced the trauma.

According to the Army Sexual Assault Prevention and Response website (www.sexualassault.army.mil/), the military has developed two types of reporting methods: restricted and unrestricted. *Restricted reports* allow a victim to file an official report, receive medical attention, control the amount of information released, and request counseling. However, it does not provide the survivor with the opportunity to prosecute their offender unless they choose to re-file as unrestricted. An *unrestricted report* gives the survivor all of the same benefits as the restricted report except their report is given to their command and they cannot change to a restricted report. Unrestricted reports also provide the survivor with an opportunity to prosecute their offender.

According to the 2012 annual report on sexual assault in the military, the Department of Defense (DOD) stated that 3,374 people reported being sexually assaulted, though they estimate 26,000 service members experienced unwanted sexual contact. The report shows that 88% of the victims were female and 12% were male. More than half (51%) of the victims were between the ages of 20-24, with second largest age group (25%) being 25-34. Of those that filed unrestricted

reports, the victims stated that 90% of the time their perpetrator was male and only 2% stated their attacker was female, leaving the gender of 8% of perpetrators unreported.

The annual report on sexual assault in the military also shows that the Army has the most sexual assaults with 2.3 people reporting per 1,000 service members. The Navy and Air Force are next with 2.1 per 1,100 and then the Marine Corps with 1.7 per 1,000. The military categorizes offenses according to the following: rape, aggravated sexual assault and sexual assault, aggravated sexual contact, abusive and wrongful sexual contact, indecent assault, nonconsensual sodomy, and attempts. In 2012, the most frequent occurrence was abusive and wrongful sexual contact (35%) followed by aggravated sexual assault (28%) wrongful sexual contact (25%) and rape (27%). The results of the report also show that in 2012, 62% reported service member on service member assault followed by 22% reporting service member on non-service member assault.

Although the DOD has seen a steady increase in the number of reports since 2007, they attribute this growth to the creation of the Sexual Assault Prevention and Response Program (SAPR). As a result of this program, victims of MST are being educated on the ways in which they can report their assaults. According to the Veterans' Administration (VA) website all patients are screened for MST as they enter the VA health care system (http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf).

The recorded history of MST stems back to World War II. However, this was during a time when veterans were not given a forum to report assaults. During the Vietnam era women began reporting sexual abuse in higher rates (Valente & Wight, 2007). Military Sexual Trauma did not become a common term until the early 1990s as a result of the "Tailhook scandal." This scandal occurred in September 1991 at the Tailhook Association Symposium. The report states

that more than 100 U.S Navy and Marine Corps veterans sexually assaulted 83 female and 7 male civilian and military personnel (O'Neil, 1998). In 1996, what was then determined at the time to be the largest sexual assault scandal in military history occurred in Virginia at the Aberdeen Proving Ground. Twelve Army instructors were investigated for sexually assaulting fifty women, which included twenty-six rape accusations. Eleven of the twelve were either court martialed or were given administrative sentences; one was acquitted of all charges (Zumer, 2013 & Haydon, 2011).

MST in the past two years has received a lot of press coverage because of two new incidents that became public knowledge. In July of 2012 instructors at Lackland Air Force Base were accused of sexually assaulting female recruits. What started out as a small number of women stepping forward has now become sixty women forging complaints against thirty-two instructors (Forsyth, 2013; O'Toole, 2013; Parrish, 2012a; Parrish, 2012b: Sprier, Davis, & Sanchez, 2012; Whitlock, 2012). Another incident just a short while later brought further attention to Virginia when an Air Force Lieutenant in charge of the Sexual Assault Prevention and Response (SAPR) program was charged with sexually assaulting a female outside of the military (Dowd, 2013; Whitlock, 2013c).

In January of 2013, the U.S. Armed Services Committee held a public hearing into sexual assaults in the military in response to the Lackland Air Force Base scandal. This occurred only after a petition was signed by more than 10,000 people including seventy members of Congress requesting that a hearing be held (Forsyth, 2013; Parrish, 2012) It was during this hearing that General Mark Welsh, the chief of staff for the Air Force placed the responsibility of the rape of female military members on the women themselves and the "hook-up mentality" that women are raised in (Davidson, 2013; Dowd, 2013). President Obama was quoted as saying in several

articles “If we find out somebody is engaging in this stuff [sexual assaults], they’ve got to be held accountable – prosecuted, stripped of their positions, court-martialed, fired, dishonorably discharged, Period. It’s not acceptable.” (Davidson, 2013; Dowd, 2013).

Differences between Combat-Related Trauma and MST

After completing a review of the literature it is evident that there are some similarities between combat-related trauma and MST (e.g., the development of psychological distress, traumatic event happening during military service, and threats to the person’s physical integrity). However, there are many more differences; the most notable being that in combat-related trauma, there is a greater likelihood of the trauma survivor coping with having harmed and/or killed another person. On the other hand, MST survivors may be more likely than combat trauma survivors to be coping with trauma that was inflicted by someone they once thought they could trust (e.g., a fellow soldier).

According to a study by Hoge et al. (2004), 48% to 65% of combat infantry soldiers reported being responsible for the death of an enemy soldier and 14% to 28% stated that they were responsible for the death of a civilian. A study by Maguen and colleagues (2010) cites slightly lower numbers (40%) of soldiers reporting having killed another human being in combat. Soldiers who reported killing enemies or civilians were at greater risk for PTSD, alcohol abuse, anger management issues, and interpersonal problems than those soldiers who did not cause the death of another human being (Maguen et al., 2010).

One of the key differences between combat-related trauma and MST is that in MST the institutional trauma that occurs after the assault has taken place can be more “traumatic” than the assault itself. More often than not, the survivor is sexually assaulted by other military personnel who are generally in their unit. The survivor is then forced to continue to live and work with the

perpetrator(s) on a daily basis. Compounding that, the information about the sexual assault is frequently leaked out to the unit putting the survivor at greater risk for further victimization. These two facts alone can increase feelings of helplessness and powerlessness; they also play an extensive role in whether or not a survivor chooses to report the crime (Kimerling, et al., 2007; Street, Kimerling, Bell & Pavao, 2011).

Street et al. (2011) also address the culture of the military and the role it plays in MST. They state that because the military promotes the need for their soldiers, marines, and airmen to be "strong, tough, and physically powerful" (pp. 138), survivors are at a greater risk for developing thoughts of being "weak, vulnerable and unable to defend oneself" (pp. 138). Along with these self-perceptions come increased feelings of guilt and shame. Research has also shown that survivors of MST are nine times more likely to develop PTSD than those who experience combat-related trauma only (Kimmerling, et al. 2007; Street et al., 2011).

Potential Effects of Trauma

Posttraumatic Stress Disorder (PTSD). A person must experience symptoms in the following four categories before receiving a diagnosis of PTSD: 1) the person must have experienced feelings of intense fear, helplessness, or horror during or immediately after the event 2) they must have persistent re-experiencing of the traumatic event 3) persistent avoidance and 4) persistent increased arousal (pp. 463). Additionally the symptoms must persist for at least one month after the traumatizing event and the person must experience significant impairment in basic functioning (e.g., difficulty maintaining employment and relationships).

Symptoms of re-experiencing may come about in the form of intrusive thoughts, nightmares, and flashbacks. In an effort to avoid the feelings attached to the event, the person may experience symptoms of avoidance such as not thinking or talking about the event and

avoidance of activities, places and people that may remind them of the event. Symptoms of numbing involve an inability to remember important parts of the event; the person may also lose interest in things that they used to enjoy, feel as though they are detached from others, have a restricted range of affect and a sense of a foreshortened future. Finally, symptoms of increased arousal may show up in the form of an inability to fall or stay asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance and an exaggerated startle response (American Psychiatric Associations (APA) *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition- Text Revised* (DSM-IV-TR) (2000).

Complex PTSD (CPTSD). Through her extensive research on the impact of childhood sexual abuse Judith L. Herman was the first to propose the idea of Complex Posttraumatic Stress Disorder (CPTSD) in 1992. Herman (1992), describes CPTSD as resulting from prolonged and/or repeated trauma that is most often interpersonal in nature. Another distinct component of CPTSD is that in most situations the person was unable to escape their traumatic experience due to fear of physical, psychological, maturational, environmental, or social constraints (Cloitre et al., 2011; Herman, 1992). Although the two most identified examples of CPTSD are childhood sexual abuse and physical abuse, Cloitre et al. (2011) provides many other examples such as domestic violence, sex trafficking, slave trades, torture victims, refugee and civilian war victims, genocide campaigns and child soldiers. CPTSD is particularly relevant to MST because many women who are assaulted while in the military have also experienced sexual assault and/or physical abuse as a child (Bostock & Daley (2007); Rosen & Martin 1998a, 1998b; Valente & Wight, 2007).

CPTSD was proposed as an addition to the American Psychiatric Associations (APA) *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition- Text Revised* (DSM-

IV-TR) (2000). There was also a DSM-IV field trial completed by Pelcovitz et al. (1997) where this syndrome was called Disorders of Extreme Stress Not Otherwise Specified (DESNOS) however, it was determined that there was not enough evidence to support its inclusion in the DSM-IV. Despite this finding, the committee did decide to include many of its symptoms under "associated features" of PTSD (Resick et al., 2012).

CPTSD symptoms include many of the signature characteristics of PTSD such as re-experiencing, avoidance, numbness and hyperarousal and even overlap with Major Depressive Disorder (MDD) and Borderline Personality Disorder (BPD). However, several characteristics set CPTSD apart from PTSD such as affect dysregulation, dissociation, memory disturbances, poor attention regulation and/or concentration. There are varied definitions of CPTSD in the literature, and some researchers even propose two additional symptoms that are unique to CPTSD: a change from previous personality characteristics and loss of previously sustaining beliefs (Cloitre et al., 2011; Resick et al., 2012). Because there is so much variance in the conceptualization of CPTSD, more research is needed in order to determine reliable measures that can identify CPTSD symptoms (Resick et al., 2012).

Impact of PTSD and Complex PTSD. PTSD can be a debilitating disorder that impacts many different facets of a person's life. Harkness and Zador (2001) write about the ways in which each symptom cluster could impact a person's ability to develop and maintain interpersonal relationships. They believe symptoms that show up in the re-experiencing cluster make it difficult for a person to be present in the moment. The numbing and avoidance symptoms impact a person's ability to identify, modulate, and express feelings. The hyperarousal symptoms impact a person's ability to trust and leave the person feeling unsafe. Finally, other symptoms such as self-hate, shame, fear, unresolved guilt and grief, and fear of losing others,

make it particularly difficult for a person with PTSD to experience the vulnerability needed to develop and maintain attachments.

The changes caused by PTSD are most evident in veterans with children and significant others, as it is common for those with PTSD to isolate themselves from the important people in their lives and withdraw from raising their children. In an effort to minimize or control their feelings and emotions, people with PTSD may over-use distraction techniques (i.e. watching T.V., exercising, video games, substance use, etc.). There are even cases where a person with PTSD may be prone to violent outbursts and destructive behavior. The findings of one study has shown that those with PTSD are more likely to be in a relationship where domestic violence occurs than those who do not have PTSD and that the divorce rate among those with PTSD is twice that of those without (Harkness & Zador, 2001).

Methods for Treating Survivors of Trauma

Acceptance and Commitment Therapy (ACT). As far back as 1986 there have been randomized control trials of ACT; however it was not until 1999 that Steven Hayes published the book *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change* that this treatment approach began to gain further attention. ACT is utilized to decrease avoidance and/or escape strategies that clients may use in order to cope with unwanted, painful thoughts, feelings, memories, emotions and images. ACT aims to help clients increase their willingness to engage with the painful thoughts, feelings, memories, emotions and images while engaging in behaviors that help them live a more vital meaningful life. Through ACT, clinicians are able to teach clients ways of noticing how their symptom driven behavior functions in the context of their lives and asks whether their behavior is improving or lowering their quality of life. (Harris, 2009; Luoma, Hayes &Walser, 2007; Orsillo & Batten, 2005).

ACT has six core components: contacting the present moment, defusion, acceptance, self-as-context, values work, and committed action. *Contacting the present moment* speaks to being psychologically present and engaging with whatever is happening in the moment. *Defusion* is a technique used to help clients objectively view their thoughts and feelings. ACT therapists work to help clients recognize their thoughts and feelings as they arise by using the language such as "I'm noticing I having thoughts of being angry" while also recognizing that they do not always have to listen to what their mind it telling them. According to Luoma et al. (2007) *willingness* occurs when a client is in contact with the present moment, experiencing both positive and negative thoughts and feelings, while simultaneously behaving in ways that move them towards their values. They note that willingness is an "all-or-none quality" (pp. 24) meaning that a client is either willing or unwilling to accept their thoughts and feelings for what they are and still do things that are important to them.

Harris 2009 describes two parts of the self: the thinking self and the observing self. One could view the *thinking self* as the part of the mind that generates thoughts, feelings, memories, emotions, and beliefs, while the *observing self* refers to self-as-context. Luoma et al. (2007) states that the "self is more like a context or arena for experience, than like an experience itself" (pp. 19). Luoma et al. (2007) goes on to describes s*elf-as-context* as the ability for a consistent self to observe and think independently outside one's experiences.

One major focus of ACT is defining values (or areas of living) to help the client to identify goals that are in service of their values. *Committed action* can be defined as a series of actions that moves a client in the direction of his or her chosen values despite the painful thoughts, feelings, memories, emotions, and images that come with PTSD. Finally, although there are six core components of ACT, they all have one thing in common: they work towards

psychological flexibility which refers to being open, present and acting in ways that move a person towards their values in order to live a more vital meaningful life (Harris, 2009; Luoma et al., 2007).

Cognitive Processing Therapy (CPT). Patricia Resick and Monica Schnicke developed CPT in 1992 as a treatment for rape-related PTSD. CPT is a trauma-focused cognitive behavioral approach to therapy. It is different from other types of cognitive therapy as Resick and Schnicke propose that PTSD symptoms stem from conflicts between new information and beliefs with ways of thinking one had prior to the traumatic event. They believe that these conflicts often occur around themes of safety and danger, but they can also occur around self-esteem, competence, or intimacy. CPT is a highly structured mode of therapy that takes place over twelve sessions (Resick et al., 2008; Resick & Schnicke, 1992).

There are three key components of CPT: psychoeducation, exposure, and cognitive behavioral therapy (CBT) techniques. Psychoeducation about PTSD (i.e. symptoms, impact, etc.) happens over the course of the therapy but is most intensively addressed during the first session. The exposure component comes in the form of trauma narratives in which the client is asked to write and re-write in great detail his or her traumatic event, the meaning behind it and their beliefs about why it happened (Resick et al., 2008 & Resick & Schnicke, 1992). During the cognitive part of CPT, clients deal directly with the maladaptive cognitions that develop after the traumatic event between new information and prior ways of thinking which are referred to as "stuck points." In CPT the client and therapist also work towards identifying "faulty thinking patterns and assumptions. Typically, this faulty thinking falls into one of five categories detailed in the following paragraph (Resick and Schnicke, 1992).

Themes of safety, trust, power/control, esteem, and intimacy are addressed towards the end of treatment; typically, a new theme is addressed in each session in order to identify possible overgeneralizations in a person's thought process. *Safety* typically refers to both the safety of the individual and the individual's loved ones which could include perceptions on whether or not they can keep themselves or others safe. Since interpersonal trauma often diminishes a person's ability to trust others, the *trust* module is designed to challenge the client's "all-or-nothing" trust patterns. *Power and control* helps clients deal with thoughts of helplessness and obsessive needs to control all aspects of one's life. The *self-esteem* portion of therapy usually involves helping the client identify and then challenge areas of insecurity. Finally, the therapist will help the client become more comfortable with giving and receiving compliments. Finally, the *intimacy* module addresses how the trauma impacts intimacy with others and self-intimacy (i.e. the ability to self-soothe or fears of feeling lonely) (Resick & Schnicke, 1996; Resick, Monson, & Chard, 2007).

Eye Movement Desensitization and Reprocessing (EMDR). Francine Shapiro began the development of EMDR in 1987. Initially in EMDR, the patient would be required to think about a distressing traumatic thought, image, or memory while tracking Shapiro's finger back and forth. Shapiro argued that this finger tracking through bilateral stimulation helps enhance the client's information processing through desensitization of the traumatic event. Patients reported that after following this technique the thought, image, or memory became less distressing (Chemtob, Tolin, van der Kolk & Pitman, 2000). Shapiro (1999) herself noted that EMDR is more complex than it seems as it is "an integrated form of therapy incorporating aspects of many traditional psychological orientations and one that makes use of a variety of bilateral stimuli besides eye movements" (pp. 37).

EMDR requires that patients think about several aspects regarding the traumatic event including but not limited to images, emotional and physical responses, and both the negative and positive views they have developed of themselves. There are currently eight phases of EMDR treatment: patient history and treatment planning, preparation, assessment, desensitization and reprocessing, installation of positive cognition, body scan, closure and reevaluation (Chemtob et al., 2000 & Shapiro, 1999).

