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AN ANALOGUE STUDY OF EXPECTED WORKING ALLIANCE AND HOPE WITH VICTIMS OF MILITARY SEXUAL TRAUMA AMONG CIVILIAN AND MILITARY-ORIENTED THERAPISTS

Alishia D. Salyer, Ph.D.

Western Michigan University, 2023

Victims of military sexual trauma (MST) face unique challenges as they pursue mental health treatment and supportive care. Understanding what factors impact potential treatment outcomes is critical in aiding in their recovery (Castro et al., 2015; Kroviak, 2020). Although a substantial amount of research has been conducted to evaluate prevalence and client factors associated with treating victims of MST (Teit et al., 2015; Turchik & Wilson, 2010), little is known about therapists' factors including therapists' expectations working with such clients. The purpose of this study was to examine the relationships between therapist type (military-affiliated versus civilian), therapist gender, client gender, multicultural competence, military cultural competence, and therapist expectations of working alliance and therapist hope for clients.

Participants were 108 licensed clinical mental health providers in which 63% identified as military-affiliated and 37% as civilian therapists. Female identified therapists represented 73% of the sample and 27% were male identified. The sample was 78.7% Caucasian/White, 7.4% African American/Black, 4.6% Biracial, 2.8% Asian, .0.90% Native Hawaiian/Other Pacific Islander, and 5.6% other race/ethnicity. Of the total participant sample, 7.4% also identified as Hispanic/Latino/or Spanish identity. Participants represented 6 different clinical mental health degree types and four different mental health provider license types.

An analogue quasi experimental design and regression analyses were used in the study comprising five independent variables including therapist participant gender, therapist type (military versus civilian), multicultural competence (MCKAS-R; Lu, 2017), military cultural competence (AMCC; Meyer et al., 2015), and MST client gender. Gender of an MST client was an independent analogue experimental variable manipulated to create two conditions of exposure through a vignette, the client being either male or female and having experienced MST. The dependent variables included therapists' expectations as measured by the Working Alliance Inventory (Hatcher & Gillaspy, 2006) and therapist hope as measured by the Therapist Hope for Clients Scale (Bartholomew et al., 2020).

Descriptive statistics and correlations were calculated to initially investigate relationships among the variables. Two 2X2 MANOVA statistical analyses were conducted. The first MANOVA examined possible main and interaction effects associated with therapist type, client gender, and therapist expectations of working alliance and therapist hope. The second MANOVA examined possible main and interaction effects associated with therapist gender, client gender, and therapist expectations of working alliance and therapist hope with MST victims. Findings indicated that therapist type, therapist gender, client gender, and their interactions did not demonstrate statistically significant multivariate effects on working alliance and therapist hope.

Multiple regression analyses were used to investigate the extent to which multicultural competence and military cultural competence predicted working alliance and therapist hope. Regression analyses indicated that multicultural competence was not a statistically significant predictor of working alliance and therapist hope. However, military cultural competence was a statistically significant predictor of both working alliance and therapist hope. Findings, implications, limitations, and directions for future research are discussed.

AN ANALOGUE STUDY OF EXPECTED WORKING ALLIANCE AND HOPE WITH VICTIMS OF MILITARY SEXUAL TRAUMA AMONG CIVILIAN AND MILITARY-ORIENTED THERAPISTS

by

Alishia D. Salyer

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for the degree of Doctor of Philosophy
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Alishia Salyer

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CHAPTER I

INTRODUCTION

The existence of sexual violence within the U.S. military is a long-standing concern, recognized as a widespread problem with negative mental health outcomes (Allard, Nunnink, Gregory, Klest, & Platt, 2011). Prevalence rates indicate high incidence of sexual violence with 3.9% of men and 38.4% of women reporting having experienced sexual harassment or assault while serving in the military (Wilson, 2018). With such an overwhelming number of affected individuals, key concerns have arisen regarding treatment needs for victims of military sexual assault. Efforts to address such concerns include focus on screening, appropriate and efficacious treatment, the burden of care on existing military and veteran medical resources, as well as the impact of known gender differences in treatment outcomes (Allard et al., 2011; Kimerling, Gima, Smith, Street, & Frayne, 2007; Turchik, Pavao, Hyun, Mark, & Kimerling, 2012; U.S. Commission on Civil Rights, 2013). Despite the prevalence of military sexual trauma cases, there is a lack of literature regarding the comparison of military to civilian-based providers with this specific population of clients. Furthermore, there appears to be no research at present considering the potential impact of therapist's multicultural competence or military cultural competence and expectations of working alliance and therapist hope with victims of military sexual trauma, and how these may differ between civilian and military-affiliated therapists. To aid in clarification within this study, military-affiliated therapists are defined. The definition of

military-affiliated therapists includes licensed therapists working as mental health providers within the armed services, therapists working for the Department of Defense or Department of Veterans Affairs (VA) healthcare system, therapists having previously served in the armed forces, or therapists that self-identify as working largely with military populations (at least 50% of caseload). This study intended to investigate and understand therapist characteristics that may be important in counseling male or female victims of military sexual trauma. These include: (a) military versus civilian therapist status (b) multicultural competence, (c) military cultural competence, (d) expected working alliance and therapist hope with victims of military sexual trauma, (e) as well as possible implicit gender bias of victims of military sexual assault.

Background of the Study

Military Sexual Trauma

Military sexual trauma (MST) is an event of sexual harassment or sexual assault that occurred during an individual's time serving in the military (Wilson, 2018). Prevalence rates have found that 15.7% of all military personnel and veterans have reported MST when both harassment and assault are measured together, with rates of 3.9% for men and 38.4% for women (Wilson, 2018). Of those serving in the US military in 2018, it was reported by anonymous survey that 20,500 service members experienced sexual assault including 13,000 women and 7,500 men (U.S. Department of Defense SAPRO, 2020b). Unfortunately, military sexual trauma is not a recent phenomenon as reports and concerns have a long-standing history with prolific examples of sexual misconduct spanning decades. Consequently, the prominence of sexual violence in the military led to a U.S. Congressional mandate in 1992 for the Department of Veterans Affairs (VA) to provide treatment to victims of military sexual trauma (Allard et al., 2011).

Military sexual trauma is often associated with mental health disorders such as posttraumatic stress disorder (PTSD), anxiety disorders, and depressive disorders (Gross et al., 2019; Tiet, Leyva, Blau, Turchik, & Rosen, 2015) and greater severity of negative outcomes as compared to civilian sexual trauma (O'Brien & Sher, 2013; Surìs, Lind, Kashner, & Borman, 2007). As military sexual trauma appears to increase the severity and potential complexity of treatment, it is prudent for explicit attention to be placed upon unique factors differentiating MST from non-military events of sexual trauma.

The Department of Veterans Affairs (VA) has a standardized definition of military sexual trauma, employs a universal screening program, and uses comprehensive treatment protocols in response to the burgeoning need of treatment for those having experienced sexual harassment and assault while serving in the US military (Marino, Wolgast, Speck, Kenny, & Moriarty, 2019; U.S. Department of Veterans Affairs, 2020a). However, not all victims of MST can or choose to seek care through the VA, but rather obtain services with civilian mental health providers (Allard et al., 2011; Kimerling et al., 2007). Civilian-based therapists consequently are called to fill the gap and provide treatment for this vulnerable population. Unfortunately, civilian therapists often have little exposure or experience working with military service members and veterans, lacking any formal graduate or professional training specific to military populations (Tanielian et al., 2014). It is important that all practicing therapists demonstrate cultural competence in working with special populations such as military service members and veterans to reduce the risk of potentially harming clients and engaging in unethical practice (Forziat, Arcuri, & Erb, 2018; Price, Stickley, & Prosek, 2015; Sue & Sue, 2012).

Multicultural Competence

Multiculturalism and diversity have received growing attention over the previous decades in the fields of psychology, social work, and counseling, serving as a fundamental feature in the profession of counseling psychology. The multicultural counseling and psychotherapy (MCP) movement has expanded and become more defined in American psychology since the Civil Rights era, highlighting the importance of multicultural competence to reduce the risk of engaging in culturally insensitive or oppressive therapy practices for diverse clients (APA, 2003; Wendt, Gone, & Nagata, 2015). The American Psychological Association's (APA, 2003) approval of the multicultural guidelines was a pivotal event. It highlighted the recognition and deliberate focus on issues of diversity that deviated from the standard practice of using White, middle-class norms as models of human development, behavior, and wellness (Arredondo & Perez, 2006; Vera & Speight, 2003). Mental health providers are challenged to become effective in working with diverse clients, demonstrating understanding and multicultural competence across varying social and cultural contexts (Constantine, Miville, & Kindaichi, 2008; Scheel, Stabb, Cohn, Duan, & Sauer, 2018). As military service members and their families make up a distinct subset of society (Coll, Weiss, Draves, & Dyer, 2012), the application of cultural competence is essential, particularly when working with at-risk clients including military sexual trauma victims.

Military Cultural Competence

Military cultural competence is an important consideration when working with victims of military sexual trauma. Military clients and veterans are noted as a unique population with their own culture of psychological norms encompassing values, beliefs, traditions, and language (Fenell, 2008; Yamada, Atuel, & Weiss, 2013). Furthermore, there are subcultures within military

culture as demarcated by branch, career field, rank, and job type. A strict hierarchical structure known as the chain of command is followed by all military personnel with clear expectations of specific roles, duties, and respect of superiors and subordinates (Exum, Coll, & Weiss, 2011). Although each branch has a unique creed and set of values (e.g., duty, loyalty, commitment, and honor), all branches in the military subscribe to the warrior ethos (Redmond et al., 2015). Stemming from the warrior ethos, a warrior identity is ascribed with prized masculine gender ideals including strength, power, dominance, and rationality (Do & Samuels, 2020). In contrast, empathy, open expression of emotion, and weakness are scorned as feminine or non-heterosexual attributes (Zaleski, 2015). Female service members often report experiences of having to "hide their femininity" for fear of retaliation and ridicule as well as sexual harassment or assault (Crowley & Sandhoff, 2017; Silva, 2008). Warrior identity and gender-based differences are important components of military culture and mental health service providers should demonstrate competence with knowledge, awareness, and skills when working with military service members and veterans. Such cultural competence is increasingly prudent when working with victims of military sexual trauma.

Differences Between Military-Oriented Therapists and Civilian Therapists

Current treatment for military sexual assault has undergone extensive review and standardization to enhance the effectiveness for both men and women. This stands in marked contrast that little to no research has been conducted in review of therapist factors in working with victims of military sexual trauma. Therapists have an overwhelming influence in the efficacy of client outcomes based upon clinical skills and competencies, attitudes, and knowledge (Soto, Smith, Griner, Domenech Rodríguez, & Bernal, 2018; Sue, Arredondo, & McDavis, 1992; Sue, Zane, Nagayama Hall, & Berger, 2009). Research has established that

therapists' biases and assumptions can negatively impact the working alliance with clients from special populations (Vasquez, 2007; Wendt, Gone, & Nagata, 2015). Mental health counselors lacking specialized training and/or demonstrating low multicultural competence or military cultural competence may be more at risk to hold and impose personal beliefs and attitudes in opposition to a service member or veteran (Meyer, Hall-Clark, Hamaoka, & Peterson, 2015; Prosek & Holm, 2014).

The lack of military cultural competence may significantly impact the efficacy of treatment with military populations, and this may be seen more acutely when working with at-risk clients such as victims of military sexual assault (Baltrushes & Karnik, 2013; Brommelsiek, Peterson, Amelung, 2018). Those having experienced MST may have also experienced negative reactions from authority figures and peers including disbelief, blame, or inaction (Burns, Grindlay, Holt, Manski, & Grossman, 2014; Monteith, Gerber, Brownstone, Soberay, & Bahraini, 2019). A poor or harmful response from mental health providers resulting from low military cultural competence often leads to premature termination of treatment (Scudder, 2017) and may function to exacerbate distress experienced by victims of MST. Mental health providers lacking military cultural competence may experience greater difficulties in working with victims of military sexual trauma. Difficulties may include an insufficient knowledge base, lack of military-specific treatment skills, low awareness of personal attitudes and biases, and inadvertent endorsement of negative stereotypes (e.g., "angry veteran"), and gender bias affiliated with the military which may include increased acceptance of rape myths (Carrola & Corbin-Burdick, 2015; Hoyt, Klosterman Rielage, & Williams, 2011; Mueller, 2017; Strom, 2012; Zimmerman, Castronova, & ChenFeng, 2016). It is unknown how the practice of multicultural competence

without specific knowledge, skills, or training related to the military influences psychotherapy with victims of military sexual trauma.

Gender Bias

Gender bias may be held by military and civilian mental health professionals, with the potential to negatively impact treatment outcomes with victims of military sexual trauma. Military affiliated therapists that strongly align with military culture may inadvertently reinforce gender bias that exists in the military in which assumed masculine-norms are applied to both male and female victims (Forziat, Arcuri, & Erb, 2017). Counselors that reinforce patriarchal systems of authority or power differentials may amplify discomfort for victims whose perpetrators were male and/or a superior personnel member (Bell & Reardon, 2011). Civilian therapists may also inadvertently endorse gender bias in working with victims of military sexual trauma, as those with low military cultural competence may hold beliefs based on stereotypes about military populations.

Stereotypes and myths about the military may include perceiving male MST victims as unfeeling, violent, aggressive, and make assumptions of hypermasculinity and strength that reinforce acceptance of rape myths (e.g., "Why didn't you fend off your perpetrator" or "real men don't get raped"; Fenell, 2014). Stereotypes specific to women may include minimization of MST as society often assumes women serve in non-combat military roles that reduces risk and exposure to traumatic events (Street, Vogt, & Dutra, 2009).

Statement of the Problem

Therapists' attitudes, biases, and competence are important in working with any counseling client. While a substantial amount of graduate and professional training emphasizes the importance of multicultural competence and working with special populations, military

clients and their specific needs are often unaddressed. Therapists with low military cultural competence may have a reduced ability to understand and connect with military clients and thereby obtain lower working alliance (Forziat, Arcuri, & Erb, 2017) as compared to therapists with high military cultural competence. Poor working alliance may be even more pronounced if therapists hold personal beliefs that are contradictory to military culture (Prosek & Holm, 2014). Similarly, therapists with low military cultural competence may feel less hopefulness in helping military clients as compared to therapists with high military cultural competence. Therapists' qualities such as the ability to work within the client's worldview and hopefulness are considered powerful contributors to therapeutic outcomes (Frank, 1995; O'Hara & O'Hara, 2012), warranting further study working with military populations. Victims of military sexual trauma may be at increased risk of bias. Due to the scarcity of research, differences in multicultural competence, military cultural competence, and possible gender bias between military and civilian therapists are unknown in the context of working with military sexual trauma victims.

Purpose of the Study

No psychological literature to date has assessed military and civilian therapists' gender, multicultural competence, military cultural competence, working alliance, and therapist hope related to counseling male or female victims of military sexual trauma. This study aims to address the gap in the research literature of military sexual trauma in efforts to assist current conceptualization working with victims with consideration of possible gender differences in therapist perceptions.

Research Questions

1. Is there a relationship between therapist type (military vs. civilian), client gender, and therapist expectations of working alliance and therapist hope with victims of military sexual trauma?

2. Is there a relationship between therapist gender and client gender, with therapist expectations of working alliance and therapist hope with victims of military sexual trauma?
3. What is the nature of the relationship between the variables of therapist gender, therapist type (military vs. civilian), multicultural competence, military cultural competence, client gender, and the variables of therapist expectations of working alliance and therapist hope with victims of military sexual trauma?

Hypotheses

1. It is hypothesized that that there will be significant effects associated with therapist type (military vs. civilian), and client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma.
2. It is hypothesized that that there will be significant effects associated with therapist gender, client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma.
3a. It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for Hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute significant unique variance to predicting the criterion variable of therapist expectations of the working alliance.
3b. It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for Hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute significant unique variance to predicting the criterion variable of therapist hope with victims of military sexual trauma.

Definitions of Major Constructs

Military Sexual Trauma (MST)

The Department of Veteran Affairs adopts the language of the U.S. Federal statute for counseling and treatment for sexual trauma of the Veteran's Benefits Act (1992). Military sexual trauma (MST) is defined as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training." Section 1561 of Title 10, United States Code, defines "sexual harassment" as "conduct that involves unwanted sexual advances, requests for sexual favors, and deliberate or repeated offensive comments or gestures of a sexual nature" (U.S. Department of Defense SAPRO, 2020a). In the present study, military sexual trauma will include the two categories together, military sexual harassment and military sexual assault.

Cultural Competence

Cultural competence entails awareness of one's own cultural identities, continual self-reflection and self-awareness of one's attitudes, values, and biases, as well as knowledge of historical traumas and abuses that have affected communities of color, sexual minority groups, and under-privileged individuals (Constantine et al., 2008; Scheel et al., 2018). To be culturally competent in mental health practice means that a provider possesses the ability to understand, communicate with and effectively interact with diverse clients across cultures. Cultural competence in practice also entails a therapist being aware of their own world view and biases as well as developing positive attitudes towards the cultural differences of clients (Sue, Arredondo, & McDavis, 1992). By gaining knowledge of different cultural practices and world views,

therapists can more effectively engage others and understand their unique experiences (Bernal & Domenech Rodriguez, 2012).

Military Cultural Competence

Military cultural competence is an extension of the concept of multicultural competence in that an individual seeks to gain understanding of the worldview of military service members and veterans. Again borrowing from multicultural competence theory, military cultural competence requires a therapist to (a) gain awareness of one's own attitudes, values, and biases towards the military, service members, and veterans, (b) acquire knowledge pertaining to military culture and its defining characteristics, values and principles, organizational structure, and social norms, and (c) acquire skills and training to effectively provide treatment for service members and veterans presenting to mental health treatment. Military cultural competence is further developed with an understanding of the dichotomous worldview (them vs. us) within military culture, reflective of the military-civilian divide (Atuel & Castro, 2018).

Working Alliance

Working alliance is understood as affective and cognitive components of therapy that center upon the quality of the relationship between client and therapist (Gaston, 1990). Bordin (1979) states that working alliance is necessary to the therapeutic process in which the client and therapist maintain a collaborative focus with negotiation through the course of treatment. The three specific aspects of Bordin's (1979) theory are (a) the consensus between client and therapist on the goals of the therapy, (b) the client's consensus with the therapist that the therapy goals and tasks will address the problems the client brings to treatment, and (c) the strength of the relational bond between the client and the therapist.

Therapist Hope

Therapist hope is a domain-specific conceptualization of hope that is understood as a therapist's hope in a client (Bartholomew et al., 2019). Comparisons can be drawn from the seminal work of Snyder's Hope Theory (Snyder, 2002). Therapist hope is operationalized as a consolidation of identified goals with a client, belief and agency to help a client achieve change, and future-oriented thinking or pathways toward change that aids a client (Bartholomew et al., 2019; Snyder, 2002).

CHAPTER II

REVIEW OF THE LITERATURE

Military Sexual Trauma

The incidence of sexual violence within the U.S. military is not a recent occurrence, with accounts of widespread sexual harassment and assault spanning decades. With increased focus on women's rights and female roles in the military, growing concern brought the late arriving attention to military sexual trauma with highly publicized accounts of sexual misconduct. Such events include the Tailhook conference in 1991 and the Air Force Academy sexual assault scandal in 2003 (Zaleski, 2015). In 1992, Congress began passing a series of laws that directed the Department of Defense to take action in prevention of sexual harassment and sexual assault in the military (Women Veterans Health Programs Act, 1992). The Department of Veteran Affairs adopted the term military sexual trauma (MST) and began implementing universal MST screening in 2002, providing free counseling treatment and healthcare to all veterans and conditions associated with sexual trauma occurring in military service (Allard et al., 2011; Kimerling et al., 2007). Formal reports of active-duty personnel experiencing MST began in 2006 which established a baseline rate of approximately 34,000 service members in that year having experienced sexual assault (U.S. Department of Defense, 2020b). The development of prevention training efforts and increased discussion of military sexual trauma resulted in a sharp initial drop in rates following the 2006 baseline report; nevertheless, the rates of harassment and sexual assault appear to be increasing within the past three years (U.S. Department of Defense, 2020b). The recent murder of Army Specialist Vanessa Guillen on April 22, 2020 also sparked a

national conversation regarding the high prevalence of sexual violence still existing in the military. The movement involved many female service members and veterans reporting their personal experiences on social media with the hashtag #iamvanessaguillen (Grantham-Philips, 2020). As women are coming forward disclosing their accounts of sexual harassment and assault in the military, the accuracy and barriers of reporting are being scrutinized.