During the first stage of treatment (patient history and treatment planning), the clinician evaluates for barriers to change, dysfunctional behaviors, symptoms and illness characteristics. The clinician will also identify the index trauma that will be used throughout treatment. In the second phase (preparation), the clinician works towards developing a rapport with the client through the use of psychoeducation, providing a rationale for EMDR, and by teaching coping skills the client can use when trauma-related material emerges. During the third phase of treatment (assessment), the client and clinician work together to identify the distressing memory that will be the focus of the session. This phase also includes several other components such as, identifying an associated negative cognition, identifying an alternative positive cognition, rating the validity of the positive cognition using a 7 point scale, and identifying trauma-related physical sensations and their bodily location (Shapiro, 1999, pp. 141). The fourth phase (desensitization and reprocessing) involves the patient thinking about the painful image, negative thoughts and bodily sensation related to the event while following the clinician's moving finger (bilateral stimulation) (Chemtob et al., 2000 & Shapiro, 1999).

The fifth phase of treatment (installation of positive cognition) requires the patient to think about the painful memory while rehearsing the positive cognition they identified in the fourth phase. In the sixth phase (body scan), the patient is asked to scan his or her body for any

negative somatic feelings (i.e. tension or physical discomfort). If there are residual feelings of discomfort, this is taken as a sign that the reprocessing did not work. In phase seven of EMDR (closure), the client is prepared to leave each session through the use of relaxation or visualization. During the eight and final phase of EMDR (reevaluation), the client and the clinician work together to determine if treatment goals have been met and maintained (Chemtob et al., 2000 & Shapiro, 1999).

Interpersonal Psychotherapy (IPT). Gerald Klerman and Myrna Weissman developed IPT in 1984 for the treatment of major depressive disorder. It has since been adapted and used for anxiety disorders as well. IPT is different from many other types of therapy used to treat trauma because it is not exposure based. Rather than focus on the trauma itself, clients are asked to look at current life events, feelings and mood in order to help them make interpersonal changes in their lives (Bleiberg & Markowitz, 2005; Graf & Markowitz, 2012; Markowitz, 2010).

The rationale for adapting IPT for the treatment of PTSD was that many trauma survivors are not willing to do exposure based therapies (such as EMDR and CPT). Although developed for group psychotherapy, IPT has primarily been used in an individual therapy setting. It is a manualized treatment approach that takes place over the course of fourteen weeks. IPT targets many of the interpersonal difficulties that develop as a result of PTSD (i.e., difficulty trusting others, low self-esteem, problems establishing boundaries, and fears of intimacy and/or vulnerability) (Bleiberg & Markowitz, 2005; Graf & Markowitz, 2012; Markowitz, 2010).

IPT generally targets one of four areas: interpersonal role dispute, role transition, grief, or interpersonal sensitivity. *Interpersonal role dispute* refers to post-trauma conflicts that have emerged between intimate partners, family, and/or friends usually around expectations within the

relationship. These interpersonal conflicts often exacerbate PTSD symptoms. *Role transition* occurs when there is a disruption in interpersonal functioning as a result of the trauma (i.e., divorce, hiring and/or firing from current job, and impact of PTSD symptoms on social functioning). *Grief* refers to a client's reaction to the violent death of someone close. Finally, *interpersonal sensitivity* is used when a client had difficulty within their significant relationships following the traumatic event (Brakemeier & Frase, 2012; Campenini et al., 2010).

Mindfulness Meditation (MM). Mindfulness is a relatively new technique being used in psychotherapy. Current mindfulness therapies have their roots in Buddhist principles that have been around for centuries (Brazier, 2013; Rosenzweig, 2013). They have since been adapted into a variety of different mindfulness therapies for instance Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), and Mindfulness Based Relapse Prevention (MBRP). There are also cognitive therapies that have mindfulness components such as ACT and Dialectical Behavior Therapy (DBT) (Vujanovic, Niles, Pietrefesa, Schmertz, & Potter, 2011). Although a full review of all these therapies is beyond the scope of this paper, a review of the major components will be discussed in the following paragraph.

Using mindfulness based interventions with those diagnosed with PTSD have proven to be effective. Some studies have shown that mindfulness practice can improve emotion regulation, and decrease both anxiety and depressive symptoms (Brown & Ryan, 2003; Vujanovic, Bonn-Miller, Berstein, McKee, & Zvolensky, in press; Vujanovic et al., 2011). The primary concepts taught through mindfulness are as follows: development of an awareness and attention to the present moment, non-judgmental acceptance of ourselves, compassion in response to others suffering, and ability to show loving-kindness towards others and ourselves.

These concepts are taught generally through the use of visualization and guided meditation (Rosenzweig, 2013).

Prolonged Exposure (PE). PE was developed by Edna B. Foa; the first study that evaluated the efficacy of PE was completed in 1984. Although PE has received notoriety for the treatment of PTSD, it has a longstanding history of being used to treat other anxiety related disorders such as Obsessive Compulsive Disorder and specific phobias. PE's roots are in Emotional Processing Theory (EPT) which was also developed by Foa and Kozak (1986). EPT states that "fear is represented in memory as a cognitive structure that includes information about the fear stimuli, the fear responses and their meaning" (pp. 3). This means that when people, places and/or things remind the person of the traumatic event, he or she often projects this fear to situations that are likely safe (Foa, 2011; McLean & Foa, 2011).

PE has three main components: *in vivo* exposure to trauma reminders, imaginal exposure to the memory of the traumatic event, and processing the imaginal exposure. In addition to these three components, clinicians offer psychoeducation about PTSD and a rationale for using imaginal exposure as well as training in controlled breathing (Foa, 2011). PE is usually the primary treatment method used to reduce fear, guilt, shame and other emotions commonly found in PTSD. These symptoms are reduced by having clients confront the people, places, and things that induce fear and anxiety because they remind them of the traumatic event.

PE is a manualized treatment approach that typically occurs over the course of eight to fifteen sessions. During the first session, the clinician offers psychoeducation about PTSD and the treatment rationale. They also identify which trauma will be discussed throughout treatment; if a person has a history of multiple traumas, they are asked to identify their "index trauma" (i.e., the trauma that creates the highest amount of distress for the client). Also during the first session,

the client is taught a breathing technique they can use throughout the treatment process as a means to manage anxiety that may emerge during and/or after the exposure exercises (Foa, 2011).

During the second session, the clinician focuses on how the client has reacted to the trauma, so the client can understand that their reactions are common among most that have PTSD. Clients are also introduced to *in vivo* exposure during session two. *In vivo* exposure refers to “real-life confrontation with feared stimuli” (pp. 4). Both the client and clinician work together to develop a list of people, places and/or things the client has been avoiding since the traumatic event; they are then asked to rate them in order of how much distress each would cause if the client was confronted with them. Typically, clients are given in vivo assignments; for homework they are asked to remain in the situation for a minimum of forty-five minutes in order to acclimate to the distressing emotions and anxiety that come about during the session. The clinician encourages the client to stay with the distressing emotions as stopping too soon can reinforce avoidance strategies (Foa, 2011).

Imaginal exposure (i.e., exercises in which “the patient imagines himself or herself reliving the traumatic experience,” pp. 6) begins during session three and is done in all remaining sessions. Imaginal exposure usually lasts about forty-five minutes and is always followed by a period of post-exposure processing. The processing that occurs after the exposure is an important part of PE. Through discussion with the clinician about the imaginal exposure, the client can form new insights and possibly even identify unrealistic thoughts and beliefs they may have about the event. The client is instructed to listen to the audio taped session each day as a part of their treatment homework. During the final PE session, the client and clinician address what the client learned and how the client can sustain progress (Foa, 2011).

PsychodynamicTherapy (PDT). Psychodynamic therapy (PDT), developed by Sigmund Freud is one of the oldest forms of psychotherapy. However, there has been little research examining the efficacy of PDT for PTSD (Kudler, 2007; Woller, Lishsenring, Leweke, & Kruse, 2012). Most PTSD treatments are manualized, but PDT for PTSD is not. This has been cited as one of its shortcomings and as one reason that it has not received more research attention. Part of the reasoning for not having a treatment manual is because there are many different ways a clinician can offer PDT, which depends on the theoretical framework (i.e. drive theory, ego psychology, self-psychology, object relations, etc.). With or without a manual, clinicians all over the world are working with trauma survivors using PDT (Kudler, 2007; Schottenbauer, Glass, Arnkoff, & Gray, 2008; Woller, Lishsenring, Leweke, & Kruse, 2012).

According to the American Psychiatric Association (2004), PDT has the ability to address many of the after effects of PTSD, including interpersonal issues and changes in personality, while focusing on how early development impacts the way one responds to trauma. Okey, McWhirter, and Delaney (2000) found that those who developed PTSD also developed a series of interpersonal issues such as poor relationship quality, lack of social support and connectedness, and withdrawal from relationships. One of PDT's primary focuses is the improvement of interpersonal relationships through the client/therapist dyad. The goal is for the client to develop insight into other relationship patterns, while simultaneously experiencing a new relationship with the therapist; this new relationship is designed to provide the client with what they were missing in early relationships, which will hopefully allow them to make changes in the current interpersonal functioning (Okey et al. 2000; Perakyla, 2004; Schottenbauer et al., 2008).

PDT devotes a great deal of time to examining at how early exposure to trauma impacts current life functioning. A PDT therapist would typically try to help the client develop insight into and/or confront the meaning of the trauma event (Schottenbauer et al., 2008). According to Krupnick (2002), this could include addressing "underlying beliefs, attitudes, and thematic contents that have made the particular trauma so difficult to integrate" (pp. 923). Another role of a PDT therapist is to identify the defense mechanisms the client is employing to protect them from the overwhelming affective states. In doing this, the therapist can help the client become aware of the defenses, determine whether they are adaptive or maladaptive, and then reduce the use of maladaptive defenses (Frederickson, 1999; McWilliams, 1994).

It has been argued that PDT may be more effective in treating those who have experienced complex trauma than other recommended treatments for single event traumas (i.e. CBT and EMDR) (Herman, 1997; Schottenbauer et al. 2008). CPTSD symptoms can emerge in social and interpersonal functioning and survivors often have comorbid Axis I and/or Axis II disorders, they may have difficulty in overall adjustment. PDT may offer these clients a chance to process past traumas in order to develop new insight into their defenses, which can help them improve their coping skills.

Somatic Experiencing (SE). Research has shown that people with PTSD symptoms may first report to the primary care physician with somatic complaints such as shaking, trembling, increased heart rate, heart disease, immune system disorders, diabetes, and chronic pain. Therefore, in 1996, Peter Levin developed SE which is a mind-body approach that targets the way a body responds to trauma. The goal is to target the client's somatic complaints by regulating the body's response as well as addressing the emotions and cognitions a person has as

a result of the traumatic event (Leitch, 2007; Leitch, Vanslyke, Allen, 2009). The primary method of achieving this is by teaching clients concrete skills

> …to reduce their hyperarousal and dysregulation through tracking shifts in the nervous system by observing breath (rapid, shallow, panting), heart rate (increase, decrease), muscle tension, shifts in posture, changes in skin color, and involuntary body movements (eyes, head, neck, shoulders, hands, legs); resource use (internal and external); grounding techniques; pendulation (moving between states of relative organization and disorganization within the nervous system,); and titration (the process of gradually accessing somatic activation, body sensations, feelings and thoughts associated with the traumatic experience so that the nervous system can adjust to each increment without becoming overwhelmed (Leitch, Vanslyke, Allen, 2009, pp. 13)

Although SE was developed originally for long-term therapy, it has since been adapted into a brief format that has been used extensively with survivors of natural disasters. The idea is that SE should be offered almost immediately after the trauma to help people regulate their nervous system, which makes them more likely to develop healthy ways of coping and less likely to develop chronic PTSD symptoms. The brief format is advantageous because many people who have experienced natural disaster trauma do not have the time and resources for long-term treatment. Offering brief SE enable these clients to quickly develop skills that can be used to cope with the trauma symptoms and their challenging situation (Leitch, 2007; Leitch, Vanslyke, Allen, 2009).

Stress Inoculation Therapy. During the 1980's Donald Meichenbaum developed a new form of cognitive-behavioral therapy called Stress Inoculation Therapy (SIT). Since its inception SIT has been used to treat a variety of clinical populations including, patients with chronic pain,

psychiatric disorders, and medical conditions. It has also been used with sexual assault survivors, athletes who exhibit performance anxiety, and those who are chronically exposed to traumatic events such as military personnel, police officers, and nurses (Meichenbaum, 2003). Proponents of SIT also believe in the importance of working directly with the identified patients significant other, family members, or community leaders in hopes of preventing secondary victimization (Meichenbaum, 2008).

SIT is a three-phase treatment approach aimed at helping individuals develop both inter and intrapersonal skills to prevent and/or reduce the impact of life stressors (Meichenbaum, 2003). One of the ways this is achieved is through inoculation. *Inoculation* is a scientific term used to describe the process of exposing a person to lower form of a disease in order for the person to develop immunity or at the very least to develop antibodies against the larger form of the disease (Meichenbaum, 2008). This is translated into psychotherapy by “bolstering the individual’s repertoire of coping responses to milder stressors [which] can serve to build skills and confidence in handling more demanding stressors” (Meichenbaum, 2003, pp. 408).

Although SIT is a manualized treatment approach, it was designed to be flexible and should be tailored to meet the needs of each individual and the type of stress they are experiencing. Sessions can be as short as one session for twenty minutes to as long as forty sessions one hour in length (Meichenbaum, 2008). The three phases of treatment are as follows: 1) conceptual-education, 2) skills acquisition, consolidation, and rehearsal and finally, 3) application and follow through. During the *conceptual-education* phase of treatment the therapist conducts a thorough assessment in order to identify their psychosocial history, adaptive and maladaptive coping skills used in the past, and long and short-term goals. The therapist will also educate the client on the phases stress reactions go through (i.e. preparing for the stressor,

confronting the stressful situation, handling to overwhelming feelings, and reflecting on how the client's coping efforts went). The therapist will also help the client see the differences between changeable and unchangeable circumstances of stressful situations (Meichenbaum, 2003).

During the second phase of treat, *skills acquisition, consolidation and rehearsal,* the therapist's role is to begin teaching the client coping skills that are designed to meet the needs of the clients type of stress. The skills training initially is taught and practiced during the clinical sessions through the use of imagery, role playing, and behavioral practice (Meichenbaum, 2003; 2008). The skills training could be problem focused or emotionally focused. If it is problem focused the therapist will work with the client on developing problem-solving skills, assertiveness training, and use of social supports. When developing emotionally focused skills the clinician helps the client with perspective taking, emotional regulation, and cognitive reframing. The final part of this phase of treatment is to work with the client on identifying potential barriers to effectively using the skills and then brainstorm ways that this can be prevented from happening (Meichenbaum, 2003).

During the final phase of treatment, *application and follow-through* the client will be asked to identify events and/or emotions that could represent high-risk stress triggers. The clinician then has the client practice the skills with family members or other trusted people in their lives. It is hoped that client will begin gradually practicing the skills *in vivo*, meaning as stress occurs in their daily lives. There is also a relapse prevention portion of this phase where the clinician helps the clients to view setbacks as learning opportunities instead of failures. Once the clinician and client feel sufficient progress is made sessions will be cutback and only offered as follow-up or the term used in SIT is "booster sessions" (Meichenbaum, 2003; 2008).

Supportive Counseling (SC). Supportive counseling is a non-directive approach used by clinicians. SC techniques can be found in many other therapy modalities as they are viewed as foundational skills to be used in the therapeutic dyad, SC however, was not developed originally for this purpose. According to Brenner (2012) the primary focus of SC is strengthening the therapeutic alliance by paying particular attention to empathy, genuineness, compassion, safety and trust. Brenner (2012) adds that there is a need on the therapist's part to show acceptance and unconditional positive regard for the client. There does not happen to be a great deal of research that assesses the efficacy of SC alone for PTSD. Instead, SC is often used in research studies as a credible control treatment to compare with other approaches such as PE and CPT.

Summary

In summary, what we know through research is that combat trauma and MST are two very different forms of trauma. The greatest difference is that in combat trauma the trauma most often results from causing harm to another, whereas in MST the trauma is the result of a trusted colleague physically assaulting the trauma survivor. These traumas can cause various responses, some soldiers will develop PTSD symptoms, some with develop the full diagnosis, but often times the soldier will not develop any symptoms at all. The prevalence rates of PTSD are varied depending on the research study being looked at, but in general, studies are reporting between 15 and 50%. We do know that most soldiers who are going overseas to serve are at risk for being exposed to potentially traumatic events.

Given the rates of exposure to potentially traumatic events, it seems important to begin looking at the ways clinicians choose treatment methods for survivors of combat trauma and MST. PDT has been used since its inception around 1880 to treat trauma survivors (Mitchell & Black, 1995). However, as research has progressed over the last thirty years, so has the

emergence of new, effective techniques. As a result, PDT became overshadowed by Evidence-Based Treatments such as, PE, CPT, and EMDR which are the most well-known evidence-based treatments being used with trauma survivors today. In Addition, ACT, IPT, MM, and SIT are all therapy modalities that have been adapted to treat PTSD. SE was developed for the treatment of PTSD but does not yet have the empirical evidence to support it being considered an evidence-based treatment. Finally, SC is now seen as a therapy that has its roots in most if not all therapy modalities.