Prevalence of military sexual trauma. The Department of Veteran Affairs mandatory screening program reports that approximately 1 in 4 women and 1 in 100 men have experienced sexual harassment or assault while serving in the military (National Center for PTSD, 2019). Military sexual trauma has often been portrayed as a "female concern," as it disproportionately affects women as compared to men. However, as men represent 85% of military personnel, the absolute number of male victims of military sexual trauma is comparable to that of women (Eckerlin, Kovalesku, & Jakupcak, 2016). Women in the Marine Corps (7.0%) and Navy (5.1%) were more likely to report experiencing sexual assault than women in the other branches, whereas Air Force women (2.8%) were less likely (Davis & Grifka, 2017b). Men in the Navy (0.9%) were more likely to report experiencing sexual assault than men in the other branches, whereas Air Force men (0.3%) were less likely (Davis & Grifka, 2017b). The differences in prevalence rates between branches is not entirely clear; however, it is understood that leadership tolerance for sexual harassment or differing consequences for perpetrators may influence reporting rates (Barth et al., 2015). Other research has suggested that Marines and Navy service members may be at higher risk for sexual assault as the highest self-reported rates of assault occur on Navy ships (Morral, Schell, Cefalu, Hwang, & Gelman, 2018). This may reflect that environments with high populations of service members and high confinement may be a risk

factor for sexual assault. Further research is needed to explore this possible risk factor and differing prevalence rates of sexual assault across the military branches.

Prevalence rates in research studies provide average estimates of MST in veteran samples ranging between 20% and 45% (Allard et al., 2011; Surís & Lind, 2008; Wilson, 2018). Select studies report significantly higher rates of MST, particularly when measures included both sexual assault and harassment as compared to only assault (Wilson, 2018). Wolff and Mills (2016) had a participant group where 90% of female veterans having served from World War II to the War in Afghanistan had experienced at least one form of MST including harassment, coercion, attempted sexual assault, or assault. The variation in prevalence rates of MST within the existing research literature is likely attributable to varying definitions, response formats (e.g., in-person, telephone, mail), and participant recruitment strategies (Surís & Lind, 2008; Wilson, 2018).

The U. S. Department of Defense SAPRO (2020b) annual report on sexual assault in the military indicates an established baseline prevalence of 34,000 active-duty service members having experienced sexual assault during their time of service within the 2006 fiscal year. Expansive prevention efforts led to a reduction in survey estimated rates compared to the original 2006 baseline; however, estimates of sexual assault from 2016 to 2018 has increased alarmingly from 14,900 (4.3% women, 0.6% men) to 20,500 (6.2% women, 0.7% men; U. S. Department of Defense SAPRO, 2020a). The number of formal reports of sexual assault by service members within each fiscal year has steadily increased from 2012 to 2019, from 2,828 to 6,236 reports (U.S. Department of Defense SAPRO, 2020a). This increase in MST reporting has been framed as a positive development, suggesting improvement in the military climate that allows victims to feel more capable in coming forward (U. S. Department of Defense SAPRO, 2020b). To encourage reporting, the Department of Defense offers (a) restricted reporting, which permits

confidential reporting to designated military personnel without triggering an official investigation, and (b) unrestricted reporting, which prompts a criminal investigation (Mengeling, Booth, Torner, & Sadler, 2014; U. S. Department of Defense SAPRO, 2020c). However, not all victims of MST disclose events of harassment or assault to chain of command or make a report to medical personnel. There are implications that MST is consistently under-reported due to numerous barriers to disclosure (Allard et al., 2011; Castro et al., 2015).

Barriers to disclosure. It is concerning that events of MST go unreported due to multiple barriers to disclosure (Katz, 2016b). In a study of active-duty service members having experienced sexual assault, 85% of male and 69% of female service members did not make any official report, with 39% of men and 58% of women stating that they did not want anyone to know about it (Davis & Grifka, 2017c). Numerous research studies demonstrate that reporting of MST is heavily impacted by barriers including feelings of shame, fear of retaliation including career consequences, concern of dismissive or invalidating responses, poor support, fear of broken unit cohesion, issues of confidentiality, lack of knowledge about reporting or services, and insufficient or failed accountability of reporting efforts by chain of command (Allard et al., 2011; Burns et al., 2014; Dardis, Reinhardt, Foyes, Medoff, & Street, 2018; Katz, 2016b; Kimerling et al., 2007; Mengeling et al., 2014). Military values including unit cohesion, loyalty, and collectivism may also serve to discourage MST victims from reporting sexual harassment and assault by fellow service members (Hoyt, Klosterman, Rielage, & Williams, 2011). Victims who choose to report incidents of harassment and sexual assault in which the perpetrators are co-workers or superior officers residing in the same unit, may face retaliation as the report would serve to interrupt military duties, unit cohesion, and leadership (Allard et al., 2011). Fractured unit cohesion as a result of reporting MST may result in a victim experiencing open ridicule and

hostility from previously trusted others within their unit (Burns et al., 2014; O'Brien, Keith, & Shoemaker, 2015). Furthermore, a victim may be labeled as the cause of broken unit cohesion. This may result in receipt of negative performance evaluations, decreased or thwarted opportunities for advancement and promotion, re-assignment to another unit, assignment, or duty-station which may derail the victim's military career (Dardis et al., 2018; Monteith, Gerber, Brownstone, Soberay, & Bahraini, 2019).

Threats to military career. Many victims report having their military careers destroyed as a direct result of reporting MST, with little to no disciplinary action to the perpetrator (Burns et al., 2014; Dardis et al., 2018). Victim narratives cite incidents where perpetrators were protected with requests for burden of proof or with reasoning that substantiated reports would damage the perpetrator's career (Burns et al., 2014). Other victim accounts describe fear, threats, and actions of retaliation including charges of adultery, fraternization, and underage drinking leading to an Article-15. Male victims have reported being accused of being gay and administratively discharged, or referral for psychological evaluation to be diagnosed with a personality disorder and subsequently discharged (Hunter, 2007; Mengeling et al., 2014; Monteith et al., 2019; O'Brien, Keith, & Shoemaker, 2015).

Reporting military sexual trauma. The process by which military sexual trauma is reported is complex, serving as an additional barrier to reporting (Castro et al., 2015). Victims may file incidents of sexual harassment or assault through restricted or unrestricted reporting pathways. Restricted reports involve a confidential filing where only select military personnel are notified excluding chain of command and law enforcement, and the victim can receive medical care, psychological treatment, and other supportive services (U.S. Department of Defense SAPRO, 2020c). Restricted reports are made through a sexual assault response

coordinator (SARC), a health-care professional, or a military victim advocate on base, rather than a victim's superior or chain of command (Zaleski, 2015). In comparison, unrestrictive reports involve unit leadership and law enforcement, triggering a criminal investigation (U.S. Department of Defense SAPRO, 2020c).

Leadership response. The attitude and responses from military leadership are instrumental in the event of reporting and the resulting responses directed toward victims, both positive and negative. Mengeling and colleagues (2014) examined the factors affecting the official reporting decisions of female service members having experienced MST. They found that real and perceived attitudes as well as support of leadership served a gatekeeping role whereby positive and negative experiences of reporting were shaped by the reactions they received (Mengeling et al., 2014). Due to the military's hierarchical structure, the role of gatekeeper is even more identifiable in the decision to file an official MST report. One study exploring secondary victimization of female veterans reported that over two-thirds of those that reported an incident of sexual assault during military service were actively discouraged or denied a formal report (Campbell & Raja, 2005). Victims may also experience disbelief and minimization from peers and higher-ranking officers after reporting events of MST, with questioning of the victim's intentions, consent, and personal responsibility for the outcome of events (Katz, 2016b). MST and the negative responses received from others after disclosing MST have been associated with institutional betrayal in which a victim feels betrayed by the military branch or institution, perpetration and/or unsupportive response from previously trusted individuals, abuse of power (e.g., superior), and failure to uphold military values (Monteith et al., 2019; Smith & Freyd, 2013). In addition to institutional betrayal, such negative interactions and lack of support from military officials is associated with increased self-blame cognitions, shame, and reduced help-

seeking behaviors extending beyond discharge from the military (Andresen, Monteith, Kugler, Cruz, & Blais, 2019; Campbell & Raja, 2005; Mengeling et al., 2014).

Not all reactions to MST disclosure are negative. Dardis et al. (2018) identified positive instrumental and emotional reactions to disclosure of MST by military and medical personnel. Proactive responses to allegations included pressing charges, perpetrator losing rank or transferred, leadership making clear that MST behaviors are unacceptable, granting victim requests for transfer, belief in the victim, validation, empathy, and guidance toward support services. Positive experiences leading to satisfaction with reporting outcomes have been associated with increased well-being and decreased psychological distress as compared to those who felt unsatisfied with reporting outcomes (Bell, Street, & Stafford, 2014). Monteith et al. (2019) found that male victims' experiences of "supportive reactions were rare, but instrumental to recovery."

Military culture. Military culture shapes the attitudes, values, and social norms of service members that, while effective in the context of accomplishing the military mission, may serve as an impediment to help-seeking following MST. Prized values of stoicism with restricted emotionality, personal strength, and courage may decrease victims' willingness to report or seek out assistance. Victims may instead believe in diminishing their emotional experience, avoiding feelings of weakness, and embracing an attitude of "suck it up and drive on" (Hall-Clark et al., 2019). Stigma also plays a significant role in help-seeking behaviors, as the emotional distress experienced by victims following MST is often misconstrued as weakness (Holland, Caridad Rabelo, & Cortina, 2016; Juan, Nunnink, Butler, & Allard, 2017). Stigma towards mental health is an unintentional byproduct of military culture in that mental health problems are viewed as reflecting weakness (Gibbons, Migliore, Convoy, Greiner, & DeLeon, 2014). Although the U.S.

military has made efforts to de-stigmatize mental health with promises of minimal negative career consequences, service members often perceive disclosure to others of one's mental health difficulties with distrust due to associated risk for loss of promotion, loss of security clearance, or medical discharge (Weiss & Coll, 2011). Stigma towards seeking mental health services in the military often extends beyond an individual's time of service, affecting help seeking for services through the VA or civilian agencies (Kulesza, Pedersen, Corrigan, & Marshall, 2015).

The impact of MST: Adverse mental and physical health outcomes. The impact of military sexual trauma on victims can be devastating, resulting in deleterious effects of mental and physical health, military career, and well-being following military service (Bell, Street, & Stafford, 2014; Castro et al., 2015). Studies show that men and women experience significant psychological effects of MST with high rates of post-traumatic stress disorder (PTSD), depression, anxiety disorders, and substance abuse (Eckerlin et al., 2016; Kimerling et al., 2010) as well as suicidal behaviors (Kimerling, Makin-Byrd, Louzon, Ignacio, & McCarthy, 2016; Monteith et al., 2016), eating disorders (Blais et al., 2017) and sexual dysfunction (Allard et al., 2011; Eckerlin et al., 2016). Both male and female MST survivors experience increased risk of cognitions of "unbearability, unlovability, and unsolvability" predicting future suicidal behaviors (Wiblin, Holder, Holliday, & Surís, 2018). Victims of MST are found to have poorer health and quality-of-life outcomes compared to those without a history of MST (Surís et al., 2007). Men and women similarly experience disruption in relationships with family and friends, difficulty trusting others, isolation, and cognitive avoidance (Mattocks et al., 2012; Monteith et al., 2019). Physical symptoms may include sleep disorders, headaches, chronic fatigue, gastrointestinal problems, pelvic pain, menstrual problems, and overall poorer health (Allard et al., 2011; O'Brien & Sher, 2013; Surís & Lind, 2008). MST has also been shown to increase difficulties in

transition back to civilian life following discharge with increased unemployment and homelessness as compared to veterans without a history of MST (Brignone, Gundlapalli, & Blais, 2016; Pavao et al., 2013). Adverse mental health outcomes are also noted for gender differences among victims of MST.

Gender differences in military sexual trauma. Research of military sexual trauma has reported discrepancies in severity of psychological symptoms and treatment response between men and women. While women are at higher risk for MST exposure, there is mounting evidence that men demonstrate poorer treatment response following MST as compared to women (Tiet et al., 2015). Gender roles and gender socialization, particularly masculinity within the military, are noted to differentiate the experiences between men and women following military sexual trauma (Bell, Turchik, & Karpenko, 2014). These differences have been associated with varying expectations of risk as the stereotyped identity of a sexual assault victim is female and/or weak, and most men never consider that they can be sexually assaulted (Allard et al., 2011; Morris, Smith, Farooqui, & Surís, 2014).

Women. Female MST survivors are reported to be nine times more likely to develop PTSD than women without a history of sexual assault (Galovski et al., 2022). One study of 270 women comparing civilian and military sexual assault victims found that women having experienced MST demonstrated greater severity of PTSD symptoms as compared to those experiencing sexual assault in civilian settings (Surís et al., 2007). Other studies have found that women having experienced MST are found to have significantly higher rates of anxiety, depression, alcohol and substance abuse, eating disorders, impulsive behaviors including compulsive spending, and over-exercising as compared to civilian sexual assault victims (Blais et al., 2017; Kimerling et al., 2007; O'Brien & Sher, 2013). In a sample of 407 female

veterans, those endorsing MST were more likely to have co-occurring PTSD and substance use disorders as compared to women that experienced other military related stressors; indicating a cumulative effect of MST (Yalch, Hebenstreit, & Maguen, 2018). Tiet and colleagues (2015) found that female MST victims demonstrated more severe depressive symptoms and less angry and violent symptoms as compared to other female veteran's receiving PTSD treatment. The impact of MST on women's reproductive health involves difficulties in both physical and emotional health. Women with a history of military sexual trauma report increased problems in gynecological health including sexual dysfunction, delay or opting to not have children, infertility, pregnancy complications, preterm delivery, and delayed access to reproductive health care (Ryan et al., 2014; Zephyrin, 2016). Within a study of female veterans, those having experienced sexual assault were more likely to report delaying having children, choosing never to have children, and infertility (Ryan et al., 2014). Rape during military service resulting in pregnancy is associated with further difficulties. Within a small sample of seven women, 43% reported having elected abortions, 29% gave birth but felt unable to bond with the child and gave up for adoption, and 29% gave birth and raised the child (Zaleski & Katz, 2014). It is of note that despite the small sample, all participants within the study were raped within 18 months of entering military service between the ages of 18 and 22 and were unemployed and unmarried at the time of the interview (Zaleski & Katz, 2014). Women report that sexual assaults and harassment are a leading contributor to prematurely separating from the military (Dichter & True, 2015). It is assumed that premature separation is even higher among women who experience pregnancy as a result of rape in the military. These factors are unique to the experience of female MST victims, and should be addressed accordingly with gender-specific treatment.

Within treatment for MST, while men and women share similar experiences of shock, disgust, and self-blame cognitions, women appear to present with some gender-specific variability (Morris et al., 2014). Both men and women may feel betrayed by their bodies following MST, but women uniquely describe beliefs that the appearance or shape of their bodies "invited" the sexual assault (Bell, Turchik, & Karpenko, 2014). Narratives of female victims in treatment cite themes of self-blame which are often closely associated with violated self-identity (Northcut & Kienow, 2014) which may be closely associated to female identity in the context of sexual assault. The difficult role women in the military often describe, balancing feminine and masculine traits, may present itself within treatment. For example, women may use denial and minimization of MST due to fear of reinforcing negative beliefs about female service members, given the pressure to be perceived as competent and capable as their male peers while in service (Herbert, 1998).

Men. Male veterans have demonstrated poorer outcomes as compared to women following treatment for MST (Holder, Holliday, Williams, & Surís, 2018; Juan et al.,2017; Tiet et al., 2015; Voelkel, Pukay-Martin, Walter, & Chard, 2015). For example, male MST victims are more likely to receive diagnosis of bipolar disorders, psychotic disorders, and adjustment disorder, as compared to female MST victims who receive diagnosis of PTSD, alcohol, and anxiety disorders (Kimerling et al., 2007). It is suggested that men have greater severity and duration of psychiatric symptoms following MST as compared to women (Elder, Domino, Rentz, & Mata-Galan, 2017; O'Brien, Gaher, Pope, & Smiley, 2008; Street, Gradus, Stafford, & Kelly, 2007). Sexual disorders and AIDS are also more common in male victims than for women (Kimerling et al., 2007). Male veterans presenting to treatment for MST report greater symptoms

of anger, irritability, and violent behaviors associated with PTSD as compared to female veterans (Bell, Turchik, & Karpenko, 2014; Elder et al., 2017).

Men are more likely to experience MST from a same-sex perpetrator (Street et al., 2007). Subsequently, unique elements of military sexual trauma have been found to impact men's treatment of MST include masculinity, increased acceptance of rape myths, and questioning of sexual identity and/or orientation (Elder et al., 2017; Monteith et al., 2019; Zaleski, 2015). Turchik and Edwards (2012) argue that gender role socialization begins in childhood, and male rape myths are prevalent because of gender stereotypes and social norms regarding masculinity and male sexuality which may in turn be reinforced in the military. As the military promotes "masculine" values such as strength, toughness, and restricted emotionality, the development of hypermasculinity may be an undesirable byproduct (Zaleski, 2015). Rape myths such as "a man can't be raped by a woman" and "real/strong men don't get raped" may exacerbate distress in male MST victims as they endorse conflicting hypermasculine beliefs in treatment (Juan et al., 2017; Monteith et al., 2019; Turchik & Edwards, 2012). Male veterans having experienced MST may also share beliefs that their "manhood was stolen," they are "less of a man," and they are no longer worthy of a military identity as they failed to align with the military ideals of strength and masculinity (Bell et al., 2014; O'Brien et al., 2015). Self-blame cognitions (e.g., "why didn't I fight back?") are also associated with increased acceptance of rape myths in male MST victims and questioning of gender identity (Bell et al., 2014; Monteith et al., 2019). Men that experience an erection, ejaculation, or other physiological reactions during an experience of sexual assault may also struggle with gender identity and questioning their sexual orientation (Bell et al., 2014). It is probable that men display differences in symptom presentation and emotional distress

following MST as compared to women due to gender roles, gender stereotypes, and perceived risk of sexual assault in society overall (Yamada et al., 2013).

Risk factors for MST. Women, sexual minorities, those of unmarried relationship status, lower education attainment, use of alcohol, and prior sexual victimization are risks factors for military sexual trauma (Lofgreen, Carroll, Dugan, & Karnik, 2017; Surís & Lind, 2008; Williams & Bernstein, 2011). Estimated prevalence rates of 20-45% for sexual assault occurring within women service member's time in the military may indicate that military service functions as a unique risk factor for women. This is in comparison to overall lifetime prevalence of sexual assault by civilian women at 23.4% (Breiding et al., 2014). It is concerning that the incidence of MST is so high when the average time of military service is confined to two to six years, indicating an alarming concentration of risk (Allard et al., 2011; Lofgreen et al., 2017; Surís & Lind, 2008). In a 2016 *Workplace and Gender Relations Survey* (Severance, Debus, & Davis, 2017), younger service members (less than age 25; 61% women and 49% of men) were reported to be at increased risk for sexual assault as compared to older personnel (age 30 and older; 15% women and 29% men). The report also found lower enlisted service members (E1-E4) at higher risk for MST comprising 70% and 67% of female and male victims of sexual assault, respectively (Severance et al., 2017). The combined individual factors of service members that are female, younger, sexual minorities, and/or of enlistment rank, indicate that lower levels of power and control, significantly increase risk in the rigid hierarchical structure of the military (Harned et al., 2002; Turchik & Wilson, 2010).

Sexual minority status. While not the focus on the present study, it is prudent to highlight the increased risk posed to those identifying as LGBT+ (Davis & Grifka, 2017a). Prior to 2016, the Department of Defense did not measure prevalence of MST affecting service members who

identify as LGBT, due to prohibition of open sexual minority status associated with the Don't Ask, Don't Tell (DADT) policy (Romaniuk & Loue, 2017). A report from the 2016 fiscal year indicated that while LGBT service members represent only 5% of the active-duty military population, they have increased prevalence rates of sexual harassment (22.8%) and sexual assault (4.5%) as compared to non-LGBT identifying servicemembers (6.2% and 0.8%) (Davis & Grifka, 2017b). Some gay and lesbian veterans having experienced MST report perceiving or having been told explicitly that they were targeted because of their sexual orientation. These targeted events of sexual violence have the potential to influence victims' experience of developing internal homonegativity and creating conflict in their previously stable identities (Bell, Turchik, & Karpenko, 2014). A study comprising 332 transgender veterans presenting for VA treatment demonstrated high prevalence rates of MST, with nearly one in five transgender men and one in seven transgender women endorsing experiences of MST (Lindsay et al., 2016). These rates are consistent with other studies of MST prevalence among transgender veterans (Kimerling, Gima, Smith, Street & Frayne, 2007; Klingensmith, Tsai, Mota, Southwick, & Pietrzak, 2014). As transgender female veterans present the highest risk, above the risk of cis-gender women, it highlights concerns for this vulnerable population (Lindsay et al., 2016). Despite the repeal of Don't Ask, Don't Tell (DADT) policy for the armed forces, the overall increased risk of MST for sexual minorities is likely a result of persisting attitudes of discrimination, homophobia, and transphobia in the military (Gurung et al., 2018).