Putting it into Practice

While there is a great deal of research supporting the various treatment methods discussed throughout this paper, what is missing in the literature is information about how clinicians go about choosing the appropriate treatment. In addition to the sheer number of choices, they must also contend with the complex nature of traumatic events and the fact that every individual responds differently to them. These choices can force clinicians to take several personal as well as client treatment indicators into account. From the clinician's standpoint, this might include their discipline or theoretical orientation, training and/or experience in specific treatment methods, agency expectations, and the empirical research. There are also client treatment indicators that may influence these decisions such as, demographic presentation, medical history pre and post deployment, evidence of childhood traumas, previous diagnoses, deployment history, nature and specifics of the traumatic event, presenting symptoms, and both financial and insurance status.

CHAPTER III

Methodology

Research Questions

This research study aimed to answer the following three questions: 1) what factors contribute to a clinician's decision when choosing which treatment method(s) to use with trauma survivors? 2) do clinicians select different trauma interventions when treating combat-related trauma and military sexual trauma? and 3) what elements of combat-related trauma versus MST inform a clinician's intervention choice? Two hypotheses were developed in response to these research questions: 1) clinician factors would have a higher degree of influence on treatment decisions then client-related factors and 2) the type of trauma described in the two vignettes would not result in different trauma-oriented intervention choices. A hypothesis was not developed in response to question three because it is exploratory in nature.

Purpose of Research

The literature shows that thousands of soldiers are returning from war with both visible and invisible wounds. Both groups (i.e., survivors of combat-related trauma and MST) will likely carry with them memories, fears, anger, and confusion (Corso et al., 2009); however, the two types of trauma also have elements that are distinctly different. To this point, there have been hundreds, if not thousands, of research studies on the effects of war on combat veterans (Armistead-Jehle, et al., 2011; Bernhardt, 2009; Castro, 2009; Corso, et al., 2009; Garske, 2011; Hoge, 2004; Kudler, 2007; Lapierre, 2007; Maguen, 2009). However, less research is focused on the impact of MST on soldiers (Bostock, 2007; Hope, et al., 2009; Kimerling, 2007; Monson, et al., 2006; O'Neil, 1998; Resick, et al., 2007; Rosen, et al., 1998a; Rosen, et al., 1998b; Rowe, et al., 2009; Skinner, et al., 2000; Street, et al, 2011; Valente, et al, 2007).

Although there has been a great deal of research on the impact of war and MST on soldiers and veterans, the literature does not really distinguish treatment strategies for combat-related trauma and MST. There is also a gap in the literature regarding a clinician's decision-making process when determining which treatment method to use. As a result of the impact that combat-related trauma and MST have on veterans, it is important for both the military and mental health professionals to be mindful of empirically supported treatment strategies. However, it is just as important to develop a greater understanding of how clinicians choose treatment methods for survivors of combat-related trauma and MST. Therefore, my goal was to determine if clinicians treat survivors of combat-related trauma and MST differently and to determine what factors, if any, influence treatment decisions.

Research Method and Design

This is a descriptive study that includes both exploratory features and an experimental design. According to Rubin and Babbie (2013), descriptive studies typically focus on "objectivity, precision, and generalizability of the description" (pp. 51) and seek to describe situations and events. The study is also exploratory because certain aspects lacked priori hypotheses due to the absence of relevant prior research. An experimental design is used when a researcher wants to control threats to internal validity and usually entails participants being randomized into a minimum of two groups (Rubin and Babbie, 2013). Since participants were randomly assigned to either a combat-related trauma vignette or a MST vignette, and because both case vignettes are highly similar except for the type of trauma described, one can assert that this component of the study was experimental.

The data are quantitative in nature and were obtained by posting an online questionnaire on Survey Monkey (Appendix A). Quantitative methods tend to provide more precise, objective

data than qualitative methods. Using an online survey as the method for data collection increases the possibility of obtaining a larger, geographically diverse sample, which in turn could increase the likelihood that the results can be generalized to a larger population (Rubin & Babbie, 2013).

A pilot study was approved (Appendix B) and conducted using the clinical staff at my current field placement agency: the Brattleboro Retreat in the Uniformed Service Program (USP). Four clinicians, two psychologist and two social workers with various levels of experience (i.e. 2 – 15 years) took the survey and provided feedback about the length of time it took to complete the survey, spelling and grammar errors, and confusion around the content. They also made suggestions on areas that may have been excluded from the survey.

Study Sample

Characteristics. The participants were a convenience sample of volunteer clinicians over the age of 18 who were serving or have served as mental health professionals. Participants were eligible to participate in the study if they were currently working with or have worked with survivors of combat-related and/or military sexual trauma. Participants were not required to have a predetermined number of years experience. Participants must have had a Master's degree or Doctorate degree and must also have been licensed to practice in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. Participants could have worked for either the Veterans Administration (VA) or any other organization that serves these particular populations or may work out of a private practice. For the purpose of this study, mental health professionals with no experience in treating these two types of trauma were excluded from participation. Keeping exclusion criteria to a minimum provided the researcher with a better opportunity to

obtain the minimum sample size (N=50). No eligible participant was excluded due to race, ethnicity, gender, or sexual orientation.

Sample Selection. This study used non-probability sampling methods and employed a combination of snowball and convenience samples. Because this study used non-probability sampling methods, the sample is at risk of not being representative of the surveyed population. This is also a concern because the number of participants is relatively small when taking into consideration the number of mental health professionals serving the men and women of the military.

I used several different recruiting strategies in order to obtain an optimum sample size. First, the non-profit organization Give an Hour agreed to help with the recruitment process by posting the survey on their website (Appendix C). This organization helps veterans from both the Iraq and Afghanistan wars identify clinicians who will provide pro bono mental health services. Second, my mentor also had additional contacts within the International Society for Traumatic Stress Studies (ISTSS) and the American Psychological Association (APA) Trauma Division. A link to the study was made available to the 1,255 members of the APA Trauma Division and 2,500 members of ISTSS (Appendix D).

A recruitment email (Appendix E) was also sent to a variety of different social work societies: California Society for Clinical Social Work, Georgia Society for Clinical Social Work, Pennsylvania Society for Clinical Social Work, and the Minnesota Society of Clinical Social Work who all agreed to distribute my survey to their members (Appendix F-I). In an effort to increase diversity among survey respondents, recruitment emails were sent out via the Greater Boston Association of Black Social Workers and the National Association for Puerto Rican and Hispanic Social Workers (Appendix J) who both agreed to advertise this study via email

(Appendix K & L). The recruitment e-mail (Appendix M) sent to members included a statement asking participants to forward their recruitment e-mail to friends and colleagues who may be eligible for participation. I also advertised my research study on social media sites such as Facebook and LinkedIn. After initial contacts were made, I relied on snowball sampling methods to obtain future participants.

Ethics and Safeguards

Confidentiality and anonymity. The survey portion of this study was conducted online and did not ask participants for any identifying information; these methods ensured participant anonymity. The questionnaire (Appendix A.4 – A.6) was posted on Survey Monkey, an internet survey service that offers the choice to de-identify names, e-mail addresses or IP addresses. This feature also guaranteed anonymity for participants.

Some participants were contacted via e-mail and others found the link to the survey via their organization's website. For those who were contacted via e-mail they received a message (Appendix M) that explained how I planned to protect anonymity. The recruitment e-mail also contained a statement which gave assurance that any and all information gathered would be kept in a locked file cabinet and would not be given to any outside agency. For those who found the link to the survey on their website, confidentiality and anonymity were discussed in the informed consent document (Appendix A.3). When the study was completed, collected data was shared with the researcher's mentor as well as the researcher's thesis advisor.

All data is secured electronically and protected by password. All data will be kept secure for three years as required by federal regulations. After that time, the data will be destroyed. In the case that the data are still needed for research purposes, they will continue to be kept in a secure electronic location until it is no longer needed, then destroyed.

Risks and benefits of participation. There was minimal risk involved in this study for a couple of reasons. Participants were not asked to report on sensitive matters. Rather, the focus was on their standard professional practices. However, because participants were required to read through a vignette about either combat-related trauma or military sexual trauma, it is possible that the vignettes could have evoked uncomfortable thoughts, feelings, or emotions in the participants. It was assumed that if the study provoked a need for psychological services, the participants, as clinicians, would have known where to find such services.

By participating in this study, clinicians were provided with the opportunity to share their experience and expertise in the field of trauma related mental health treatment. Their experience will contribute to the knowledge of their colleagues in various mental health professions. To date, there has not been an extensive amount of research on how clinicians determine their choice of treatment methods. Therefore, the findings of this study may identify best practices for clinicians to use when choosing treatment methods for trauma survivors. The findings may also help clinicians in the field to understand what factors influence a clinician's treatment decision as well as potentially provide an opportunity to streamline the process for determining treatment methods.

Informed consent. Prior to the start of the survey, the participants reviewed the informed consent document (Appendix A.3). Within the informed consent document, there was an explanation of the nature of participation, the risks and benefits of participating in the study and a statement about the voluntary nature of the survey, which included an explanation about the option to withdraw without penalty. Before the participant could move on to the survey portion, they had to select "I agree" or "I do not agree." If the participant selected I do not agree then they were redirected to another page that informed them of ineligibility (Appendix A.7) and

prohibited them from continuing to the next section of the survey. The participants were encouraged to print a copy of the informed consent to keep for their records. This was a voluntary study; however, withdrawal from the study was not always an option. The participants were required to decide whether or not they wished to withdraw prior to the submission of their survey. Because the survey was confidential in nature, once the survey was submitted, there was no way for the researcher to know which survey was theirs.

Table 1: *Research Study Design*

Research Questions	Hypotheses	Instruments/Measures	Statistical Tests
(1) What factors contribute to a clinician's decision when choosing which treatment method(s) to use with trauma survivors?	Clinician factors would have a higher degree of influence on treatment decisions then client-related factors.	Influential Factor Items	Paired sample t test
(2) do clinicians select different trauma interventions when treating combat-related trauma and military sexual trauma?	The type of trauma described in the two vignettes would not result in different trauma-oriented intervention choices.	Experimental Portion of Survey	Pearson's Chi-Square
(3) What elements of combat-related trauma versus MST inform a clinician's intervention choice?	N/A	Influential Factor Items	N/A

Data Collection

Description of data. The data for this study is quantitative in nature and was collected via online surveys. Participants completed an online questionnaire (Appendix A.4 – A.6). The questionnaire consisted of three parts: 1) the presentation of a case vignette followed by a series of questions related to treatment approaches, 2) a follow-up section where we revealed the intent of the study followed by some additional questions and finally 3) a section containing demographic questions. The survey took approximately forty-five minutes to complete. Before proceeding to the questionnaire, participants were asked to read and agree to informed consent by checking a box that stated, "I agree." If a participant selected "I do not agree," the clinician would have then been redirected to a screen that thanked them for his/her interest in the study and informed them why they could not proceed with the questionnaire.

The first part of the questionnaire asked participants to read a case vignette of a veteran who has been exposed to combat-related traumatic events or MST. Participants were randomly selected to receive one of the two vignettes. The combat-related case vignette was based on material publicly available on the National Center for Posttraumatic Stress Disorder website. The MST case vignette was based on a vignette taken from a chapter in the book *Caring for Veterans with Deployment-Related Stress Disorders* (Ruzek, Schnurr, Vasterling, & Friedman, 2011). The MST vignette came from a chapter entitled *Sexual Harassment and Sexual Assault During Military Service* (Street, Kimerling, Bell & Pavao, 2011).

After reading the case vignette, participants were asked to review a list of items related to a variety of empirically supported trauma treatments. Participants were asked to select one of the following four statements for each item: 1) "Yes, I have used this method and I might use it with this client" 2) "Yes, I have used this method but I would not use it with this client" 3) "No, I

have not used this method but I might use it with this client" 4) "No, I have not used this method and I would not use this with this client." During data analysis these items were recoded into either "Yes, I would use this intervention" or "No, I would not use this intervention."

In the second part of the study, two key ideas were revealed to the participant: 1) that there were, in fact, two vignettes for this study one related to combat trauma and the other to MST and 2) the intent of the study is to gather information on how clinicians would treat combat trauma versus MST. Participants were asked to rate a variety of different questions on a five point Likert scale (1 = not at all, 2 = a little, 3 = a moderate amount, 4 = a lot, and 5 = entirely): whether gender influenced the treatment decisions; whether certain demographic factors in the case vignette influenced their treatment decisions; the importance of key elements of MST and combat-related trauma in decision making processes; and factors that may influence a clinician's treatment decisions.

Part three of the study asked a series of demographic questions such as the participant's age, gender, race/ethnicity, educational background, licensure status, professional experience, professional training and work history was collected upon completion of the survey. This background information was useful for determining correlates of survey responses.

Study instrument. When identifying vignettes for this study, the plan was to identify two that could be considered "typical" combat-related trauma and MST cases. It was also important to try and find vignettes that were empirically supported, meaning they were used as training material and/or used in peer reviewed journal submissions. Once the cases were identified, we then altered them so that the only difference between then was the type of trauma (combat-related trauma vs. military sexual trauma); all other client variables were the same (i.e. age, years in the military, symptoms, branch of service, etc.). For the purpose of this study it was

determined that the vignettes would be written in a way to keep the gender of the identified patient neutral.

The survey used for this study was developed in collaboration with my mentor. We began by identifying empirically supported (and other) treatment methods for treating trauma. Out of concern for participant burden, we limited our survey to the following commonly used methods: Acceptance and Commitment Therapy (ACT), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), Interpersonal Therapy (IPT), Prolonged Exposure (PE), Psychodynamic Therapy (PDT), somatic experiencing (SE), stress inoculation therapy (SIT), supportive counseling (SC), and mindfulness meditation (MM). The final selection of methods was based on a consensus of what the researchers believed would be most likely endorsed by trauma professionals based on published treatment guidelines and their own experience.

Rather than simply asking clinicians what brand of therapy they would use with each vignette (e.g., ACT vs. CPT), it was determined that each brand of therapy would be described at the level of its key distinguishing techniques. This approach provides greater assurance that the clinician is endorsing a particular intervention rather than a philosophy of intervention. Published adherence measures to specific trauma therapy manuals were used (when available) to operationalize the techniques found in each form of therapy. Adherence measures both specify the key components of each mode of therapy and dictate how and when these components are presented to the clients. A review of the literature was conducted and randomized trials that included adherence measures were identified. Principle investigators for each study were contacted to obtain the respective adherence measures.

Rather than attempting to describe each treatment in its entirety (which would have yielded a prohibitively long survey), we identified the components of each therapy that most clearly distinguished it from the others. Each distinguishing component was translated into generic language that removed orientation-specific jargon and then put into an "I would" statement that the clinicians were asked to endorse or not endorse (See Appendix A.6). The resulting items for each treatment method were then sent to a recognized expert on each type of therapy (most were authors of key studies or otherwise involved in leadership roles associated with therapy). The experts were asked to determine whether the items accurately reflected the mode of treatment and if not to suggest edits. Experts were also asked to identify the top five items they believed should be included in the survey to represent their brand of therapy. We prioritized these suggestions in our selection of final survey items.

Reliability and Validity of Study Design

According to Rubin and Babbie (2013) *reliability* is achieved if the survey instrument is able to obtain consistent results over time. The more reliable the instrument, the less room there is for random errors. *Validity* is achieved when the instrument accurately measures what it is intended to measure (Rubin and Babbie, 2013). This survey will have both face validity and content validity. The survey was designed based on adherence measures and was reviewed by a variety of experts in the field, some of which are the original authors of the therapeutic techniques.

Data Analysis

Upon completion of the study, the variables were coded using the Statistical Package for Social Sciences (SPSS) version 21 according to the correct level of measurement (i.e. nominal, ordinal, scale, etc.). Descriptive statistics (i.e., mean, standard deviation, frequency percentage,

etc.) were used to analyze and present the demographic data. According to Weinbach and Grinnell (2010), descriptive statistics are used to "summarize and communicate the most important, salient characteristics of the data set" (pp. 20). Descriptive statistics were used to provide the reader with a simple summary of sample characteristics, which can be useful in determining the credibility of the other results.

Inferential statistics were used to test the hypotheses. Inferential statistics determine whether differences and associations observed in the sample were large enough to infer that they did not result from chance. If so, one can infer a statistically significant finding in the population from which the sample was drawn Weinbach and Grinnell (2010). Chi-Square tests were conducted on the responses to the experimental manipulation in order to determine if there was a significant difference in the way participants responded to the combat-related trauma vignette and the MST vignette. Paired sample t-tests were used to determine whether there was a relationship between how strongly clinicians endorsed client factors versus clinician factors as determinants of their work with trauma patients. Finally, the exploratory question regarding the factors that most likely influenced clinician's treatment decisions when dealing with combat trauma and military sexual trauma was addressed by examining the items in each trauma category that received strong endorsement by 40% or more of the sample.

What follows in the next chapter is a presentation of the descriptive and inferential statistics that determined whether or not the hypotheses were supported. I begin with reporting the participant demographics as well as the participant educational and professional histories. Next, I present the results of the comparison of thirty-nine client factors and the following four clinician factors: formal training, theoretical orientation, empirical literature, and supervisor consultation. From there I report the differences in treatment choices for the combat-related

trauma and MST vignettes. Finally, I present the elements of combat-related trauma and MST that would alter a clinician's treatment approach.

CHAPTER IV

Findings

Upon completion of the data analysis we were able to answer all three questions posed in the methodology section of this paper. First, we determined that participants were more likely to endorse clinician characteristics as being important in influencing treatment decisions. Second, we found that clinicians were unlikely to let the mere fact that a client experienced combat-related trauma versus military sexual trauma alter their selection of specific therapy techniques. Finally, we were able to determine which elements of combat-related trauma and MST were most likely to influence a clinician's treatment approach.

Descriptive Statistics

Participant demographics. A total of 107 clinicians participated in this study but only 63 completed the survey in its entirety. Approximately 75% identified as female and the remainder identified as male. Of the 107 participants, 82.8% identified as European/European American, 9.4% Latino/Hispanic American, 6.3% identified as African/African American, 3.1% Native American, 1.6% identified as Arab/Arab American, and 1.6% identified as mixed races. The total exceeds 100% because participants were able to select more than one racial category.

Educational and professional history. More than half of the participants (56.5%) hold a degree in psychology, 33.9% hold a degree in social work, 3.2% are marriage and family therapists, 3.2% are mental health counselors, 1.6% have a degree in psychiatry, and 1.6% have a degree in psychiatric nursing. Fifty percent of the sample holds a master's degree, 34.4% hold a PhD, 14.1% hold a doctorate degree, and 1.6% holds an MD. Almost half of the participants (48.6%) are working in the Veterans Administration, 34.6% are working in private practice, 15.4% in community-based organizations, and 3.6% in psychiatric hospitals. The majority of the

participants (81.3%) are licensed to practice in their respective states. The largest groups of participants (29.7%) have been practicing for more than twenty years; the next largest group were clinicians who have worked from zero to five years (25%). Participants were also asked how long they have been working with trauma survivors; 31.7% have been working with survivors of trauma for six to ten years, 27% for zero to five years and 42% for more than eleven years.

Inferential Statistics

Question One

The first question being addressed in this study was the following: what factors contribute to a clinician's decision when choosing which treatment method(s) to use with trauma survivors? There were four clinician characteristics developed and measured against thirty-nine client treatment indicators (see table 2 below for a complete list of both the clinician characteristics and client treatment indicators.)

Table 2: *Clinician Characteristics and Treatment Indicators*

	Clinician Characteristics
1	Your experience and formal training in specific techniques
2	Your theoretical orientation
3	Findings from empirical literature
4	Prior consultation with a supervisor or senior clinician
	Client Treatment Indicators
1	Whether the client endorses suicidal ideation
2	Client's current level of functioning
3	Client has a traumatic brain injury (TBI)
4	If the client witnessed the death of a fellow soldier
5	If the client witnessed the death of an enemy
6	If the client witnessed the death of a civilian/child
7	If the client was harassed by a fellow soldier
8	If the client was harassed by a stranger
9	Client somatic complaints
10	Client's current medication use

11	Client's current health condition
12	Client was injured during deployment
13	Client's age
14	Client's gender
15	Type of trauma (e.g., combat vs. military sexual trauma)
16	Number of deployments
17	Number of traumatic events
18	If the client experienced institutional trauma after index event
19	If the client caused harm to an enemy
20	If the client caused harm to a fellow soldier
21	If the client caused the death of an enemy
22	If the client felt shame, fear, guilt, etc.
23	If the client was assaulted by a stranger
24	If the client was assaulted by a fellow soldier
25	If the client was unable to trust their commanding officers
26	If the client was unable to trust their fellow soldiers
27	If the client was responsible for handling the remains of a fellow soldier or enemy
28	If the client was exposed to firefights, IED's, and mortar attacks
29	The client's financial status
30	The client's insurance status
31	The client's previous therapy experiences
32	The client's stated treatment preferences
33	The client's service connected disability status
34	Client's level of social support
35	If the client caused the death of a fellow soldier
36	The client's ability to tolerate affect/emotions
37	Specific presenting symptoms
38	Comorbid diagnoses
39	Client history of childhood/developmental trauma

Hypothesis 1: Clinician characteristics would have a higher degree of influence on treatment decisions then client treatment indicators.

Paired Sample t-tests were run to determine if there was a significant difference in the degree of influence of the four clinician characteristics on treatment decisions compared to the influence of the thirty-nine client treatment indicators. The overwhelming majority of comparisons were statistically significant in a direction that favored clinician characteristics. For the most part (75%), clinician characteristics were given a higher mean rating than the client treatment indicators, which suggests that participants were significantly more influenced by

clinician characteristics than they were influenced by client treatment indicators. There were fewer exceptions to this rule (25%) where client characteristics were deemed as equally important to clinician characteristics and the ratings were therefore not statistically distinguishable. There were even fewer situations (2%) where client characteristics were rated as more important than clinician characteristics. In reporting our findings below, we will begin with these non-significant findings and then present the significant differences favoring clinicians followed by significant differences favoring clients. For a complete picture of the results please refer to tables 3 - 6 (pp. 113-132).

Formal training (Table 3). Of the thirty-nine client treatment indicators the following three items were rated as equally important as the clinician's "experience and formal training in specific techniques" as potential determinants of treatment approach whether the client endorsed suicidal ideation, client's current level of functioning, and if the client has a traumatic brain injury (TBI). The remaining thirty-six comparisons were statistically significant in the direction favoring the therapist's experience and formal training in specific techniques as more important in guiding the treatment approach.

Theoretical orientation (Table 4). Of the thirty-nine client treatment indicators the following eight items were rated as equally important as the clinician's "theoretical orientation": if the client has a traumatic brain injury (TBI), whether the client endorsed suicidal ideation, the client's current level of functioning, the client's comorbid diagnoses, the client's specific presenting symptoms, the client's ability to tolerate affect/emotions, the client's level of social support, and if the client caused the death of a fellow soldier. The remaining thirty-one comparisons were statistically significant in the direction favoring the therapist's theoretical orientation as more important in guiding the treatment approach.

Empirical literature (Table 5). Of the thirty-nine client treatment indicators the following nine items were rated as equally important as "findings from the empirical research literature:" client has a traumatic brain injury (TBI), comorbid diagnoses, specific presenting symptoms, whether the client endorsed suicidal ideation, client's current level of functioning, the client's ability to tolerate affect/emotions, client's level of social support, if the client caused the death of a fellow soldier and client history of childhood/developmental trauma. The remaining thirty comparisons were statistically significant in the direction favoring findings from the empirical literature as more important in guiding the treatment approach.

Supervisor Consultation (Table 6). Of the thirty-nine client treatment indicators, the following nineteen items were rated as equally important as "prior consultation with a supervisor or senior clinician:" client's current health condition, the client's stated treatment preferences, if the client caused the death of a fellow soldier, number of traumatic events, client's level of social support, client history of childhood/developmental trauma, if the client was assaulted by a fellow soldier, client somatic complaints, if the client caused harm to a fellow soldier, if the client felt shame, fear, guilt, etc., if the client was unable to trust their fellow soldiers, the client's ability to tolerate affect/emotions, specific presenting symptoms, if the client was unable to trust their commanding officers, if the client witnessed the death of a civilian/child, client's current medication use, client was injured during deployment, if the client witnessed the death of a fellow soldier, and comorbid diagnoses.

The remaining twenty comparisons were statistically significant. There were seventeen items in which "prior consultation with a supervisor or senior clinician" was more likely to influence treatment decisions than the client treatment indicators. However, there were three client treatment indicators rated as more likely to influence treatment decisions than prior

consultation with a supervisor or senior clinician: the client's current level of functioning, if the client has a traumatic brain injury (TBI) and whether the client endorsed suicidal ideation.

Question Two

The second question addressed through this was: do clinicians select different trauma interventions for treating combat-related trauma and military sexual trauma? Participants were randomly assigned to receive either the combat trauma vignette or the MST vignette. They were then asked to consider a series of trauma-oriented treatment interventions (see Appendix A.6 for a list of treatment interventions), with the following options: "yes, I have used this method and I might consider using it with this client," "Yes, I have used this method but I would not use it with this client," "No, I have not used this method but I might consider using it with this client," and "No, I have not used this method and I would not use it with this client."

Hypothesis 2: The type of trauma described in the two vignettes would not result in different trauma-oriented intervention choices.

Chi-square tests were performed to determine whether those randomly assigned to the combat-related trauma vignette versus the MST vignette differed in their selection of the fifty-three trauma-related intervention options presented to them. We first compared the two vignettes on every intervention item using all four response options. Unfortunately a violation occurred in that over 20% of the cells had expected values less than five, arguing against the use of chi-square tests.

We next combined and recoded the four possible responses into two groups to correct this violation. Group one contained those who selected "yes, I have used this method and I might consider using it with this client" and "No, I have not used this method but I might consider using it with this client." Group two contained "Yes, I have used this method but I would not use

it with this client" and "No, I have not used this method and I would not use it with this client." This final recoding resulted in an indication of whether the clinician would or world not use a particular intervention for the vignettes while ignoring the issue of whether they had prior experience with the intervention. The combat-related trauma and MST groups were then compared on every item using the recoded response options. Yates correction for continuity was used in these analyses. No significant differences were found.

Participant demographics. The logic of the experimental manipulation depends on the assumption that the process of random assignment rendered the MST and combat groups to be equivalent in terms of demographic characteristics that might bias their answers to the post vignette questions. Analyses were conducted to determine whether there were significant differences between the participants who received the combat-related vignette and the MST vignette. An independent sample t-test was performed to determine if there was a statistically significant difference in age between both groups and no significant difference was found. Pearson chi-square analyses were performed on the following demographic variables to determine if there was a statistically significant difference between groups: highest degree earned, discipline, licensure status, years in practice, years in practice with trauma survivors, and place of employment. No significant differences were found. Thus, we can tentatively conclude that randomization was successful in equalizing the two groups on relevant characteristics.

Question Three

The final question being addressed through this research is the following: what elements of combat-related trauma versus MST most inform a clinician's intervention choice? Clinicians were asked to respond to seventeen questions about combat trauma and MST on a five-point Likert scale with the following anchors: 1 = not at all, 2 = a little, 3 = a moderate amount, 4 = a

lot, and 5 = entirely. While determining the methods of analysis for this question it became clear that several of the items that were designated as “MST” elements could potentially overlap with combat-related trauma because of the way they were written. Although, the items were kept in two separate groups it is impossible to know whether those who endorsed the overlap items were responding in a way consistent with combat-related trauma or MST.

Frequencies were used to determine which of the seventeen factors were most likely to influence a clinician’s choice of interventions. There was no hypothesis for this question as it was exploratory in nature. Responses for “a lot” and “entirely” were combined and those that exceeded 40% will be reported below. The cut off score of 40% is an arbitrary number, which was selected because 30% was thought to be too low and 50% eliminated all but two items. Detailed results are presented in Appendix R.

Combat-related trauma (Appendix R). There were a total of ten items coded as combat-related factors: if the client witnessed the death of a fellow soldier, if the client witnessed the death of an enemy, if the client witnessed the death of a civilian/child, if the client caused harm to an enemy, if the client caused harm to a fellow soldier, if the client caused the death of an enemy, if the client caused the death of a fellow soldier, if the client was responsible handling the remains of a fellow soldier or enemy, if the client was exposed to firefights, IED’s and mortar attacks, and if the client felt fear, shame, guilt, etc. Four of these ten combat-related trauma elements were endorsed by forty percent (or more) of participants as influencing their intervention choices “a lot” or “entirely:” if the client caused the death of a fellow soldier (50.8%); if the client caused harm to a fellow soldier (46.0%); if the client felt fear, shame, guilt, etc. (46.0%); and if the client witnessed the death of a civilian/child (41.3%). The remaining five items were not endorsed as strongly.

Military sexual trauma (MST) (Appendix R). There were a total of seven items coded as military sexual trauma factors: if the client was harassed by a fellow soldier, if the client was harassed by a stranger, if the client experienced institutional trauma after the index event, if the client was assaulted by a stranger, if the client was assaulted by a fellow soldier, if the client was unable to trust their commanding officers, and if the client was unable to trust their fellow soldiers. Three of these even MST elements were endorsed by forty percent (or more) of participants as influencing their intervention choices “a lot” or “entirely:” if the client was assaulted by a fellow soldier (52.4%); if the client was unable to trust their follow soldiers (45.2%); and if the client was unable to trust their commanding officers (44.5%). The remaining four items were not endorsed as strongly.

Summary

Results showed that clinician characteristics in most cases were significantly more likely to influence their intervention strategies than the treatment indicators. The results also showed that clinicians who participated in this survey did not differ in the way that they would treat a client who suffered combat-related trauma or a client who suffered military sexual trauma. Finally, the results showed what trauma descriptors were most likely to influence intervention strategies for combat-related trauma and MST. In the following chapter of this paper I will begin to discuss the potential meaning of these results and the implications for clinical practice.

CHAPTER V

Discussion

Introduction

The results of the survey provided both support and challenges to the hypotheses that emerged from the research questions. First, the findings generally supported the first hypothesis that stated that clinician characteristics would be rated as a more important factor in treatment decisions then client treatment indicators. Second, the findings supported the hypothesis that clinicians would not distinguish combat-related trauma versus MST when selecting trauma-oriented intervention strategies. The final question of the survey was purely exploratory and showed that the elements of combat-related trauma and MST that were most likely to influence treatment decisions were interpersonal in nature and related to fellow soldiers.

Implications for Clinical Practice

In the following sections I will discuss how the clinician characteristics in this survey outweighed client variables as influencers of treatment approach. I will then move into a discussion about the differences in treating combat-related trauma and MST. Finally, I will discuss how some elements of combat-related trauma and MST were more likely to influence clinician treatment decisions then others. For all three of these sections I will also discuss the implications of the results and where possible, link the results back to previous literature.

Clinician's characteristics outweigh treatment indicators. In most cases, the clinicians indicated that they would be more influenced by factors related to their training, orientation, research, and consultation than by any number of factors related to the client. It seems that one potential explanation for this is the emergence of evidence-based practice (EBP) procedures. The American Psychological Association (APA) developed guidelines for EBP and stated that

clinicians should utilize evidence-based research, the clinician's expertise, and client characteristics, culture and preferences to inform their practice (APA Task Force on Evidence Based Practice, 2006; Levant & Hasan, 2008). The belief is that EBP will not only improve patient outcomes but also reduce health care costs (Drisko, 2013).

The participants in this study seemed to place an emphasis on their own experience and formal training, which is in line with the expectations set by APA and EBP. APA states that experience and formal training allows for the clinician to integrate evidence-based research and clinical data into their formulation and interventions (APA Task Force on Evidence Based Practice, 2006; Levant & Hasan, 2008). EBP practice encourages a balance between the clinician's expertise and the client treatment preferences. In fact, EBP guidelines encourage a collaborative approach between the clinician and client as it relates to treatment planning and suggest that it is an indicator of successful treatment (APA Task Force on Evidence Based Practice, 2006; Drisko, 2013; Levant & Hasan, 2008). While this study did not ask clinicians to assess the value of collaborative decision making, it is something that I wondered about after reviewing the results, as three out of four clinician factors (e.g., experience and formal training, theoretical orientation, and empirical research) were rated as significantly more influential than "the client's stated treatment preferences" only consultation with supervisor was rated as equally important. This may be an area for future research.

The results of this study may lead one to consider the potential for clinicians to overlook alternative effective evidenced-based trauma treatments. Sometimes our own education and experience can cloud our ability to realize that our intervention may not be as effective as one would hope with a particular client. In some cases there are even studies showing evidence-based treatments as having modest efficacy rates and surprisingly high attrition rates. For instance,

Tuerk et al. (2011), found that only 49% of their participants showed long-term symptom reduction and had a 1/3 dropout rate when using PE for combat-related PTSD. This may be due, in part, to clinicians choosing ineffective treatments. Therefore, there is a strong argument to be made that clinicians should not only consider their preferred method of treatment but also evidence-based treatment outside of their specific orientation as well as client variables when selecting treatment interventions.

It is also possible, that some clinicians may label the client as "resistant to treatment" when the first intervention has proven to be unsuccessful. For instance in an article written by Foa, Gillihan, and Bryant (2013) they speak to "targeting more treatment-resistant populations" (pp. 76) and then go on to talk about populations like those with complex PTSD who have difficultly regulating affect/emotions and tolerating distress. In instances such as this, it may be necessary to take into account the client's treatment indicators (i.e., client's presenting symptoms, client's ability to tolerate affect/emotions, and co-morbid diagnoses) in order to determine whether to continue treatment, adjust or change treatment, or whether a referral is necessary rather than label the client "treatment-resistant" which implies that the problem lies within the patient rather than the intervention itself.

APA and EBP, maybe in an effort to avoid such circumstances, cautions clinicians to be aware of the limits of their experience, knowledge, and training. This is in line with both the National Association of Social Worker (NASW) ethics and APA's ethics, which state that clinicians should only work within the parameters of their education, training, and licensure (socialworkers.org; apa.org). This may suggests that the participants in this study are trying to adhere to the ethical guidelines of their profession. If the best treatment approach is outside of the realm of the clinician's expertise, then EBP and ethics suggest that the clinician should seek

consultation and where necessary offer referrals (APA Task Force on Evidence Based Practice, 2006; Drisko, 2013; Levant & Hasan, 2008). It would seem that clinicians from this study might be aware of this expectation given that they also placed a greater emphasis on supervision and consultation than many client treatment indicators (e.g., the client's age, gender, financial status, insurance status, type of trauma, etc.).