Prior sexual victimization. Veterans who have experienced MST are significantly more likely to endorse past experiences of childhood physical and sexual abuse as compared to veterans without MST histories (Surís & Lind, 2008; Wolfe-Clarke et al., 2017). A Department of Defense (DOD) report indicated that 26% of military service members who made a confidential

report regarding MST also endorsed experiencing sexual trauma prior to military service (U. S. Department of Defense, 2015). Childhood abuse, particularly sexual abuse, is considered a risk factor for future re-victimization in the military (Sadler, Booth, Cook, & Doebbeling, 2003; Turchik & Wilson, 2010). Wolfe-Clarke and colleagues (2017) have found in a sample of 328 male veterans, that those with a history of childhood sexual abuse were 50% more likely to experience MST as compared to 4% of those with no history of childhood sexual abuse. A sample of 135 female veterans reporting MST likewise demonstrated high rates (52.6%) of sexual abuse as children (Kelly, Skelton, Patel, & Bradley, 2011). The impact of childhood trauma and military sexual trauma in veterans is cumulative with significant, deleterious outcomes affecting mental and physical health, interpersonal functioning, and quality of life (Bell, Turchik, & Karpenko, 2014; O'Brien, Keith, & Shoemaker, 2015; Surís & Lind, 2008). Abuse over time may lead to the development of self-blame schemas, and further instances of abuse or re-victimization are perceived as confirmatory evidence of defectiveness and worthlessness (Katz, 2016b). Emotion dysregulation, self-blame cognitions, negative coping strategies, less self-compassion, poor interpersonal skills, and substance abuse are associated with childhood abuse (Barlow, Turow, & Gerhart, 2017; Walsh, Fortier, & DiLillo, 2010). Subsequent re-victimization by MST may exacerbate such distress. Additional risk factors beyond the event of MST may complicate the projected course of treatment for military sexual trauma. Therefore, it is important for therapists to thoughtfully consider and gain practice with appropriate competence-based protocols and techniques to address the unique needs of survivors presenting for mental health care.

Treatment of military sexual trauma. In 2005, the Department of Defense created the Sexual Assault Prevention and Response Office (SAPRO; Turchik & Wilson, 2010). This office

began to work collaboratively with the Department of Veteran Affairs in a targeted effort to identify victims of MST. These efforts included implementation of a universal screening program, increased prevention efforts, standardization of training materials and treatment protocols, advanced medical care and counseling services to victims, and increased accountability of both the perpetrator and the military institution (Kimerling et al., 2007; Lofgreen, Kathryn, Dugan, & Karnik, 2017). In conjunction with universal screening of MST, VA facilities are also mandated to provide treatment for all honorably discharged veterans endorsing MST, regardless of disability rating or qualifying status for other VA-related healthcare and services (Baltrushes & Karnik, 2013; U. S. Department of Veteran Affairs, 2020b).

Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) are considered the gold standard of PTSD treatment and cited as appropriate for MST victims (Katz, 2016a; Zaleski, 2015). Both treatments were selected by the Department of Veteran Affairs for national standardization of care for veterans and 98% of VA medical centers now offer both (Steenkamp, Litz, Hoge, & Marmar, 2015). Numerous studies have demonstrated effectiveness in both individual and group formats for CPT (Holliday, Holder, & Surís, 2018; Mullen, Holliday, Morris, Raja, & Surís, 2014; Steenkamp et al., 2015; Zalta et al., 2018) as well as individually-based programs for PE (Nacasch et al., 2011; Steenkamp et al., 2015). Eye-movement desensitization and reprocessing therapy (EMDR) is receiving growing attention and application in treatment with military sexual trauma victims. Within the *VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress*, EMDR therapy has been cited as an efficacious treatment for treating patients with PTSD including MST (Management of Posttraumatic Stress Disorder Work Group, 2010). In a sample of civilian female rape victims,

EMDR and PE demonstrated comparable treatment efficacy with reductions in PTSD symptoms as compared to a waitlist group from baseline to posttreatment and 6-month follow-up (Rothbaum, Astin, & Marsteller, 2005). A stratified analysis of four studies demonstrated greater efficacy of EMDR for female victims of sexual assault (two studies) than for those who experienced other types of trauma, such as motor-vehicle accidents or combat-related trauma (Jonas et al., 2013). The American Psychological Association (2017) provides conditional support for the use of EMDR, noting that it may be appropriate for individuals but not supported as a strongest evidence-based treatment such as CPT, PE, cognitive behavioral therapy (CBT), and cognitive therapy (CT). While EMDR has received empirical support as an evidenced-based treatment in civilian based studies and select samples of veterans, it has not been fully integrated into the VA system and currently there is a lack of research literature specific to MST victims (Steenkamp et al., 2015).

There are conflicting reports regarding the effectiveness of CPT and PE between studies of males versus female MST victims. Tiet et al. (2015) reported comparable treatment response for MST in a sample of men and women following intensive VA PTSD programs comprising a combination of individual CPT, group CPT, prolonged exposure therapy, and EMDR. Comparing baseline to 4-month follow up assessment, male victims showed significant reduction in PTSD, depression, and violent symptoms, but increased alcohol and drug use and no change in reported quality of life. Female victims showed significant reductions in PTSD and depression symptoms as well as improved quality of life; but greater severity in drug use (Tiet et al., 2015). In contrast, Voelkel and colleagues (2015) reported gender differences in treatment outcomes whereby women demonstrated a sharper reduction of PTSD symptoms following a 7-week program of CPT as compared to men. Similarly, Khan et al. (2020) found

that female veterans demonstrated greater reductions in PTSD symptoms from CPT as compared to men. However, both men and women experienced similar benefits for PE. Gender role socialization may explain the differences in outcomes within CPT as it is a narrative treatment approach. For example, CPT may be more appropriately suited for women who demonstrate increased verbal and emotional expression of feelings. Gender role stress of male MTS survivors has also been associated with maintaining depressive symptoms related to perceptions of emotionality and inferiority (Juan et al., 2017). As avoidance behaviors in men decrease in PTSD-focused treatment, it is likely that the resulting increase in negative affect is felt as inconsistent with masculine gender norms and values, which may function to maintain distress (Khan et al., 2020).

Addressing the role of self-blame cognitions has been referenced as an essential component of effective treatment. Holliday and colleagues (2018) theorize that reductions in negative cognitions, particularly self-blame cognitions, during CPT precedes the reduction of PTSD symptoms. Within their study of 32 MST victims (23 women, 9 men), it was found that only changes in self-blame cognitions predicted a decrease in PTSD symptomology from baseline to 6-month follow-up (Holliday et al., 2018).

While CPT and PE have gained substantial empirical support and demonstrated positive treatment outcomes, attrition rates are noted as a significant problem (Cook et al., 2013). Critics have voiced concern that the approaches are not well suited for veterans having experienced multiple traumas or complex PTSD (Cook et al., 2013). Long-standing patterns of avoidance and shame may create difficulties for MST victims to tolerate high levels of distress, complete written homework assignments (e.g., trauma narrative), and maintain regular attendance (Zaleski, 2015). CPT and PE have also demonstrated high nonresponse rates, where many

patients continue to have PTSD symptoms (Steenkamp et al., 2015). Alternative treatments that integrate re-construction of cognitive schemas (e.g., self-blame) and emphasize interpersonal factors may be more effective for veterans presenting with complex PTSD presentations such as a history of childhood abuse in combination with MST (Elder et al., 2017; Bedard-Gilligan et al., 2016).

Mental health providers should be malleable to the unique needs of MST survivors when making treatment and assessment considerations (Culbreth, Newsome, & Whiting, 2015). The use of in-person interviewing in addition to routine screening may be effective in identifying victims of MST (Surís & Lind, 2008). Secrecy and isolation may follow MST, particularly for men, as they perceive making a report or seeking treatment as an indication of weakness and loss of masculinity (O'Brien et al., 2015). It may be prudent to direct male MST survivors towards individual therapy rather than group therapy to reduce the risk of dropout for those endorsing or seeking high degrees of confidentiality and secrecy. As the needs of a unique veteran are elucidated, group therapy may be deemed appropriate as it offers the opportunity for emotional support, reduced isolation, and improvement of interpersonal skills with emphasis on safe relationships (Katz, 2016a). It is discouraging and unfortunate that many female veterans cite reluctance to receive treatment at VA facilities due to harassment by other veterans in the waiting room and by providers while seeking care (Worthen, 2011). Other women who have previously served in the military refrain from seeking services at VA locations due to self-perceived lack of "Veteran woman" identity, in which "real veterans" are characterized as men (Street et al., 2009). As women tend to demonstrate more socialization as compared to men, the use of all-female MST treatment groups may be particularly useful for women that report discomfort in seeking treatment in male-dominated environments (Bell et al., 2014). Due to the unique characteristics

of men with MST, clinicians who treat this population may need specific guidance and training. It is suggested that additional instruction and preparation be offered to those who deal with males with MST (Morris et al., 2014).

Multicultural Competence

Mental health professionals are challenged to become effective in working with diverse clients, demonstrating understanding and cultural competence across varying social and cultural contexts (Constantine et al., 2008; National Association of Social Workers, 2015). Working with special populations requires the adoption of a culturally competent perspective with awareness of personal biases, stereotypes, and assumptions (Sue, Arrendondo & McDavis, 1992; Sue & Sue, 2012; Weiss & Coll, 2011). It has been acknowledged within the fields of psychology and counseling that it is unethical for mental health providers to work with clients of diverse backgrounds without appropriate training or competence (Sue, 1998; Sue et al., 1992). To work effectively with minority groups in counseling, multicultural competence and treatment adaptations may be required in order to build therapeutic relationships through knowing a person, developing trust, and demonstrating respect for the individual. It is also prudent for the counselor to understand and/or address racism, poverty, stereotypes, prejudices, race relations, oppression, and communication styles with diverse clients (Sue & Sue, 2012).

Sue, Arredondo, and McDavis (1992) called the profession of counseling psychology and related mental health fields to adopt a series of multicultural competencies and standards when working with diverse clients. The tripartite model of Multicultural Competence (Sue et al., 1982) outlines three dimensions of cultural competency including (a) beliefs and attitudes, (b) knowledge, and (c) skills. The first dimension of the model advocates that culturally competent counselors actively engage in self-reflection to gain awareness of behavior, values, biases,

preconceived notions, and personal limitations (Sue et al., 1992). The second dimension emphasizes that therapists obtain knowledge and understanding of their own worldview by which they operate, recognizing that people are a product of cultural conditioning, and this in turn may impact counseling with clients from diverse populations, particularly those of other racial and ethnic groups (Sue et al., 1992). Therapists are encouraged to gain specific knowledge of the cultural groups of whom their clients represent, understanding sociopolitical influences including the impact of historical trauma and the negative effects still present today. The third dimension of cultural competency consists of acquiring specific skills including appropriate, evidence-based treatments and techniques in working with diverse populations and minority groups (Sue et al., 1992). This model of cultural competence has served as a cornerstone by which the field of psychology, social work, and mental health practice have built graduate training programs and competency-based proficiency measures such as state and national exams and boards.