Treatment of combat-related trauma and MST. The fact that there were no significant differences in the way clinicians decided to treat the patients in the two vignettes might suggest that the clinicians gave greater emphasis to the post-trauma symptoms than the nature of the traumatic event when selecting trauma-oriented interventions. This notion is supported by the fact that the vignettes were written so that everything was the same except for the traumatic event. It is also relevant to point out that most evidence-based treatment (EBT) guidelines are geared toward the diagnosis and symptoms of PTSD rather than the specific type of trauma. Therefore, clinicians to some extent are trained to match interventions to PTSD symptoms (APA Task Force on Evidence Based Practice, 2006). Evidence-based treatments (EBT) are treatment interventions that have shown efficacy in at least two randomized clinical trials (RCT) and have a designated treatment manual (APA Task Force on Evidence Based Practice, 2006; Laska, Smith, Wislocki, Minami, & Wampold, 2013; Levant & Hasan, 2008). Though this study did not assess specifically whether clinicians were using EBTs with their clients many of the techniques examined in this study were from evidence-based treatments (i.e., PE, CPT, EMDR), a review of EBTs being used with combat-related trauma and MST will follow.

In an effort to improve patient care and treatment outcomes, the Veterans Administration (VA) has designated two EBT's as first-line treatments for PTSD: prolonged exposure therapy (PE) and cognitive processing therapy (CPT) (Foa et al., 2013; Karlin et al., 2010; Karlin &

Agarwal, 2013; Laska et al., 2013). Despite the fact that these interventions were not developed for the purpose of treating veterans, the VA selected these two interventions to be first-line treatments. Selection was due in part because there has been increased research looking at the effectiveness of PE and CPT in veteran populations and it seems to be as effective in veteran populations as it is in the civilian population and even shows treatment gains five years post treatment (Karlin et al., 2010; Monson et al, 2006; Schnurr et al., 2007). While there is an increase in the amount of research looking at PE and CPT with combat-related trauma, there remains a significant gap in the literature surrounding the effectiveness of PE and CPT with survivors of MST. It is important to note that CPT was developed for the treatment of sexual assault and rape. Therefore, one might expect that it would be effective for MST; however additional research is needed to support this inference. If it is correct that CPT is a better choice for MST than other trauma-treatments then it may be a mistake for clinicians to ignore type of trauma when selecting their interventions.

Trauma Descriptors and Their Influence

Combat-related trauma. When reviewing the results of what trauma descriptors would be most likely to influence treatment interventions, it became apparent that the items related to witnessing, causing harm to, or causing the death of a fellow soldier were of greater influence than items related to harming enemies combatants. This finding may be representative of the fact that there are official core values instilled in soldiers (loyalty, honor, integrity, courage, etc.) and marines (semper fidelis, honor, commitment, etc.) when entering the military or the unofficial value of never leaving a soldier behind (army.mil; airforce.com; marines.com). The bonds developed between soldiers in addition to the values instilled in military personnel are likely to

play a role in how they respond to witnessing, causing harm to, or causing the death of a fellow soldier.

One of the key distinctions between combat-trauma and MST is the fact that in combat trauma there is a greater likelihood that the traumatic event is related to harming or killing another person. Research suggests that soldiers are reporting in large numbers (between 40% and 65%) that they have caused the death of another human being while in combat (Hoge et al., 2004; Maguel et al., 2010). While there is some research looking at the effects of killing enemy combatants (Maguen et al., 2009; Maguen et al., 2010; Van Winkle & Safer, 2011), none emerged that has looked at the effects of killing or causing harm to fellow soldiers.

Research does suggest that soldiers responsible for the death of an enemy combatant are at greater risk for PTSD, alcohol abuse, irritability, and interpersonal issues than soldiers who did not take the life of a human being while in combat (Maguen et al., 2009; 2010). It seems plausible to think that if a soldier is responsible for harming and/or killing a fellow solider, they are at an even greater risk of developing these symptoms as well as feeling as though they betrayed the trust of their fellow soldiers. It also seems possible that they may experience elevated levels of shame, guilt, remorse, and fear in part due to the values instilled in them from day one of basic training (Adler, Bliese, & Castro, 2011). Research also suggests that guilt is a strong indicator for suicidal ideation among combat veterans (Bryan, Ray-Sannerud, Marrow, & Etienne, 2013). It is clear that the clinicians who participated in this study thought that this factor would influence their treatment decisions. Therefore, more research is needed to determine how harming and/or killing a fellow soldier not only impacts the soldiers themselves but also how clinicians should factor this into their treatment approach and whether it can impact treatment outcomes.

Military sexual trauma. The three items most likely to influence treatment decisions for MST were very similar to those that were most likely to influence treatment decisions for combat-related trauma. They were interpersonal in nature and involved having been harmed by a fellow soldier or the inability to trust commanding officers and fellow soldiers. Similar to that of combat-related trauma, the values that are instilled in military men and women are to protect your brothers and sisters in arms and, to be able to do this, you need to trust the person standing beside you. When in a war zone, one needs a sense of trust in others in order to survive, therefore, being assaulted by a fellow soldier is one of the greatest - if not the greatest - form betrayal a soldier or marine could experience. Betrayal trauma is a relatively new term being used to describe incidences where a person or institution with whom you are dependent upon violates you in some way (Freyd, DePrince, & Gleaves, 2007; Kelly, Weathers, Mason, & Pruneau, 2012). The psychological effects of knowing that your life is in the hands of someone who assaulted you could be immeasurable. Research suggests that those exposed to betrayal trauma are at increased risk for the development of severe PTSD together with significant trust related issues (Gobin & Freyd, 2013; Smith & Freyd, 2013).

There are two studies showing that the institutional trauma that MST survivors endured after the sexual assault can be more traumatic that the assault itself. This re-traumatization is due in part to the facts that: (a) the survivor has to continue to live and work with their attacker and (b) information surrounding the assault is often leaked out resulting in further peer harassment and ridicule (Kimerling, et al., 2007; Street, Kimerling, Bell & Pavao, 2011). Therefore, it was important that clinicians in this study recognized that the interpersonal nature of MST can be extremely damaging to an individual and, as a result, should be taken into consideration when determining treatment interventions. There is now a heightened awareness of sexual assault in

the military due to recent scandals in the Air Force over the past two years (Forsyth, 2013; O'Toole, 2013; Whitlock, 2012; Whitlock, 2013b). As a result, there will likely be an increase in the number of men and women seeking treatment for MST. Those who work with survivors of MST not only need to be cognizant of the military culture but they also need to keep up with the latest treatment research.

Limitations and Strengths

Study limitations

Survey questionnaire. During the data collection process we learned that one of the greatest limitations to this study was the length of the survey. Despite our attempts to reduce participant burden by shortening the survey both before and after the pilot study, many clinicians did not complete the survey. One could make the argument that funding was not only a limitation but also played a role in the small sample. It is possible that if we were able to provide sufficient incentives for participation that we could have obtained a larger sample and higher completion rate. Though the survey was lengthy it provided us with an opportunity to collect a variety of data and subsequently to test a range of hypotheses that we might not have been able to test otherwise. Another limitation to the survey was that some items were worded in a less than optimal way that created ambiguities of interpretation. Specifically, the items that were intended to distinguish contextual characteristics of MST from combat-related trauma used the terms "harassment" and "assault" rather than "sexual assault" and "sexual harassment." Thus, some respondents may have assumed that these items referred to combat-related trauma events, which could have impacted the study findings pertaining to these findings.

Generalizability of the results. Another limitation of this study is the potential for the results to lack generalizability to the broader population of trauma-oriented practitioners for two

reasons: the small sample size and the nonprobability sampling methods. There were 107 clinicians who began the survey but only 63 participants answered all of the survey questions. It is unlikely that this small sample could capture all of the variability that would be found in the national population of trauma specialists. Second, and more important, the fact that the results came from a convenience sample of volunteers means that there is no reason to believe that our achieved sample is similar to trauma specialists in the field. These limitations notwithstanding, this is still a clinically meaningful sample. Of those who participated 81% are licensed, 56% have been practicing in their fields for more than 10 years, 41% have been working with trauma survivors for more than 10 years, and 46% are currently working for the VA. This may suggest that the sample has developed a certain level of expertise in the field of trauma.

Large number of statistical tests. To achieve a thorough answer to the research questions, we conducted a large number of statistical tests. Every statistical test increases the chances of committing a type I error (i.e., concluding that the null hypothesis is incorrect when it is indeed correct). Though any particular result reported in this paper may be challenged on these grounds, we believe that our overall conclusions are robust in the face of such a challenge. Where statistically significant results are reported they tend to be backed up by numerous other significant results pointing in the same direction (e.g., therapist considerations outweighing client variables in making treatment decisions). Conversely, our large number of statistical tests increases confidence in our conclusions based on non-significant results (e.g., no differences between responses to the combat and MST vignettes).

Study strengths

Despite the rather lengthy list of limitations for this study there are also several strengths. One of the greatest strengths this study possessed is its experimental design. Given that

participants were randomly assigned to either a combat-related trauma case or a military sexual trauma case, we can say with some confidence that the type of trauma was not a significant determinant of how researchers choose specific trauma-oriented techniques. However, it is important to note that it is entirely possible that if we had obtained a larger sample that more of the observed differences may have been statistically significant. Nonetheless, our experimental results are particularly striking because when clinicians were asked directly to indicate how much “type of trauma (i.e. combat-related trauma or MST)” would influence their treatment decisions 2/3 of clinicians indicated “a moderate amount” or “a lot.” This finding makes the case for conducting formal, controlled research rather than simply relying on clinical judgment.

There are two additional strengths about this study. First, to the best of my knowledge there has not yet been research on the decision-making process for the treatment of combat-related trauma or MST. There has also been very little, if any, research comparing the treatment of combat-related trauma and MST. This is important to note because this study now offers new insight into the decision-making process for clinicians. It could also add to the already abundant literature on evidence-based practice, however, this study is unique because it speaks specifically to evidence-based practice for combat-related trauma and MST. It also underscores the importance of continued research in this area. Second, there is the potential for this study, given the rather small sample, to serve as a pilot study for future research with a larger sample. Given that this is one of the first studies to look at the decision-making and treatment of combat-related trauma and MST more research is needed to look at this area with a larger population to see if similar results are replicated.

Researcher Bias

One bias or predisposition I have that could have impacted the results of the study is that I have several links to the military within my family; therefore, I have their stories and experiences in the back of my mind. It is also possible that, because I went into the project with a strong assumption that mental health professionals are not providing adequate services for survivors of combat-related trauma and MST, it is possible that this bias could have clouded my vision when completing the analysis of the results and discussion. However, I vocalized this concern and worked with my research advisors in hopes of identifying and correcting potential biased thoughts and statements.

Recommendations for Future Research

There were several questions that emerged during data analysis that weren't addressed and may serve as areas for future research. It might be helpful to determine whether years of experience would influence the way clinicians assess the importance of client treatment indicators. Along similar lines, it would also be interesting to know whether theoretical orientation played a role in the way clinicians responded to this survey. Given that many of the evidence based treatments are protocol based, it would be interesting to measure clinicians who predominantly use non-manualized PDT against clinicians who subscribe to manualized treatment such as PE, EMDR, and CPT to see if there is a difference in the way clinicians determine treatment strategies. Another area of further research might look into the circumstances under which a clinician would decide to transfer a client to a different mode of therapy from their own preferred method. Finally, the emergence of sexual abuse/assault scandals in the military over the past two years suggests that there will likely be an increase in

service members seeking mental health treatment for MST. Therefore, continued research looking at the effects of MST and preferred treatment approaches for MST survivors is needed.

Conclusion

This study is one of the first to shed light on the importance of better understanding around the decision-making process of clinicians. Specifically, this study examined how a group of clinicians determine treatment methods for survivors of combat-trauma and MST. The results suggest that psychological treatments for military trauma are not particularly dependent on the type of trauma but are strongly guided by the clinician's understanding of how to treat trauma in general and to some extent by particular contextual variables connected to the trauma. There is also evidence to suggest that clinicians should pay particular attention to the interpersonal factors involved in traumatic events when considering the impact of trauma. Military values play an important role in the way soldiers and marines conduct themselves on a daily basis, if these values and core beliefs are breeched especially while deployed there is an elevated risk for significant repercussions on a person's mental health. Therefore, clinicians should not only be aware of the values and core beliefs instilled in military personnel but also work towards understanding the meaning they held for each individual client.

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Appendix A.1
Survey Introduction

Dear Colleague,

My name is Stefanie Carreiro, and I am a graduate student at Smith College School for Social Work. I am asking for your help in completing my Master's thesis. You have been identified as a clinical practitioner who may have experience in treating military trauma. If you are willing I would like for you to participate in a thirty minute electronic survey designed to identify the techniques that clinicians typically use to treat specific types of psychological trauma.

My study focuses on what treatment methods clinicians use as well as factors that influence a clinician's decision of treatment methods. By participating in this research and sharing your clinical experiences, you could help clarify standard practice for treating military trauma. Your responses could also benefit clinical practitioners, supervisors, and educators.

Participating in the study is quite easy; you will be asked to read a case vignette and then complete an online questionnaire. This study will be anonymous in nature and not ask you for any identifying information. If you participate, an informed consent form will be presented to you as part of the online survey. You will not be asked for your signature, but only to check a box if you agree to participate.

You are eligible to participate in my study if you are currently or have worked with survivors of military trauma. Participants must have a Master's degree, Doctorate degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. Participants must have received graduate or postgraduate training to practice psychotherapy.

If you meet criteria for participating, I encourage you to take part in my study. Because participation is anonymous, I will have no way of knowing whether or not you participate. If you do not meet criteria, I encourage you to please tell any acquaintances or colleagues you know of who may be eligible to participate about this study and encourage them to participate.

If you have any questions about my research or the nature of participation, please feel free to email me at (SCarreiro@smith.edu).

Thank you for your time and interest in my research topic!

Sincerely,
Stefanie Carreiro
MSW Candidate, Smith College School for Social Work

Appendix A.2
Screening Questions

Are you currently 18 years of age or older?

Yes

No

Are you currently working or have you previously worked as a mental health professional?

Yes

No

Do you currently hold a Master's degree or Doctorate's degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry?

Yes

No

Are you currently working with or have you worked with survivors of combat-related and/or military sexual trauma?

Yes

No

*** If the potential participant answers "No" to anyone of the screening questions they will be sent to another page that has the following statement:

"Unfortunately you do not meet eligibility requirements for participation in this study. Thank you for your interest in my research!"

Appendix A.3
Informed Consent Document

Investigator: Stefanie Carreiro, School of Social Work

My name is Stefanie Carreiro and I am a MSW graduate student at Smith College School for Social Work. You are being asked to participate in a research study conducted through Smith College School for Social Work. The College requires that you give consent to participate in this research study.

The following document will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. If you have any additional questions related to your participation in the study please feel free to contact the principal investigator whose information is located at the bottom of the page.
After review of this document if you decide to participate in the project, please check the box "I Agree" located at the bottom of the page. You will be given an option to print this form upon completion of the study.

Nature and Purpose of the Project

The purpose of this research study is to understand different treatments for military trauma. Data collected as a result of this study will be used for an MSW Thesis, dissemination and/or presentation, as well as for publication.

Explanation of the Procedures

In order to be eligible for participation in this study you must have experience in treating survivors of combat-related trauma and/or MST. You will be asked to participate in an online survey which will last approximately... You will be provided with two case vignettes and asked questions related to treatment methods for the individual. Upon completion of the survey you will also be asked a series of demographic questions.

Discomfort and Risks

There will be minimal risk involved in this study for a couple of reasons. You will not be asked to report on sensitive matters rather the focus will be on your standard professional practices. However, because you will be required to read through a vignette about either combat-related trauma or military sexual trauma, it is possible that the vignettes could evoke uncomfortable thoughts, feelings, or emotions in the participants. It can be assumed that if the study provokes a need for psychological services then as a clinician you will know where to find such services.

Benefits

By participating in this study you will be provided with the opportunity to share you experience and expertise in the field of trauma related mental health treatment. Your experience will contribute to the knowledge of your colleagues as well as across other disciplines in terms of the treatment of trauma. To my knowledge, there has not been an extensive amount of research on how clinicians determine their choice of treatment methods. Therefore, this study may identify

best practices for clinicians to use when choosing treatment methods for trauma survivors, it may also help clinicians' in the field to understand what factors influence a clinician's treatment decision as well as potentially provide an opportunity to streamline the process for determining treatment methods.

Anonymity/Confidentiality

To ensure anonymity the online survey will not ask participants for any identifying information. Upon completion of the study any and all information collected during the research process will be kept in a locked file cabinet for a period of approximately 3 years. Throughout the research process my mentor, thesis advisor, and I are the only people who will have access to the information you give as well as any notes that may be taken.

Upon completion of this study data will be used for the purpose of an MSW Thesis, dissemination and/or presentation, and publication.

Refusal/Withdrawal

Refusal to participate in this study will have no effect on any future services you may be entitled to from Smith College. Anyone who agrees to participate in this study is free to withdraw from the study prior to final submission of their survey. However, because participation in this study is anonymous once the survey has been submitted withdrawal from the study is not an option, as the researcher will have no way to identify which survey is yours.

Any questions regarding the conduct of the project of questions pertaining to your rights as a research subject or research related injury should be brought to the attention of Smith College School for Social Work Human Subjects Review (413) 585-7974.

Any Questions about the conduct of the research project should be brought to the attention of the principal investigator.

Investigator: Stefanie Carreiro
Email Address: SCarreiro@Smith.edu

BY CHECKING "I AGREE" BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION IN THE STUDY, AND YOUR RIGHTS AS A RESEARCH SUBJECT AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

I Agree

I Do Not Agree

Appendix A.4
Combat-Related Vignette

Jamie is a 25-year-old Marine Corps Specialist who enlisted following the terrorist attacks of September 11, 2001. After basic training, Jamie was deployed to Iraq as a member of a military police unit.

While in Afghanistan Jamie reports having been exposed to numerous traumatic events during convoy escorts and security details. Jamie also reports coming under small arms fire on several occasions, witnessing dead and injured civilians and Iraqi soldiers and on occasion feeling powerless when forced to detour or take evasive action. As a result of these missions Jamie began to develop increasing mistrust of the operational environment, as the situation "on the street" seemed to deteriorate. Often times Jamie felt that the unit and fellow soldiers were placed in harm's way needlessly.

On a routine convoy mission, serving as driver for the lead HMMWV (HUMVEE), Jamie's vehicle was struck by an Improvised Explosive Device (IED). The IED showered Jamie's neck, arm, and leg with shrapnel, sadly another member of the vehicle team was even more seriously injured. Jamie described "kicking into autopilot," driving the HUMVEE to a safe location, and jumping out to do a battle damage assessment. Jamie denied feeling much pain at that time but was evacuated to the Combat Support Hospital (CSH) for treatment. After several days Jamie was deemed ready to Return to Duty (RTD) despite requiring crutches and suffering chronic pain from retained shrapnel. Jamie quickly became angry at the command and doctors; despite not being able to perform duties effectively Jamie was required to stay in theatre. After returning to theatre Jamie began to develop insomnia, hypervigilance, and an exaggerated startle response. Initially, Jamie reported that dreams of the event were becoming more intense and frequent. Jamie also reported having suffered intrusive thoughts and flashbacks of the attack. Soon after returning from CSH Jamie began to withdraw from friends and family and also suffered anhedonia, feeling detached from others.

Jamie was going through rehabilitation for battle injuries and after two months of unsuccessful treatment and worsening depressive and anxiety symptoms, Jamie was evacuated to a stateside military medical center via a European medical center. Jamie was screened for psychiatric symptoms and was referred for outpatient evaluation and management. It was determined that Jamie met DSM-IV criteria for acute PTSD given the reported symptoms (i.e. insomnia, anxiety, hyperarousal, and continued autonomic arousal). Jamie feared being thought of as "different, irritated, or aggressive" therefore was ambivalent about taking passes or convalescent leave.

Appendix A.5
Military Sexual Trauma Vignette

Jamie is a 25-year-old Marine Corps Specialist who enlisted following the terrorist attacks of September 11, 2001. After basic training, Jamie was deployed to Iraq as a member of a military police unit.

During one particularly stressful firefight, Jamie became disoriented and was slow to keep up with the other members of the unit as they moved into some of the most dangerous fighting. Afterward, Jamie reported that fellow soldiers were "looking at me funny, like they didn't think they could trust me anymore." The next night, while at the latrine, Jamie was grabbed from behind and held down by two soldiers while each one took turns raping Jamie. During the assault, the assailants said things like, "This should teach you that you've got to start pulling your weight around here." Jamie knew that the two assailants were members of the unit but was not able to identify them specifically.

After this event, Jamie returned to the sleeping quarters without telling anyone about the experience. Jamie became socially isolated from others in the unit, preferring to "be alone." Despite not having spoken of this incident to anyone, Jamie felt like everyone knew what had happened. After the attack Jamie began to develop insomnia, hypervigilance, and an exaggerated startle response. Initially Jamie reported that dreams of the event were becoming more intense and frequent. Jamie also reported having suffered intrusive thoughts and flashbacks of the attack. The missions became progressively more stressful and frightening for Jamie because others in the unit could not be depended on. Jamie constantly worried about how the slightest misstep could cause the unit members to get angry and potentially provoke another attack. Jamie continually asked "why did this happen to me, why not someone else… why did I have to be raped?"

After returning home from deployment Jamie began to withdraw from friends and family and also suffered anhedonia, feeling detached from others. As a result of these symptoms Jamie's decided to see a psychiatrist at the VA. While at the VA Jamie was screened for psychiatric symptoms and was referred for outpatient evaluation and management. It was determined that Jamie met DSM-IV criteria for acute PTSD given the reported symptoms (i.e. insomnia, anxiety, hyperarousal, and continued autonomic arousal). Jamie feared being thought of as "different, irritated, or aggressive" therefore was ambivalent about taking passes or convalescent leave.

Appendix A.6
Survey Questionnaire

Part One

Please indicate how you would treat this client by choosing among the interventions below. Please base your answers on your past experiences with similar clients.

***** Each question is multiple choice and participants can select one of the following four answers for each statement:**

1) "Yes, I have used this method and I might consider using it with this client"
2) "Yes, I have used this method but I would not use it with this client"
3) "No, I have not used this method but I might consider using it with this client"
4) "No, I have not used this method and I would not use this with this client."

1. I would use metaphors and experiential exercises to increase the client's willingness to notice and accept (rather than trying to judge, control, avoid, or escape) intrapsychic events (e.g., painful thoughts and/or feelings). My aim would be to promote committed action toward on of the client's desired goals.

2. I would encourage the client to focus on the reality of their difficulties in the present moment (rather than attempting to see their situation differently).

3. I would help the client notice that his/her pre-therapy strategies of managing and attempting to control problems have not been helpful in reaching the client's stated goals.

4. At the outset of therapy, I would assess the client's experiential avoidance, thought suppression, and broader life values and goals.

5. I would help the client to recognize that thoughts are just thoughts and feelings are just feelings. They do not need to be taken literally and they do not have to define the client. For example, the client will be taught to experience the difference between "I am anxious" and "I notice that I am having feelings of anxiety."

6. I would help my client to participate in valued life activities while allowing unwanted thoughts and feelings to occur.

7. I would ask the client to write trauma narratives including sensory details, causal explanations, and key impact of the trauma. These narratives would be recounted repeatedly

during and outside the therapy sessions. Narratives from early sessions would be compared with later narratives.

8. I would help the client to differentiate their thoughts from feelings by recording their traumatic event, their response to the event, and the feelings and behaviors that resulted from the event. I would also have the client complete homework focused on identifying the link between activating events, belief systems, and emotional consequences.

9. I would help the client to identify and challenge conflicting and/or strong negative beliefs about his/her trauma using probing questions.

10. I would explain the information processing theory of PTSD as a rationale for treatment.

11. I would use questions to challenge the client's maladaptive beliefs (e.g., what is the evidence for and against your belief? Are you thinking in all-or-nothing terms?). The client would also be encouraged to challenge his/her own beliefs for homework.

12. I would help the client to identify faulty thinking patterns and assumptions using questions that challenge his/her beliefs and then help the client to generate alternative beliefs. The client would be encouraged to identify other faulty thinking patterns and assumptions for homework.

13. I would introduce topics of safety, trust, power/control, esteem, and intimacy in the treatment. I would ask the client to identify his/her conflicting and/or strong negative beliefs related to these topics for homework.

14. I would assign the client to practice giving and receiving compliments and doing pleasant activities for homework.

15. I would conduct a detailed assessment of the client's lifetime exposure to traumatic events with the aim of identifying: (a) an image that best represents the trauma memory, (b) his/her affective and physiological responses during each event, (c) negative thoughts about the self-connected to the event, and (d) desired positive thoughts about the self that could replace the negative thoughts.

16. I would use eye movements or bilateral stimulation to desensitize trauma memories, while the client holds an image of the trauma memory in mind. My aim would be to reduce client distress to a 0 or 1 level on an 10-point subjective distress (SUD) scale.

17. I would help the client to adopt alternative positive thoughts by having the client hold positive thoughts in mind along with his/her trauma memory until the client rates the positive memory at a 6 or 7 on a 7-point validity (truthfulness) scale.

18. At the end of each session, I would tell the client to "take a snapshot" of any remaining disturbances so that they can be targeted in the next session. The client will be instructed to keep a log of negative experiences that may come up between sessions. At the start of each new session, I would revisit previously targeted material to determine if treatment effects have been maintained.

19. I would educate the patient about the interpersonal difficulties associated with PTSD, such as becoming socially isolated (due to avoidance and numbing symptoms), difficulty trusting others, vulnerability in social interactions, problems establishing boundaries, and fears of intimacy.

20. If relevant, I would help the client to recognize and alter patterns of becoming involved with abusive or exploitive people.

21. At the end of therapy, I would help my client to mourn the loss of our relationship and the loss of prior relationships. I would also help the client anticipate triggers that could expose him/her to further interpersonal trauma or withdrawal from others.

22. The therapy sessions would involve 45-60 minutes of repeated, revisiting of trauma memories (ideally, with eyes closed and the memory told in the first person present tense accompanied by sensory details).

23. At the beginning of treatment, I would help the client to develop a hierarchy of avoided trauma reminders.

24. I would assign the client to listen to recordings of his/her imaginal exposure sessions (as frequently as once per day) and (if possible) place himself or herself in objectively safe situations that have previously caused trauma-related anxiety or avoidance.

25. I would talk with the client about his/her exposure experiences by comparing his/her thoughts and affective reactions at the time of the trauma with his/her thoughts and affective reactions in the present.

26. I would teach the client that avoidance maintains PTSD symptoms and prevents helpful new learning. I would also explain that repeated and extended exposure to trauma cues has many benefits including gradually reducing distress.

27. Rather than focusing specifically on trauma, I would teach the client to cope with anxiety symptoms with deep muscle relaxation and slow abdominal breathing.

28. I would teach the client how to interrupt ruminative thinking with thought stopping (i.e., mentally shouting “stop”).

29. I would show the client how to respond to stress by using self-talk to replace negative thoughts (e.g., “I am going to lose control”) with positive thoughts (e.g., “I did it before and I can do it again”).

30. I would include assertiveness training aimed at helping the client to express wishes, opinions, and emotions without alienating others.

31. I would help the client to identify, challenge, and change unhelpful or inaccurate thoughts and beliefs (e.g., the world is extremely dangerous or the client is extremely incompetent). Maladaptive beliefs will be replaced with adaptive, functional and/or realistic beliefs.

32. I would help the client become aware of unconscious thoughts, fears, wishes, conflicts and/or maladaptive use of defenses connected with his or her trauma.

33. I would help the client to explore unappreciated meanings of his/her trauma within the context of his or her unique developmental history (e.g., early losses abuse, or neglect).

34. I would support the client’s characteristic repertoire of psychological defenses against unpleasant thoughts, feelings, and memories including trauma memories.

35. I would attend to any inappropriate repetitions of past relationship patterns within the therapeutic relationship (transference) and any unwarranted reactions toward my client (countertransference). I would consider the potential value of bringing these issues to the client’s attention.

36. I would work within the therapeutic relationship to identify, and when necessary challenge and correct interpersonal misunderstandings and conflicts – especially when these reflect aspects of the traumatic experience.

37. I would be unconditionally supportive of the client and non-directive.

38. I would discourage the client from talking about past trauma during the sessions and instead focus on current daily problems.

39. I would educate my client about how the mind and body are connected including how trauma influences the sympathetic and parasympathetic nervous systems.

40. I would lead the client through exercises that will foster his or her ability to monitor internal bodily sensations, the immediate surroundings, and the present moment with the aim of developing sensory body awareness.

41. I would help the client to recognize signs of nervous system activation and to build an inventory of available resources for nervous system deactivation and stabilization. The client will be taught to use the term "grounding" to refer to this stabilization.

42. I would invite the client to focus on the natural cycle of his or her breathing without trying to alter it. This "breath work" will be a major theme in the treatment.

43. I would include the use of gesture, posture, and movement in order to do any or all of the following: (a) discharge nervous system activation, (b) complete and restore the body's thwarted defensive responses and/or (c) gain a sense of agency and personal safety.

44. I would lead the client through guided meditation, or teach the client how to meditate on their own.

45. I would invite the client to notice things like his or her: a) breath, b) emerging thoughts, and c) physical sensations, without trying to change or judge them.

46. I would encourage the client to practice orienting to his or her immediate surroundings in the present moment.

47. I would ask the client to practice sending "loving-kindness" to themselves or to another person.

60. I would regularly discuss results from self-report symptom assessments in sessions.
61. I would educate the client about PTSD.
62. I would offer a rationale for my choice of interventions.
63. I would use the subjective units of distress (SUDS) scale in the session.
64. I would involve yoga in my treatment plan.
67. I would review homework assignments with clients at the start of most sessions.

1. We did not specify the gender of the client in the vignette. What gender (if any) did you assign to the client?

a. Male
b. Female
c. Other

2. Did this gender choice influence any of your answers?
   a. Yes
   b. No

Part Two

When answering the following questions, please consider your general practices in treating trauma patients (beyond the case vignette).

1. How much might each of the following factors alter your treatment approach? Use this scale (1 = not at all, 2 = a little, 3 = a moderate amount, 4 = a lot, 5 = entirely)
   a. client age
   b. client gender
   c. type of trauma (e.g., combat-trauma vs. military sexual trauma)
   d. specific presenting symptoms
   e. client branch of service
   f. comorbid diagnoses
   g. client's level of social support
   h. client's rank in service
   i. client history of childhood/developmental trauma
   j. number of client deployments
   k. number of traumatic events

2. How much might each of the following factors alter your treatment approach? Use this scale (1 = not at all, 2 = a little, 3 = a moderate amount, 4 = a lot, 5 = entirely)
   a. If the client caused harm to the enemy
   b. If the client caused harm to a fellow soldier
   c. If the client caused the death of an enemy
   d. If the client caused the death of a fellow soldier
   e. If the client felt shame, fear, guilt, etc.
   f. If the client was assaulted by a stranger
   g. If the client was assaulted by a fellow soldier
   h. If the client was unable to trust their commanding officers
   i. If the client was unable to trust their fellow soldiers
   j. If the client was responsible for handling the remains of a fellow soldier or the enemy
   k. If the client was exposed to firefights, IED's and mortar attacks

3. How much might each of the following factors influence your treatment approach? Use this scale (1 = not at all, 2 = a little, 3 = a moderate amount, 4 = a lot, 5 = entirely)

   a. The client's stated treatment preferences
   b. Whether the client endorses suicidal ideation
   c. The client's service connected disability status
   d. Your formal clinical training
   e. Your theoretical orientation
   f. Findings from the empirical research literature
   g. Supervision
   h. The client's ability to tolerate affect/emotions

Part Three

Demographic Questions

1. How old are you _____?

2. What gender do you identify with?
   a. Male
   b. Female
   c. Other

3. Which of the following best describes your ethnic or racial background (select all that apply)?
   a. European or European (Caucasian) American
   b. Asian or Asian American
   c. Arab or Arab American
   d. African American
   e. Native American (American Indian)
   f. Latino or Hispanic American
   g. Mixed Race
   h. Other (please specify)

4. What is your highest degree earned?
   a. Bachelors
   b. Masters
   c. Doctorate
   d. PhD
   e. MD

5. What discipline do you hold your degree in?
    a. Clinical Social Work
    b. Clinical Psychology
    c. Psychiatry
    d. Marriage & Family Therapy
    e. Mental Health Counseling
    f. Psychiatric Nursing
    g. Other (please specify)

6. Do you currently hold a license to practice?
    a. Yes
    b. No

7. How long have you been practicing?
    a. 0-5 years
    b. 6-10 years
    c. 11-15 years
    d. 16-20 years
    e. More than 20 years

8. How long have you been working specifically with trauma survivors?
    a. 0-5 years
    b. 6-10 years
    c. 11-15 years
    d. 16-20 years
    e. More than 20 years

9. Where are you currently working?
    a. The Veterans Administration
    b. Private Practice
    c. Community Based Organization
    d. Other (please specify)

10. What is your typical mode of therapy with trauma survivors (select all that apply)?
    a. Individual Therapy
    b. Group Therapy
    c. Family Therapy
    d. Couples Therapy
    e. Case Management

11. Please indicate the types of trauma that you have treated in your practice (select all that apply)?
    a. Combat-Related Trauma
    b. Military Sexual Trauma
    c. Other

12. Approximately how many clients have you worked with where trauma was a major focus?
    a. 0-10
    b. 11-30
    c. 31-50
    d. 51-75
    e. 76-100
    f. More than 100

13. Which of the following treatment methods have you received formal training (i.e. seminar, classroom, online, supervision, etc.) (select all that apply)?
    a. Acceptance and Commitment Therapy
    b. Brief Eclectic Therapy
    c. Cognitive Processing Therapy
    d. Interpersonal Therapy
    e. Eye Movement Desensitization Reprocessing
    f. Mindfulness Meditation
    g. Prolonged Exposure
    h. Psychodynamic Therapy
    i. Somatic Experiencing
    j. Stress Inoculation Therapy
    k. Supportive Counseling
    l. Other

14. To what extent do you use the following treatment methods with survivors of trauma? (Will be rated on a five point Likert scale from "none of the time" to "all of the time")
    a. Acceptance and Commitment Therapy
    b. Brief Eclectic Therapy
    c. Cognitive Processing Therapy
    d. Interpersonal Therapy
    e. Eye Movement Desensitization Reprocessing
    f. Mindfulness Meditation
    g. Prolonged Exposure
    h. Psychodynamic Therapy

i. Somatic Experiencing
j. Stress Inoculation Therapy
k. Supportive Counseling
l. Other _____

Appendix A.7
Disqualification Statement

“Unfortunately you do not meet eligibility requirements for participation in this study. Thank you for your interest in my research!”