The goal of cultural competence is not comparable to other training in which one receives credit or confirmation of completion. As culture and race are subject to change through society, therapists must constantly be learning and adapting to meet the needs of others. The continued process of becoming culturally competent should be an ever-present goal for mental health professionals, as an assumption of having achieved cultural competence runs the risk of imposing unchecked biases on others (Bernal & Domenech Rodriguez, 2012).

Cultural competence is not simply an inquiry or discussion into client cultural differences. Additionally, it is pertinent that therapists refrain from “clinical anthropologist’s syndrome” in which the therapist feels excessive curiosity about multicultural clients’ ethnocultural backgrounds leading to extensive questioning that lack relevance to treatment that comes at the

expense of the client's emotional needs to educate the therapist (Comas-Diaz, 2012, p.144). It is critical to maintain awareness of cultural boundaries when working with a multicultural client as misinterpretations can result when one lacks awareness or knowledge of social-behavioral rules and project personal standards on others (Comas-Diaz, 2012). Similarly, therapists working with military populations are encouraged to develop a foundational base of knowledge, acquire awareness of personal beliefs and attitudes, and develop skills towards military cultural competence.

Military Culture

Military culture is unique compared to other cultures in that members actively choose to acculturate to the structure and norms of the military (Price, Stickley, & Prosek, 2015). There are specific components within military culture that separate it from the civilian world. The worldview that is developed in military culture is influenced by numerous factors, including the hierarchical structure of power and responsibility, emphasis on cohesion and loyalty, as well as the strong values ascribed to being a member of the military (Hall-Clark et al., 2019; Meyer, Writer, & Brim, 2016). "Each branch of the military upholds a set of core values, guidelines, norms and expectations for behavior that can influence service members' attitudes, beliefs, decisions, and behaviors" (Hall-Clark et al., 2019, p. 2).

Military structure and chain of command. The Department of Homeland Security supports the Coast Guard and the Department of Defense provides administration to the Department of the Navy (comprising the Navy and Marines), Department of the Air Force (comprising Air Force and Space Force), and the Department of the Army. The Army National Guard and Air National Guard are reserve components of their services and operate in part under state authority. The military is comprised of six military branches including the Army, Navy,

Marine Corps, Air Force, Space Force, and Coast Guard. While the Coast Guard is considered a military service, it is not classified as a military branch as its primary purpose is to aid in maritime duties within U.S. waters rather than a war fighting function. Each division of the military comprises its own personal identity and specific operations while functioning to facilitate and support one another as a whole system.

A hierarchical structure is practiced throughout each branch of the military including chain of command. Chain of command is a salient feature of the military that clearly defines the roles, responsibilities, and expected behaviors of all its members (Center for Deployment Psychology, 2020). This feature of military culture serves to establish clear boundaries, stable structure, and controlled decision making (Price et al., 2015). Chain of command is highly structured defining an individual's social and economic status as well as determining where one lives and who may speak with whom and when (Center for Deployment Psychology, 2020). Each military branch has its own ranking system, and all military personnel are assigned a rank falling into three categories including enlisted, non-commissioned officers, and commissioned officers. Each rank is assigned specific roles and responsibilities which are strictly adhered to. Within the Uniform Code of Military Justice (UCMJ), fraternization is prohibited between those of different rank, particularly between superior and subordinate personnel. The hierarchical structure serves to maintain order and discipline. The military emphasizes the importance of higher-ranking personnel to train, encourage, and develop those individuals subordinate to them for the purpose of shaping adaptive leaders, sustainment, and mission readiness (U. S. Department of the Army, 2017).

Values and principles. Military culture encompasses a unique worldview that emphasizes values, beliefs, and principles that guide behavior in joint commitment towards

completion of the military mission (Price et al., 2015). Although each military branch has its own unique set of core values, they share themes related to honor, courage, respect, commitment, and selfless service (Redmond et al., 2015). Military values are inspirational and aspirational as they promote ideals that bolster endurance, commitment, and unity within the community. The military relies on group cohesion and strong alliances, often describing one another as a family or brothers, building intense bonds of trust as they are taught to lay down their lives for one another (Hunter, 2018). Archetypes such as the "Stoic Warrior" or the "Warrior Identity" are established as principles which service members should strive for. The military ethos across the branches emphasizes selflessness, loyalty, stoicism, moral code, and excellence (Center for Deployment Psychology, 2020). The Army Warrior Ethos specifically states, "I will always place the mission first, I will never accept defeat, I will never quit, and I will never leave a fallen comrade" (U. S. Army, 2011). As warriors, service members are challenged to restrict emotional expression, push through pain both physical and mental, and exist in a constant state of combat readiness even in times of peace (Weiss & Coll, 2011).

The military ethos is a powerfully motivating principle that encourages service members to be strong and resilient; however, it has the risk of becoming a vulnerability to those when beliefs about one's warrior identity serves as a barrier to support and resources (Westphal & Convoy, 2015). Within the context of mental health treatment, the warrior identity and stoicism may afford physical and mental toughness to address enduring symptoms. Conversely, the principles may negatively impact a service member due to delay in help-seeking and minimization of symptoms until an advanced degree of distress, pain, or disease has developed (Center for Deployment Psychology, 2020). A significant part of military training is learning emotional control in which negative emotions are suppressed (Hoyt et al., 2011). It is of no

surprise that mental health is stigmatized, as many service members equate seeking helping with weakness, and fear a mental health diagnosis as evidence for being "broken" (Meyer et al., 2016).

Social norms. The military is unique in comparison to other cultures as it requires its members to form a strong, collective, and cohesive culture (Redmond et al., 2015). Unit cohesion and collectivism is the basis for most military experiences beginning with basic training or boot camp and continuing on into stateside military communities and deployments. As the military must maintain a constant state of readiness, frequent moves and transitions are normal within military life (Exum et al., 2011). Upon receipt of written orders, service members pack their bags and transition into a new environment, often leaving established friendships and units to begin again at another installation. Deployments require leave from family members and loved ones into possible lines of danger, which necessitates service members to draw support from one another in greater degrees during long intervals of time away from their at-home support system. With high interdependence, the pressure to conform and align with the majority or in-group may create individual strain on those that feel a loss of personal control when presented with unwanted experiences such as sexual harassment or assault (Yamada et al., 2013). Furthermore, when victimization occurs from a fellow service member or multiple service members, the betrayal is exceedingly damaging and is exacerbated when the victim is required to remain in the hostile and unsafe environment with a perpetrator (Bell & Reardon, 2011).

The military is a masculine world and military culture is therefore a masculine culture (Zaleski, 2015). The Warrior Identity exemplifies traditionally masculine characteristics of strength, stoicism, and power to persevere and continue in battle. In turn, identities perceived in

contrast to masculine characteristics such as femininity, emotionality, and weakness are opposed (Bell et al., 2014; Crowley & Sandoff, 2017; Zaleski, 2015).

Within the military, women are faced with the challenge of navigating in a strict, hierarchical, masculine world. Women who ascribe to feminine gender roles or appear hyperfeminine may experience harassment, ridicule, and personal violations (Crowley & Sandoff, 2017; Strong, Crowe, & Lawson, 2018). In contrast, women who embrace masculine traits and suppress expression of feminine traits may be called lesbian or labeled as “butch” (Bell et al., 2014). One study of 12 female U.S. Army combat veterans reported the ways in which they navigated their female identity in “the most masculine space” of the military (Crowley & Sandoff, 2017). Participants shared experiences of identifying as tomboys, denigrating femininity, ignoring harassment, or endorsing a high degree of tolerance to objectification and sexualized discussion. Nonetheless, the women also felt as outsiders constantly trying to “prove physically and mentally that they were worthy of being in the boys’ club of the military” (Crowley & Sandoff, 2017; p. 233). It is argued that aggressive hypermasculinity in the military creates a “rape culture,” where the devaluation of women and their feminine identity predisposes them to higher risk of rejection, punishment, and sexual violence (Zaleski, 2015).

Military culture has a powerful influence on help seeking behaviors, the development of therapeutic relationships, adherence to treatment, and clinical outcomes in psychotherapy (Convoy & Westphal, 2013). Service members and veterans identify in varying degrees with military culture, highlighting the importance of therapists to appropriately identify and understand the worldview of their clients. Military cultural competence serves to more clearly understand the worldview presented with appropriate evidence-based treatment.

Military Cultural Competence

It is important for therapists to recognize that military culture has a strong impact in framing a client's worldview that may influence the course of treatment. For example, ordinarily perceived adaptive military values, such as personal responsibility and emotional fortitude can interfere with recovery from trauma (Hall-Clark et al., 2019). As the military emphasizes strong emotional control, service members experiencing difficulties in mental health may be perceived as weak (Convoy & Westphal, 2013). The cultural values in the military may increase stigma surrounding mental health, creating greater barriers for service members as compared to individuals in civilian populations (Hall, Garland, Charlton, & Johnson, 2018). This worldview may also influence the connection and disconnection of active-duty services members and veterans in their relationships with others, including civilian therapists, who may hold differing perceptions as a result of stereotypes and misunderstanding military culture (Meyer, Writer, & Brim, 2016). Contextualizing client symptoms with consideration of military culture includes awareness and understanding of the military's indoctrination. This includes military principles, values, and social norms as well as additional stressors influencing client distress such as deployments to combat zones, war-related trauma, and the unique impact of MST (Ross, Ravindranath, Clay, & Lypson, 2015). Understanding military culture is further complicated when a client presents with potentially multiple, intersecting identities including race, ethnicity, gender identity, sexual orientation, and religion. This necessitates careful consideration of conceptualization, treatment planning, delivery of treatment interventions, as attention to such factors ultimately serves to improve client outcomes (Ross et al., 2015).

Establishing that military cultural competence is important, counselors must obtain the appropriate training to aid service members presenting to mental health treatment. Considering

military cultural competence within the context of working with victims of MST may be even more critical. A victim's military experience may shape the unique aspects of trauma focused treatment that differs from that with civilian victims (Hall-Clark et al., 2019; Zwiebach et al., 2019). A RAND report, *Ready to Serve* (Tanielian et al., 2014) assessed the military cultural competence within a sample of mental health care providers currently working in a DoD or VA setting (n = 61), being affiliated with the TRICARE network (n = 135), or civilian-based locations without military affiliation (n = 32). While most within the sample endorsed the importance of military culture in diagnosis and treatment (75%), a subset of the therapists (18%) indicated that military status made no difference in diagnosis and treatment as compared to civilian patients. Of the total therapist provider sample, only 19% endorsed having high levels of military cultural competency, with those working in a military or VA setting having the highest proportion (70%), in comparison to TRICARE network providers (24%), and civilian therapists (8%). Overall assessment of provider readiness for veteran-friendly, quality care found that only 13% of participants met readiness criteria with endorsement of military cultural competence and training or use of evidence-based care for PTSD or major depressive disorder (Tanielian et al., 2014).