Appendix B
Uniformed Service Program Permission

You should feel free to engage the USP staff in your research, so long as no patient information is used!

Kirk J. Woodring, LICSW, CGP
Senior Director
Access, Evaluation, Ambulatory and Security Services
Brattleboro Retreat
1 Anna Marsh Lane
Brattleboro, VT. 05302
802.258.4363
www.brattlebororetreat.org

-----Original Message-----
From: Carreiro, Stefanie
Sent: Monday, December 03, 2012 10:24 AM
To: Woodring, Kirk
Subject: Thesis

Kirk,

Just wanted to check in to see if you were able to send out the request for me to use USP for my thesis?

Thanks
Stefanie

Appendix C
Give an Hour Permission

Jessica Grove <jgrove@giveanhour.org>
Mar 11

to scarreiro@smith.edu

Dear Stefanie,

Yes, we were able to post your survey and I hope that it was helpful. Wishing you the best!

Take care,
Jess

Jessica Grove Program Specialist
Give an Hour
240-668-4365
jgrove@giveanhour.org
www.giveanhour.org

Stefanie Carreiro <scarreiro@smith.edu>
10/2/12

to jgrove@giveanhour.org

Jessica,

My name is Stefanie Carreiro and I am a Master in Social Work student at Smith College in Massachusetts. I am completing my graduate thesis this year and I am wondering if you or someone from your organization could help me out? For the purpose of my thesis I am looking to survey mental health clinicians on how they determine treatment methods for military personnel who have experienced combat-related trauma and/or military sexual trauma. With this being said I am looking for ways to reach out to clinicians who treat this population and I was referred to your website from one of my professors. I am wondering if there is a way for me to post my research study on your website or a way for me to get email addresses or some contact information to reach out to the providers on your website. I realize that this is a long shot but I figured it could not hurt to ask.

Thank you for taking the time to read this email and I hope you have a great day!

Appendix D
ISTSS and APA Permission Letter

Department of Psychology
College Lane
Smith College
Northampton, Massachusetts 01063
T (413) 585-3805
F (413) 585-3786

October 31, 2012

Dear Stefanie Carreiro,

I am writing to document that I will assist you in recruiting participants for your proposed Master's thesis, which aims to survey therapists who are experienced in treating combat trauma and military sexual assault.

In addition to advising you on your work, I am also a founding member of the American Psychological Association (APA) Trauma Division (Division 56) and a member of the Board of Directors of the International Society for Traumatic Stress Studies (ISTSS). APA Division 56 currently has approximately 1,255 members. ISTSS currently has over 2,500 members. Both organizations have systems in place for recruiting members to participate in research. I have outlined your proposed project to the appropriate officials within both organizations and gained enthusiastic support for advertising her study to the organization membership pending IRB approval. I believe that this procedure should yield an adequate sample of respondents.

If you have further questions about this plan then I can be happily reached by e-mail (npole@smith.edu) to discuss it further.

Sincerely,

Nnamdi Pole, Ph.D.
Associate Professor of Clinical Psychology

Appendix E
Recruitment Email to Social Work Societies

To Whom it may concern,

My name is Stefanie Carreiro, and I am a graduate student at Smith College School for Social Work in Massachusetts. I am completing my graduate thesis this year and I am wondering if you or someone from your organization could help me out? For the purpose of my thesis I am looking to survey mental health clinicians about what treatment methods clinicians use as well as factors that influence a clinician's decision of treatment methods. In an effort to increase diversity within my thesis I have researched organizations on the internet and this is where I came across yours. With this being said I am looking for ways to reach out to social workers via list serves and/or organizations. I am wondering if there is a way for me to post my research study on your chapter website or a way for you to email your chapter members a letter containing a link to my survey. I am sure you receive requests for this all the time, but I figured it could not hurt to ask anyway.

Thank you and I hope you enjoy your day!

Appendix F
California Society for Clinical Social Work Agreement

Stefanie,

CSCSW does support students in their research efforts. The easiest way is to email us your tool/ questionnaire and we will e-blast it out to our membership. We will put your email address and name on it so that the responses come back to you. If you have any questions please feel free to email or call. Good luck with your research. I know what a daunting task that can be.

Regards,

Luisa Mardones, Executive Director
California Society for Clinical Social Work
P.O. Box 1151
Rancho Cordova, CA 95741
p: (916) 560-9238
f: (916) 851-1147

Appendix G
Georgia Society for Clinical Social Work Agreement

Trisha Clymore <tclymore@comcast.net>
Jun 14

to scarreiro@smith.edu

Stefanie: Thank you for your email. What we will need from you is the IRB approval. Once we have that and the information you want to send out we can send it to our list serv. Let me know if you have any questions.

Thanks,
Trisha Clymore
Administrator GSCSW

Appendix H
Pennsylvania Society for Clinical Social Work Agreement

PA Society for Clinical Social Work <pscsw@pscsw.org>
Jun 13

to scarreiro@smith.edu

Hello Stefanie,

Hope you are doing well, and thank you for your email.

We would very much like to assist you in your research study.

You will need to end me exactly what you would like us to post. Please keep in mind that I cannot send an attachment - it must all be in the email itself.

I will pass it along for approval, and once I obtain the approval, I will forward it to our listserv and copy you on the email.

Regards,
Kathy

Kathy Beidler, Administrative Assistant
PA Society for Clinical Social Work (PSCSW)
112 Carol Lane, Richboro, PA 18954
Phone/Fax: 215/942-0775
Email: pscsw@pscsw.org
Website: www.pscsw.org

Appendix I
Minnesota Society for Clinical Social Work Agreement

Bev Caruso <bevcaruso@gmail.com>
Jun 13

to scarreiro@smith.edu

Hello,

Your research sounds valuable and interesting. You can send me your letter and the link and I will send it out to the membership. If you do a brief summary of your paper, please send it to me and I will send it to the membership.

Bev Caruso

Appendix J
Recruitment Email to GBA and NAHPSW

My name is Stefanie Carreiro, and I am a graduate student at Smith College School for Social Work in Massachusetts. I am completing my graduate thesis this year and I am wondering if you or someone from your organization could help me out? For the purpose of my thesis I am looking to survey mental health clinicians about what treatment methods clinicians use as well as factors that influence a clinician's decision of treatment methods. In an effort to increase diversity within my thesis I have researched organizations on the internet and this is where I came across yours. With this being said I am looking for ways to reach out to social workers via list serves and/or organizations. I am wondering if there is a way for me to post my research study on your chapter website or a way for me to get email addresses or some contact information to reach out to the social workers in your chapter. I am sure you receive requests for this all the time, but I figured it could not hurt to ask anyway.

Thank You,
Stefanie Carreiro

Appendix K
GBABSW Agreement

Greaterbostonassociation Ofblacksocialworkers <gbabsw@yahoo.com>
Jan 26

to scarreiro@smith.edu

Sorry Stephanie for responding that late. Better late than ever. You could send the survey and I can distribute them to our membership, and some other organizations that I have contact with.

Phernel Manigat
617. 694-7172

Appendix L
NAPHSW Permission E-mail

Dear Stefanie: If you wish to send us your questions for your thesis, I will forward to our membership and if anyone wants to respond they will contact you.

Thank you for contacting us.

Sonia Palacio-Grottola, LCSW

In a message dated 11/24/2012 11:40:03 A.M. Eastern Standard Time, SCarreiro@Smith.edu writes:

Name: Stefanie Carreiro
E-mail Address: SCarreiro@Smith.edu
Phone Number: ________xxx-xxx.xxxx

Message:
My name is Stefanie Carreiro, and I am a graduate student at Smith College School for Social Work in Massachusetts. I am completing my graduate thesis this year and I am wondering if you or someone from your organization could help me out? For the purpose of my thesis I am looking to survey mental health clinicians about what treatment methods clinicians use as well as factors that influence a clinicianâ€™s decision of treatment methods. In an effort to increase diversity within my thesis I have researched organizations on the internet and this is where I came across yours. With this being said I am looking for ways to reach out to social workers via list serves and/or organizations. I am wondering if there is a way for me to post my research study on your chapter website or a way for me to get email addresses or some contact information to reach out to the social workers in your chapter. I am sure you receive requests for this all the time, but I figured it could not hurt to
ask anyway.

Thank You,
Stefanie Carreiro

Appendix M

Recruitment E-Mail

Dear Colleague,

My name is Stefanie Carreiro, and I am a graduate student at Smith College School for Social Work. I am writing to ask for your help in completing my Master's thesis.

You are receiving this email because you have been identified as a clinical practitioner who may have experience in treating military trauma. If you are willing I would like for you to participate in a thirty minute electronic survey designed to identify the techniques that clinicians typically use to treat specific types of psychological trauma.

My study focuses on what treatment methods clinicians use as well as factors that influence a clinician's decision of treatment methods. By participating in this research and sharing your clinical experiences, you could help clarify standard practice for treating military trauma. Your responses could also benefit clinical practitioners, supervisors, and educators.

Participating in the study is quite easy; you will be asked to read a case vignette and then complete an online questionnaire. This study will be anonymous in nature and not ask you for any identifying information. If you participate, an informed consent form will be presented to you as part of the online survey. You will not be asked for your signature, but only to check a box if you agree to participate.

You are eligible to participate in my study if you are currently or have worked with survivors of military trauma. Participants must have a Master's degree, Doctorate degree in one of the following disciplines: Clinical Social Work, Marriage and Family Therapy, Mental Health Counseling, Psychiatric Nursing, Psychology, or Psychiatry. Participants must have received graduate or postgraduate training to practice psychotherapy.

If you meet criteria for participating, I encourage you to take part in my study. Because participation is anonymous, I will have no way of knowing whether or not you participate. If you do not meet criteria, I encourage you to please forward this email to any acquaintances or colleagues you know of who may be eligible to participate. The forwarding of this email to other potential participants would be very helpful! Below you will find the link to the website containing my thesis questionnaire.

Please follow this link to the survey:

If you have any questions about my research or the nature of participation, please feel free to reply to this email (SCarreiro@smith.edu) or contact me at a later date. If you reply to this email, please be cautioned not to hit "Reply all."

Thank you for your time and interest in my research topic!

Sincerely,
Stefanie Carreiro
MSW Candidate, Smith College School for Social Work

Appendix N
Experience and Formal Training

Table 3: *Experience and Formal Training vs. Client Treatment Indicators*

Pairs		Mean	t	df	Sig (2 tailed)
Pair 1	Your experience and formal training in specific techniques	3.7937	.637	62	.527
	Whether the client endorses suicidal ideation	3.6984			
Pair 2	Your experience and formal training in specific techniques	3.7937	.775	62	.441
	Client's current level of functioning	3.6825			
Pair 3	Your experience and formal training in specific techniques	3.7937	1.197	62	.236
	Client has a traumatic brain injury (TBI)	3.6190			
Pair 4	Your experience and formal training in specific techniques	3.7937	5.746	62	.000*
	If the client witnessed the death of a fellow soldier	2.7619			
Pair 5	Your experience and formal training in specific techniques	3.7937	7.217	62	.000*
	If the client witnessed the death of an enemy	2.5397			
Pair 6	Your experience and formal training in specific techniques	3.7937	5.074	62	.000*
	If the client witnessed the death of a civilian/child	2.8730			
Pair 7	Your experience and formal training in specific techniques	3.7937	5.907	62	.000*
	If the client was harassed by a fellow soldier	2.7460			
Pair 8	Your experience and formal training in specific techniques	3.7937	8.028	62	.000*
	If the client was harassed by a stranger	2.4444			

*p > .05

Pair 9	Your experience and formal training in specific techniques	3.7937	4.839	62	.000*
	Client somatic complaints	3.0159			
Pair 10	Your experience and formal training in specific techniques	3.7937	5.573	62	.000*
	Client’s current medication use	2.8730			
Pair 11	Your experience and formal training in specific techniques	3.7937	3.996	62	.000*
	Client’s current health condition	3.1587			
Pair 12	Your experience and formal training in specific techniques	3.7937	5.436	62	.000*
	Client was injured during deployment	2.8254			
Pair 13	Your experience and formal training in specific techniques	3.7937	9.221	62	.000*
	Client’s age	2.2222			
Pair 14	Your experience and formal training in specific techniques	3.7937	10.190	62	.000*
	Client’s gender	2.0159			
Pair 15	Your experience and formal training in specific techniques	3.7742	6.288	61	.000*
	Type of trauma (e.g., combat vs. military sexual trauma)	2.7419			
Pair 16	Your experience and formal training in specific techniques	3.7937	4.048	62	.000*
	Client history of childhood/developmental trauma	3.2381			
Pair 17	Your experience and formal training in specific techniques	3.7937	6.941	62	.000*
	Number of deployments	2.6667			
Pair 18	Your experience and formal training in specific techniques	3.7903	4.243	61	.000*
	Number of traumatic events	3.1290			

*$p > .05$

Pair 19	Your experience and formal training in specific techniques If the client experienced institutional trauma after index event	3.7937 2.7143	6.247	62	.000*
Pair 20	Your experience and formal training in specific techniques If the client caused harm to an enemy	3.7937 2.5873	6.873	62	.000*
Pair 21	Your experience and formal training in specific techniques If the client caused harm to a fellow soldier	3.7937 2.9841	4.512	62	.000*
Pair 22	Your experience and formal training in specific techniques If the client caused the death of an enemy	3.7937 2.7460	5.724	62	.000*
Pair 23	Your experience and formal training in specific techniques If the client felt shame, fear, guilt, etc.	3.7937 2.9365	4.532	62	.000*
Pair 24	Your experience and formal training in specific techniques If the client was assaulted by a stranger	3.7937 2.6667	6.202	62	.000*
Pair 25	Your experience and formal training in specific techniques If the client was assaulted by a fellow soldier	3.7937 2.9524	4.345	62	.000*
Pair 26	Your experience and formal training in specific techniques If the client was unable to trust their commanding officers	3.7937 2.9048	4.984	62	.000*
Pair 27	Your experience and formal training in specific techniques If the client was unable to trust their fellow soldiers	3.7742 2.9355	4.625	61	.000*
Pair 28	Your experience and formal training in specific techniques If the client was responsible for handling the remains of a fellow soldier or enemy	3.7742 2.7097	5.661	61	.000*

*p > .05

Pair 29	Your experience and formal training in specific techniques If the client was exposed to firefights, IED's, and mortar attacks	3.7937 2.7302	6.125	62	.000*
Pair 30	Your experience and formal training in specific techniques The client's financial status	3.7937 1.7302	11.501	62	.000*
Pair 31	Your experience and formal training in specific techniques The client's insurance status	3.7937 1.6032	12.308	62	.000*
Pair 32	Your experience and formal training in specific techniques The client's previous therapy experiences	3.8387 2.5806	9.391	61	.000*
Pair 33	Your experience and formal training in specific techniques The client's stated treatment preferences	3.7937 3.1746	4.250	62	.000*
Pair 34	Your experience and formal training in specific techniques The client's service connected disability status	3.7937 1.9524	11.720	62	.000*
Pair 35	Your experience and formal training in specific techniques Client's level of social support	3.7937 3.2381	3.380	62	.001*
Pair 36	Your experience and formal training in specific techniques If the client caused the death of a fellow soldier	3.7937 3.1587	3.420	62	.001*
Pair 37	Your experience and formal training in specific techniques The client's ability to tolerate affect/emotions	3.7937 3.3175	2.980	62	.004*
Pair 38	Your experience and formal training in specific techniques Specific presenting symptoms	3.7937 3.3810	2.761	62	.008*

*p > .05

Pair 39	Your experience and formal training in specific techniques	3.7937	2.566	62	.013*
	Comorbid diagnoses	3.4444			

*$p > .05$

Appendix O
Theoretical Orientation

Table 4: *Theoretical Orientation vs. Client Treatment Indicators*

Pairs		Mean	t	df	Sig (2 tailed)
Pair 1	Your theoretical orientation	3.5714	-.283	62	.778
	Client has a traumatic brain injury (TBI)	3.6190			
Pair 2	Your theoretical orientation	3.5714	-.753	62	.454
	Whether the client endorses suicidal ideation	3.6984			
Pair 3	Your theoretical orientation	3.5714	-.775	62	.441
	Client's current level of functioning	3.6825			
Pair 4	Your theoretical orientation	3.5714	.806	62	.423
	Comorbid diagnoses	3.4444			
Pair 5	Your theoretical orientation	3.5714	1.116	62	.269
	Specific presenting symptoms	3.3810			
Pair 6	Your theoretical orientation	3.5714	1.528	62	.132
	The client's ability to tolerate affect/emotions	3.3175			
Pair 7	Your theoretical orientation	3.5714	1.841	62	.070
	Client's level of social support	3.2381			
Pair 8	Your theoretical orientation	3.5714	1.895	62	.063*
	If the client caused the death of a fellow soldier	3.1587			

*p > .05

Pair 9	Your theoretical orientation If the client witnessed the death of a fellow soldier	3.5714 2.7619	3.907	62	.000*
Pair 10	Your theoretical orientation If the client witnessed the death of an enemy	3.5714 2.5397	5.231	62	.000*
Pair 11	Your theoretical orientation If the client was harassed by a fellow soldier	3.5714 2.7460	4.197	62	.000*
Pair 12	Your theoretical orientation If the client was harassed by a stranger	3.5714 2.4444	6.018	62	.000*
Pair 13	Your theoretical orientation Client's current medication use	3.5714 2.8730	3.997	62	.000*
Pair 14	Your theoretical orientation Client was injured during deployment	3.5714 2.8254	4.059	62	.000*
Pair 15	Your theoretical orientation Client's age	3.5714 2.2222	7.563	62	.000*
Pair 16	Your theoretical orientation Client's gender	3.5714 2.0159	8.114	62	.000*
Pair 17	Your theoretical orientation Type of trauma (e.g., combat vs. military sexual trauma)	3.5806 2.7419	4.662	61	.000*
Pair 18	Your theoretical orientation Number of deployments	3.5714 2.6667	5.009	62	.000*

*p > .05

Pair 19	Your theoretical orientation	3.5714	4.507	62	.000*
	If the client was assaulted by a stranger	2.6667			
Pair 20	Your theoretical orientation	3.5806	4.170	61	.000*
	If the client was responsible for handling the remains of a fellow soldier or enemy	2.7097			
Pair 21	Your theoretical orientation	3.5714	4.375	62	.000*
	If the client was exposed to firefights, IED's, and mortar attacks	2.7302			
Pair 22	Your theoretical orientation	3.5714	9.086	62	.000*
	The client's financial status	1.7302			
Pair 23	Your theoretical orientation	3.5714	10.253	62	.000*
	The client's insurance status	1.6032			
Pair 24	Your theoretical orientation	3.5806	6.030	61	.000*
	The client's previous therapy experiences	2.5806			
Pair 25	Your theoretical orientation	3.5714	9.129	62	.000*
	The client's service connected disability status	1.9524			
Pair 26	Your theoretical orientation	3.5714	4.500	62	.000*
	If the client experienced institutional trauma after index event	2.7143			
Pair 27	Your theoretical orientation	3.5714	4.818	62	.000*
	If the client caused harm to an enemy	2.5873			

*p > .05

Pair 28	Your theoretical orientation	3.5714	3.991	62	.000*
	If the client caused the death of an enemy	2.7460			
Pair 29	Your theoretical orientation	3.5714	3.395	62	.001*
	If the client witnessed the death of a civilian/child	2.8730			
Pair 30	Your theoretical orientation	3.5714	3.348	62	.001*
	Client somatic complaints	3.0159			
Pair 31	Your theoretical orientation	3.5714	3.402	62	.001*
	If the client was unable to trust their commanding officers	2.9048			
Pair 32	Your theoretical orientation	3.5645	3.175	61	.002*
	If the client was unable to trust their fellow soldiers	2.9355			
Pair 33	Your theoretical orientation	3.5714	3.020	62	.004*
	If the client felt shame, fear, guilt, etc.	2.9365			
Pair 34	Your theoretical orientation	3.5714	2.893	62	.005*
	If the client was assaulted by a fellow soldier	2.9524			
Pair 35	Your theoretical orientation	3.5714	2.726	62	.008*
	If the client caused harm to a fellow soldier	2.9841			
Pair 36	Your theoretical orientation	3.5714	2.615	62	.011*
	Client’s current health condition	3.1587			
Pair 37	Your theoretical orientation	3.5645	2.517	61	.014*
	Number of traumatic events	3.1290			

*$p > .05$

Pair 38	Your theoretical orientation The client’s stated treatment preferences	3.5714 3.1746	2.200	62	.032*
Pair 39	Your theoretical orientation Client history of childhood/developmental trauma	3.5714 3.2381	2.023	62	.047*

*p > .05

Appendix P
Findings from Empirical Literature

Table 5: *Findings from Empirical Literature vs. Client Treatment Indicators*

Pairs		Mean	t	df	Sig (2 tailed)
Pair 1	Findings from empirical literature	3.5397	-.480	62	.633
	Client has a traumatic brain injury (TBI)	3.6190			
Pair 2	Findings from empirical literature	3.5397	.597	62	.553
	Comorbid diagnoses	3.4444			
Pair 3	Findings from empirical literature	3.5397	.904	62	.369
	Specific presenting symptoms	3.3810			
Pair 4	Findings from empirical literature	3.5397	-.904	62	.369
	Whether the client endorses suicidal ideation	3.6984			
Pair 5	Findings from empirical literature	3.5397	-.922	62	.360
	Client's current level of functioning	3.6825			
Pair 6	Findings from empirical literature	3.5397	1.243	62	.219
	The client's ability to tolerate affect/emotions	3.3175			
Pair 7	Findings from empirical literature	3.5397	1.726	62	.089
	Client's level of social support	3.2381			
Pair 8	Findings from empirical literature	3.5397	1.770	62	.082
	If the client caused the death of a fellow soldier	3.1587			

*$p > .05$

Pair 9	Findings from empirical literature	3.5397	1.931	62	.058
	Client history of childhood/developmental trauma	3.2381			
Pair 10	Findings from empirical literature	3.5397	3.786	62	.000*
	If the client witnessed the death of a fellow soldier	2.7619			
Pair 11	Findings from empirical literature	3.5397	5.103	62	.000*
	If the client witnessed the death of an enemy	2.5397			
Pair 12	Findings from empirical literature	3.5397	3.274	62	.000*
	If the client witnessed the death of a civilian/child	2.8730			
Pair 13	Findings from empirical literature	3.5397	3.683	62	.000*
	Client's current medication use	2.8730			
Pair 14	Findings from empirical literature	3.5397	3.816	62	.000*
	Client was injured during deployment	2.8254			
Pair 15	Findings from empirical literature	3.5397	6.918	62	.000*
	Client's age	2.2222			
Pair 17	Findings from empirical literature	3.5397	7.398	62	.000*
	Client's gender	2.0159			
Pair 17	Findings from empirical literature	3.5645	4.290	61	.000*
	Type of trauma (e.g., combat vs. military sexual trauma)	2.7419			
Pair 18	Findings from empirical literature	3.5397	5.600	62	.000*
	If the client was harassed by a stranger	2.4444			

*p > .05

Pair 19	Findings from empirical literature If the client was assaulted by a stranger	3.5397 2.6667	4.197	62	.000*
Pair 20	Findings from empirical literature Number of deployments	3.5397 2.6667	4.628	62	.000*
Pair 21	Findings from empirical literature If the client was responsible for handling the remains of a fellow soldier or enemy	3.5645 2.7097	4.060	61	.000*
Pair 22	Findings from empirical literature If the client was exposed to firefights, IED's, and mortar attacks	3.5397 2.7302	3.979	62	.000*
Pair 23	Findings from empirical literature The client's financial status	3.5397 1.7302	9.063	62	.000*
Pair 24	Findings from empirical literature The client's insurance status	3.5397 1.6032	10.880	62	.000*
Pair 25	Findings from empirical literature The client's previous therapy experiences	3.5484 2.5806	6.276	61	.000*
Pair 26	Findings from empirical literature The client's service connected disability status	3.5397 1.9524	8.863	62	.000*
Pair 27	Findings from empirical literature If the client experienced institutional trauma after index event	3.5397 2.7143	1.090	62	.000*

*p > .05

Pair 28	Findings from empirical literature If the client caused harm to an enemy	3.5397 2.5873	5.285	62	.000*
Pair 29	Findings from empirical literature If the client caused the death of an enemy	3.5397 2.7460	4.158	62	.000*
Pair 30	Findings from empirical literature If the client was harassed by a fellow soldier	3.5397 2.7460	4.129	62	.002*
Pair 31	Findings from empirical literature If the client was unable to trust their commanding officers	3.5397 2.9048	3.056	62	.003*
Pair 32	Findings from empirical literature If the client felt shame, fear, guilt, etc.	3.5397 2.9365	2.970	62	.004*
Pair 33	Findings from empirical literature Client somatic complaints	3.5397 3.0159	3.017	62	.004*
Pair 34	Findings from empirical literature If the client was unable to trust their fellow soldiers	3.5323 2.9355	2.930	61	.005*
Pair 35	Findings from empirical literature If the client caused harm to a fellow soldier	3.5397 2.9841	2.802	62	.007*
Pair 36	Findings from empirical literature If the client was assaulted by a fellow soldier	3.5397 2.9524	2.613	62	.011*
Pair 37	Findings from empirical literature The client's stated treatment preferences	3.5397 3.1746	2.541	62	.014*

*p > .05

Pair 38	Findings from empirical literature	3.5323	2.355	61	.022*
	Number of traumatic events	3.1290			
Pair 39	Findings from empirical literature	3.5397	2.241	62	.029*
	Client’s current health condition	3.1587			

*$p > .05$

Appendix Q
Consultation with Supervisor

Table 6: *Consultation with Supervisor vs. Client Treatment Indicators*

Pairs		Mean	t	df	Sig (2 tailed)
Pair 1	Prior consultation with a supervisor or senior clinician	3.1613	.000	61	1.000
	Client's current health condition	3.1613			
Pair 2	Prior consultation with a supervisor or senior clinician	3.1613	.000	61	1.000
	The client's stated treatment preferences	3.1613			
Pair 3	Prior consultation with a supervisor or senior clinician	3.1613	-.079	61	.937
	If the client caused the death of a fellow soldier	3.1774			
Pair 4	Prior consultation with a supervisor or senior clinician	3.1475	.100	60	.921
	Number of traumatic events	3.1311			
Pair 5	Prior consultation with a supervisor or senior clinician	3.1613	-.476	61	.636
	Client's level of social support	3.2419			
Pair 6	Prior consultation with a supervisor or senior clinician	3.1613	-.616	61	.540
	Client history of childhood/developmental trauma	3.2581			
Pair 7	Prior consultation with a supervisor or senior clinician	3.1613	.839	61	.405
	If the client was assaulted by a fellow soldier	2.9839			
Pair 8	Prior consultation with a supervisor or senior clinician	3.1613	.837	61	.406
	Client somatic complaints	3.0161			

*p > .05

Pair 9	Prior consultation with a supervisor or senior clinician If the client caused harm to a fellow soldier	3.1613 3.0000	.862	61	.392
Pair 10	Prior consultation with a supervisor or senior clinician If the client felt shame, fear, guilt, etc.	3.1613 2.9677	.960	61	.341
Pair 11	Prior consultation with a supervisor or senior clinician If the client was unable to trust their fellow soldiers	3.1475 2.9508	1.022	60	.311
Pair 12	Prior consultation with a supervisor or senior clinician The client's ability to tolerate affect/emotions	3.1613 3.3387	-1.026	61	.309
Pair 13	Prior consultation with a supervisor or senior clinician Specific presenting symptoms	3.1613 3.3710	-1.186	61	.240
Pair 14	Prior consultation with a supervisor or senior clinician If the client was unable to trust their commanding officers	3.1613 2.9194	1.209	61	.231
Pair 15	Prior consultation with a supervisor or senior clinician If the client witnessed the death of a civilian/child	3.1613 2.9302	1.352	61	.181
Pair 16	Prior consultation with a supervisor or senior clinician Client's current medication use	3.1613 2.8871	1.512	61	.136
Pair 17	Prior consultation with a supervisor or senior clinician Client was injured during deployment	3.1613 2.8387	1.862	61	.067
Pair 18	Prior consultation with a supervisor or senior clinician If the client witnessed the death of a fellow soldier	3.1613 2.7903	1.911	61	.061

*$p > .05$

Pair 19	Prior consultation with a supervisor or senior clinician	3.1613	-1.987	61	.051
	Comorbid diagnoses	3.4516			
Pair 20	Prior consultation with a supervisor or senior clinician	3.1613	3.782	61	.000*
	If the client was harassed by a stranger	2.4677			
Pair 21	Prior consultation with a supervisor or senior clinician	3.1613	5.257	61	.000*
	Client's age	2.2258			
Pair 22	Prior consultation with a supervisor or senior clinician	3.1613	5.875	61	.000*
	Client's gender	2.0161			
Pair 23	Prior consultation with a supervisor or senior clinician	3.1613	7.376	61	.000*
	The client's financial status	1.7258			
Pair 24	Prior consultation with a supervisor or senior clinician	3.1613	8.886	61	.000*
	The client's insurance status	1.5968			
Pair 25	Prior consultation with a supervisor or senior clinician	3.1613	6.710	61	.000*
	The client's service connected disability status	1.9677			
Pair 26	Prior consultation with a supervisor or senior clinician	3.1639	3.455	60	.001*
	The client's previous therapy experiences	2.5902			
Pair 27	Prior consultation with a supervisor or senior clinician	3.1613	3.225	61	.002*
	If the client caused harm to an enemy	2.6129			
Pair 28	Prior consultation with a supervisor or senior clinician	3.1613	3.232	61	.002*
	If the client witnessed the death of an enemy	2.5645			

*p > .05

Pair 29	Prior consultation with a supervisor or senior clinician Client's current level of functioning	3.1613 3.6774	-3.248	61	.002*
Pair 30	Prior consultation with a supervisor or senior clinician Client has a traumatic brain injury (TBI)	3.1613 3.6290	-3.188	61	.002*
Pair 31	Prior consultation with a supervisor or senior clinician Whether the client endorses suicidal ideation	3.1613 3.6935	-3.101	61	.003*
Pair 32	Prior consultation with a supervisor or senior clinician Number of deployments	3.1613 2.6935	2.654	61	.010*
Pair 33	Prior consultation with a supervisor or senior clinician Type of trauma (e.g., combat vs. military sexual trauma)	3.1803 2.7377	2.541	60	.014*
Pair 34	Prior consultation with a supervisor or senior clinician If the client was assaulted by a stranger	3.1613 2.6935	2.385	61	.020*
Pair 35	Prior consultation with a supervisor or senior clinician If the client experienced institutional trauma after index event	3.1613 2.7097	2.353	61	.022*
Pair 36	Prior consultation with a supervisor or senior clinician If the client was responsible for handling the remains of a fellow soldier or enemy	3.1803 2.7377	2.321	60	.024*
Pair 37	Prior consultation with a supervisor or senior clinician If the client was harassed by a fellow soldier	3.1613 2.7581	2.219	61	.030*

*p > .05

Pair 38	Prior consultation with a supervisor or senior clinician If the client was exposed to firefights, IED's, and mortar attacks	3.1613 2.7581	2.201	61	.032*
Pair 39	Prior consultation with a supervisor or senior clinician If the client caused the death of an enemy	3.1613 2.7742	2.115	61	.039*

$*p > .05$

Appendix R
Influential Trauma Descriptors

Table 7: *Influential Trauma Descriptors*

Question: How might each of the following alter your treatment approach?	**Not at All**	**A Little**	**A Moderate Amount**	**A lot**	**Entirely**	**Total % (A lot & Entirely)**	**N**
Combat-Related Trauma							
If the client witnessed the death of a fellow soldier	20.6%	19.0%	25.4%	33.3%	1.6%	**34.9% (22)**	63
If the client witnessed the death of an enemy	22.2%	27.0%	27.0%	22.2%	4.8%	**27.0% (17)**	63
If the client witnessed the death of a civilian/child	20.6%	17.5%	20.6%	36.5%	4.8	**41.3% (26)**	63
If the client caused harm to an enemy	22.2%	25.4%	28.6%	19.0%	4.8%	**23.8% (15)**	63
If the client caused harm to a fellow soldier	17.5%	19.0%	17.5%	39.7%	6.3%	**46.0% (29)**	63
If the client caused the death of an enemy	20.6%	22.2%	27.0%	22.2%	7.9%	**30.1% (19)**	63
If the client caused the death of a fellow soldier	15.9%	15.9%	17.5%	38.1%	12.7%	**50.8% (32)**	63
If the client was responsible for handling the remains of a fellow soldier or enemy	25.8%	19.4%	17.7%	32.3%	4.8%	**37.1% (23)**	62
If the client was exposed to firefights, IED's and mortar attacks	19.0%	27.0%	20.6%	28.6%	4.8%	**33.4% (21)**	63
If the client felt fear, shame, guilt, etc.	25.4%	9.5%	19.0%	38.1%	7.9%	**46.0% (29)**	63
Military Sexual Trauma (MST)							
If the client was harassed by a fellow soldier	19.0%	22.2%	25.4%	31.7%	1.6%	**33.3% (21)**	63
If the client was harassed by a stranger	25.4%	27.0%	28.6%	15.9%	3.2%	**19.1% (12)**	63
If the client experienced institutional trauma after the index event	22.2%	17.5%	28.6%	19.0%	4.8%	**23.8% (15)**	63
If the client was assaulted by a stranger	27.0%	12.7%	30.2%	27.0%	3.2%	**30.2%**	63

						(19)	
If the client was assaulted by a fellow soldier	25.4%	11.1%	11.1%	47.6%	4.8%	**52.4% (33)**	63
If the client was unable to trust their commanding officers	20.6%	17.5%	17.5%	39.7%	4.8%	**44.5% (28)**	63
If the client was unable to trust their fellow soldiers	19.4%	19.4%	16.1%	38.7%	6.5%	**45.2% (28)**	62

Appendix S
Human Subjects Review Committee Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 1, 2013

Stefanie Carreiro

Dear Stefanie,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished).

Good luck with your project.

Sincerely,

Marsha Kline Pruett / lhw

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Jean LaTerz, Research Advisor
Nnamdi Pole, Research Advisor