Military affiliated therapists. Those who work within the military mental healthcare system, Department of Defense, and the VA are predisposed to training specific to building military cultural competence. Training emphasizes knowledge of military culture, awareness of issues commonly affecting service members and veterans, self-reflection upon attitudes and biases related to the military and personnel, and skills and training specific to working with members of the military population and their families (U. S. Department of Veterans Affairs, 2020a). In fact, the Department of Veteran Affairs (2020b) requires mandatory training for all

mental health providers and primary care providers who may work with victims of MST. However, not all victims of MST choose to seek services from military-affiliated therapists or treatment facilities (Kimerling et al., 2007). Due to feelings of institutional betrayal following MST, victims have been found to avoid military affiliated providers, purposefully seeking treatment from civilian providers (Holliday & Monteith, 2019). This increases the importance of civilian therapists to prepare for working with this unique and vulnerable population.

Civilian therapists. Mental health professionals that provide treatment to service members, veterans, and their families need to demonstrate military-related competencies. However, graduate training programs seldom incorporate a focus on military populations, which limits the opportunities for developing mental health professionals to gain early education, training, and experience working with military clients (Leppma et al., 2016). In a review of therapists working with veterans and families, almost half (48%) reported that their graduate training program did not prepare them or only minimally prepared them for working within this population. Of the 29% of participants that endorsed confidence in their preparation, most noted "on the job" training, personal reading, or continuing education as compared to graduate research or course work (Leppma et al., 2016). All mental health professionals working at VA facilities and affiliated programs are required to complete training addressing military cultural competence. Civilian-based counseling providers are under no similar professional board or licensing requirements to obtain preparation for working with military service members, veterans, or their families (Carter & Watson, 2018). Additionally, many civilian therapists do not regularly assess for military status, often failing to determine identifying information with potentially significant impact to treatment (Koblinsky, Leslie, & Cook, 2014). It is concerning that civilian mental health providers working with MST victims often lack clinical competencies

specific to working with military populations. This may include an absence of knowledge related to military sexual trauma and how it differs from civilian experiences of sexual violence, which is all the more influenced by a lack of awareness pertaining to specialized community resources (Bell et al., 2014; Turchik & Edwards, 2012). A web-based survey of mental health and primary care providers found that only 44% of participants screened for military service, and only 29% reported knowledge of how to refer veterans to the VA (Kilpatrick, Best, Smith, Kudler, & Cornelison-Grant, 2011).

Therapists with low levels of military cultural competence may demonstrate less comfort and confidence in working with military service members and veterans. This effect may be even more pronounced when working with victims of sexual assault. Of the limited existing literature of therapist perceptions working with victims of MST, Shepperson (2018) conducted a qualitative study exploring the experiences of 13 civilian therapists providing managed care for survivors of military sexual trauma. The themes found from interviews involved the importance of (a) learning military culture, (b) building trust, (c) navigating issues with military jargon, and (d) understanding the client's denial or refusal of treatment (Shepperson, 2018). It is telling that the theme reported most, suggesting the degree of importance by therapist participants, was related to learning military culture. Civilian therapists within the study recognized their lack of military knowledge related to military culture, with one participant reporting that an MST victim had "grilled" him by questioning his ability to help without having served in the military himself. Some civilian therapists in the study cited increased comfort working with MST victims as they gained experience and continued learning about military culture. However, not all therapists working with military service members demonstrated an active approach to developing military cultural competence, as one participant remarked on not "catching on" to a phrase of military

jargon (“down range” = overseas or deployed) until a year after having initially heard it, despite the relatively high frequency of use by service member clients.

One therapist cited initial biases and stereotypes toward military service members stating, “Military stigma. I thought all military personnel were hard core and too shell shocked to provide any information nor seek help” (Shepperson, 2018; p. 69). Similarly, another participant stated, “military clients are extreme cases, I mean any one that comes with baggage that has to be taken apart issue by issue. No case is easy, most sessions are spent creating a vocabulary of understanding often resulting and [sic] me asking more questions for clarity. I often have to extend sessions or block two hours to establish a common ground” (Shepperson, 2018; p. 70). It is interesting that while the participants noted the importance of gaining military cultural competence, the select references within the study also convey a degree of discomfort, bias, and perhaps frustration with certain aspects of military culture that impact the course of treatment in counseling. Therapists that hold prejudiced stereotypes about service members or hold antiwar beliefs may directly or indirectly impose their own values onto military clients, which results in risk of damaging the working alliance and treatment outcomes (Coll et al., 2012).

However, Shepperson (2018) also highlights positive perceptions of MST clients where one civilian clinician reported excitement to meet and work with service members as it presented a challenge and opportunity to build a strong working alliance through rapport, trust, reflective listening, and empathy. Another participant compared their perceived effectiveness to military-affiliated therapists stating, “I think I am more effective than my military counterparts. I think this because my clients don’t view me as a threat or a superior (Shepperson, 2018; p. 74).” In the absence of military cultural competence, civilian therapists may find themselves relying more heavily on strong bonds of working alliance with victims of MST.

Working Alliance

The existing psychological literature addressing military sexual trauma treatment outcomes predominantly focus on individual differences of clients or treatment modality (Allard et al., 2011) with little review of therapist perceptions working with MST victims. However, therapist factors may serve as core ingredients for therapeutic change, such as working alliance having demonstrated clear implications for treatment efficacy (Wampold, 2015). Bordin (1979) developed the concept of working alliance, outlining three dimensions including, (a) an affective bond between the client and therapist, (b) a mutual agreement on treatment goals, and (c) a mutual agreement on treatment tasks to achieve those goals. Working alliance has been identified as a core component of common factors in therapy and serves as one of the strongest predictors of treatment success (Norcross, 2011). Likewise, poor therapeutic alliance is strongly associated with dropout (Sharf, Primavera, & Diener, 2010). A recent meta-analysis across 300 studies evaluated the working alliance as a predictor for posttreatment outcomes. The authors determined that working alliance within psychotherapy was a moderately strong predictor of treatment outcomes with an overall effect size of $d = .579$ (Flückiger, Del Re, Wampold, & Horvath, 2018). Similarly, another meta-analysis review of 11 studies explored the relationship between therapeutic alliance and dropout from psychotherapy, finding a moderately strong relationship with an effect size of $d = .55$ with poorer working alliance predicting dropout (Sharf et al., 2010).

Focus on the working alliance within treatment may be essential when working with survivors of MST. Working alliance may serve to help a MST victim feel supported and believed, which promotes positive treatment outcomes (Zaleksi, 2015). The impact of MST and the secondary experience of institutional betrayal may affect the working alliance with veterans. For

example, therapists may perceive that it takes longer to establish a working alliance due to difficulties establishing trust (Bell & Reardon, 2011). Clinical recommendations for therapists include direct exploration with a client of institutional betrayal and the direct impact it may have on the working alliance in treatment (Monteith et a., 2016). Zaleski (2015) shares a compelling quote from Hembree et al. (2003) that warrants reiteration and reflection regarding the importance of developing an integration of skills, knowledge-based competencies, working alliance, and the art of psychotherapy when working with MST victims:

> However, the guidance available to therapists concerning how to develop and sustain a working alliance, how to titrate the intensity of affect expression within the therapist/patient dyad, and how to ensure that patients actually learn skills for regulating distressing affects and resolving intrusive trauma memories while employing PE, is sparse and not grounded in either theory or research. (Hembree et al., 2003, p. 27)

Therapist Hope

Hope and the therapeutic relationship have also been assessed with non-MST samples (Clearly & Dowling, 2009; Coppock et al., 2010; O'Hara & O'Hara, 2012). Hope has been found to play a role in the therapeutic alliance as demonstrated with a qualitative study of 153 mental health professionals (Cleary & Dowling, 2009). Themes gathered from descriptive surveys included the importance of collaboration between clients and mental health professionals as well as the pivotal role of hope in the therapeutic relationship to bolster positive treatment outcomes (Cleary & Dowling, 2009). Therapists' hope in their clients has also been demonstrated to significantly influence client outcomes, even above reported client hope (Coppock, Owen, Zagarskas, & Schmidt, 2010). O'Hara and O'Hara (2012) describe the therapeutic relationship as central in the development of therapist hope and identified a variety of hope-focused strategies

that may aid the course of therapy. Some therapists perceived client's previous experiences of trauma as a "blockage" or barrier in establishing hope in the client (O'Hara & O'Hara, 2012).

Operationalization and measurement of therapist hope is a recent development in the research of psychotherapy as influenced by the work of Bartholomew et al. (2019; 2020). Therapist hope is a conceptualization of hope specific to the relationship by which a clinician in psychotherapy experiences hope in their client to achieve positive treatment outcomes (Bartholomew et al., 2019). Snyder's Hope Theory (Snyder, 2002) provides foundation for the extension of hope as a unique construct held by therapists. In alignment with Hope Theory, Bartholomew similarly applies the integrated model of three components of hope: goals, agency, and pathways. Operationalized within therapist hope, the three dimensions include (a) the consolidation of identified goals with a client, (b) belief and agency to help a client achieve change, and (c) future-oriented thinking or pathways toward change that aids a client (Bartholomew et al., 2019).

Hope in therapy is not a unidirectional process flowing strictly from the client to the therapist, but a dynamic, active, bidirectional process that builds working alliance. A phenomenological study by Bartholomew and colleagues (2019) explored what it means for mental health providers to have hope in their clients. They found themes including (a) a sense of holding and possibility, (b) fundamental, dynamic, and reflective practice, (c) client influence on hope which can be positive or negative, and (d) perceived connection by hope. Therapists are described as experiencing a sense of responsibility to hold hope for clients in therapy, often conveying hope to the client where there appears to be little in the context of expected positive change (Bartholomew et al., 2019). However, hope is not a constant state, but is malleable in response to client experiences. Within the study, psychotherapists described self-reflective

practices to ground themselves, with awareness of cognitive and physical sensations of anticipation on behalf of the client which over time may be energizing for therapy (Bartholomew et al., 2019). Client factors including positive willingness, attitude, and behaviors were also noted to positively influence the development of therapist hope while a client's presentation of depressed symptoms was noted to decrease felt hope in a client. Therapist hope is described by the authors as relational in nature and inextricably linked to therapeutic alliance (Bartholomew et al., 2019; Bartholomew, Gundel, & Scheel, 2017). While no outcome data was provided, it was strongly suggested that therapists' hope in their clients influences change in psychotherapy. At present there is a lack of research pertaining to therapist hope in outcome research in civilian, military, and MST victim samples. The present study aims to further the study of therapist hope within perceived psychotherapeutic relationships with military sexual trauma victims.

Gender Bias

Gender bias is a pernicious perception of disproportionate worth or ability on the basis of gender. The presence of gender bias is unfortunately commonplace in U.S. society. Gender bias is also increasingly salient in all-male environments such as the military. Men and women often evaluate their worth through the lens of gender which is shaped by social norms and influence external and internal pressures to fulfill stereotyped roles of masculinity and femininity (Bell et al., 2014). Similarly, systemic gender discrimination influencing the types of activities that men and women experience shapes self-perceptions of "what it means to be a man or a woman" (Bell et al., 2014). Gender bias is the shaping force by which individuals come to accept and believe in rape myths. Those that endorse acceptance of rape myths often adhere to gender biased attitudes as well as the idea that the world is just, and victims therefore play a role of responsibility in

their own victimization (Vonderhaar & Carmody, 2015). Gender bias, acceptance of rape myths, and the acting out of such beliefs through sexual violence are intertwined.

Gender Bias of Therapists Towards Client Victims of Sexual Trauma. In the context of psychotherapy, it is important to consider the extent to which attitudes and beliefs of therapists impede the work of efficacious treatment. As mental health providers are also shaped by the social norms, biases, and stereotypes held by society at large, they are not exempt from endorsing gender bias, gender role stereotypes, and rape myths (Bell et al., 2014; Turchik & Edwards, 2012). Therefore, it is important to evaluate how gender bias may impact therapist expectations working with victims of military sexual trauma.

At present, there is an absence of research evaluating gender bias that therapists may engage in while working with victims of military sexual trauma. Therefore, research literature evaluating gender bias among therapists is drawn from treatment with victims of sexual violence from civilian samples. In review of existing literature, there are inconsistent findings regarding observed therapists gender bias working with victims of sexual trauma.

McKay (2001) evaluated the attitudes and acceptance of rape myths in a study of 199 doctoral level therapists. Results indicated that while a majority of therapists would “blame what happened on the man” in a rape vignette, 36% of participants conveyed skepticism of the rape event as “they would try to figure out if a rape was committed.” It is of note that the vignette was vetted and described as “very typical and believable of acquaintance rape” by experienced therapists in the pilot study (McKay, 2001). This finding suggests that therapists that engage in such inquiries may imply blame on the victim for the event of rape. A final note of the study was that therapist gender did not predict the attitudes of rape and treatment strategies adopted in the vignette of a rape victim.

In a qualitative study of civilian male survivors receiving treatment for sexual trauma, it was found that 16 of 32 clinicians feared being perceived as an abuser because of the client's transference (Yarrow & Churchill, 2009). Four therapists experienced anxiety for the client's embarrassment, two clinicians feared eliciting client anger, and another two therapists were uncertain if they wanted to hear about the abuse (Yarrow & Churchill, 2009). While Yarrow and Churchill (2009) used a small sample of mental health professionals, they still shed light on the importance of therapist perceptions as it may influence treatment outcomes in working with male sexual trauma victims.

Another study, not exclusively evaluating clients of sexual trauma has also noted therapist expectations differing across client gender. In a qualitative study by Fisher (1989) evaluating therapist-client dyads, it was found that patient gender was not associated with causal explanations for patients' experience at the onset of psychotherapy. However, further into treatment with 5-6 completed psychotherapy sessions, therapists began to report gendered differences in explaining their client's difficulties. Female therapists were reported to perceive themselves as responsible for difficulties presenting in therapy across both male and female clients. In contrast, male therapists were reported to attribute difficulties to the client (Fisher, 1989). There was also a notable interaction effect within the study. Across dyads of male and female therapists and clients, difficulties occurring in treatment were more often attributed to women, and this perspective was maintained across sessions (Fisher, 1989). While therapists do not perceive gender differences at the start of treatment, gender-based differences may occur later in mental health treatment.

Gender Bias- Military versus Civilian Providers. Bell and Reardon (2011) noted that therapists may perceive that it takes longer to establish a working alliance with victims of MST

due to difficulties establishing trust (Bell & Reardon, 2011). But the differentiation between therapist expectations between civilian and military-affiliated therapists are relatively unknown. Currently, there is no research evaluating the potential gender bias between military and civilian mental health providers. This study aims to address this gap in the research literature and promote future follow-up investigation.

Gender Bias- Multicultural Competence. Multicultural competence has been argued as a central tenet to work effectively with diverse clients and to provide culturally informed mental health practices. Multicultural competence also includes understanding and awareness of gender differences in mental health treatment. Graduate school and clinical training also emphasize the importance of addressing potential gender bias in treatment and how to work effectively across gender differences.

In a meta-analysis of 18 studies, client ratings of therapist multicultural competence and therapeutic process and outcome measures did not find any effect size variability due to client gender (Tao, Owen, Pace, & Imel, 2015). This is consistent with psychotherapy research that reports that psychotherapy outcomes do not vary based on client gender (Bowman, Scogin, Floyd, & McKendree-Smith, 2001; Griner & Smith, 2006). However, there is further research to suggest that gender-based differences may occur in mental health treatment as influenced by therapist factors. For example, in a study evaluating 31 psychotherapists providing care for 93 male and 229 female clients, gender was not related to psychotherapy outcomes (Owen, Wong, & Rodolfa, 2009). But a subset within the study of psychotherapists were found to have gender competence which was related to some therapists being better at treating men while other therapists were better at treating women. This suggests that gender differences may exist in

interaction with other therapist factors such as gender competence or specific population-based competence.

Gender Bias- Military Multicultural Competence. Competence working with special populations is a positive predictor of client outcomes in psychotherapy. Therefore, it is important to consider how working with victims of military sexual trauma may warrant understanding of the intersecting influences of military cultural competence and gender. The military is recognized as a highly masculine culture (Zaleski, 2015). Identities perceived as contradictory to masculine gender norms such as femininity may be perceived as weakness (Bell et al., 2014; Crowley & Sandoff, 2017; Zaleski, 2015). It has also been recognized that women in the military are faced with unique challenges navigating feminine gender roles within the highly masculine military environment (Crowley & Sandoff, 2017; Strong et al., 2018). Further, aggressive hypermasculine attitudes in the military may promote a "rape culture," where women are at higher risk of sexual violence (Zaleski, 2015).

There is currently no research evaluating the intersection of gender bias and multicultural competence of therapists working with victims of military sexual trauma. Recognizing that gender is a salient factor within military culture, it may be beneficial to gain increased understanding of how therapists may demonstrate gender differences working with victims of military sexual trauma. This study aims to address this gap within research literature.

Gender Bias- Working Alliance and Therapist Hope for Clients. Therapists are trained to develop strong working alliances with clients as it is understood that working alliance is a core component of common factors and serves as one of the strongest predictors of treatment success (Norcross, 2011). Similarly, therapists endorsing high working alliance are expected to report high therapist hope due to the recognized relational nature between the outcome measures

(Bartholomew et al., 2019; Bartholomew et al., 2017). Gender may potentially influence working alliance and therapist hope for clients. In a study of 120 female and 41 male therapists, gender alone was not found to be a statistically significant predictor in working alliance (Anderson & Levitt, 2015). But gender self-definition and gender self-acceptance accounted for statistically significant amounts of variance in working alliance with psychotherapy clients. This indicates that while therapist gender alone may not be a significant predictor of working alliance, other factors associated with therapist gender may suggest a possible interaction effect that may influence treatment outcomes. There is currently no research evaluating the intersection of gender bias and therapist expectations of working alliance and therapist hope for client working with victims of military sexual trauma. This study aims to address this gap within research literature.

Summary

There appears to be a substantial gap in the psychological research literature as therapist gender, multicultural competence, military cultural competence, working alliance, and therapist hope have been considered independently, but not in combination in the context of working with male and female victims of military sexual trauma. It is prudent that therapists' perceptions of male and female victims of military sexual trauma are studied to provide guidance and implications for practice development. While existing literature reports discrepancies of military cultural competence in samples comparing civilian and military-affiliated therapists, it is unknown how multicultural competence or military cultural competence measured together may relate to perceived working alliance and therapist hope in male and female MST clients. While some therapists may have familiarity with military populations and military culture due to professional experience, past or present military service, or DOD and VA affiliation, the resulting

perceptions towards male and female clients experiencing military sexual trauma is unknown. It is surprising that despite the abundance of research literature focused on evidenced-based treatments and individual client factors affecting the treatment outcomes of military sexual trauma victims, there is scant exploration or review of therapist factors working with this unique and vulnerable population. Consequently, this study serves to address the following research questions and hypotheses:

Research Questions

1. Is there a relationship between therapist type (military vs. civilian), client gender, and therapist expectations of working alliance and therapist hope with victims of military sexual trauma?
2. Is there a relationship between therapist gender and client gender, with therapist expectations of working alliance and therapist hope with victims of military sexual trauma?
3. What is the nature of the relationship between the variables of therapist gender, therapist type (military vs. civilian), multicultural competence, military cultural competence, client gender, and the variables of therapist expectations of working alliance and therapist hope with victims of military sexual trauma?

Hypotheses

1. It is hypothesized that that there will be significant effects associated with therapist type (military vs. civilian) and client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma.
2. It is hypothesized that that there will be significant effects associated with therapist gender, client gender, and therapist expectations of working alliance and therapist hope with victims of military sexual trauma.

3a. It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for Hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute significant unique variance to predicting the criterion variable of therapist expectations of the working alliance.

3b. It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for Hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute significant unique variance to predicting the criterion variable of therapist hope with victims of military sexual trauma.

CHAPTER III

METHOD

Participants

The participants comprising this study included therapists working within the U.S. and currently providing psychotherapy. Participants included a total of 108 licensed clinical mental health providers. Their ages ranged from 27-80 years old (M = 45.64, SD = 13.39). Female identified therapists represented 73% of the sample and 27% were male identified. This is consistent with previous response rates in psychological research via online recruitment where samples are characterized by predominantly White American, females (Casler, Bickel, & Hackett, 2013). The sample was 78.7% Caucasian/White, 7.4% African American/Black, 4.6% Biracial, 2.8% Asian, .0.90% Native Hawaiian/Other Pacific Islander, and 5.6% other race/ethnicity. Of the total participant sample, 7.4% also identified as Hispanic/Latino/or Spanish identity. Participants represented 6 different degree types including 60.2% doctorate in clinical psychology, 21.3% doctorate in counseling psychology, 11.1% in master's in clinical psychology, 5.6% master's in social work, 0.90% master's in counseling psychology, and 0.90% as other degree type. License types included 70.4% licensed psychologists, 18.5% licensed professional counselors, 6.5% licensed marriage and family therapists, and 4.6% licensed social workers. For inclusion in the study, participants were required to be adults at least 18 years or older and having obtained a master's or doctoral level degree in a mental health related field, holding a license in mental health-related field (e.g., licensed psychologist, licensed social worker, licensed

professional counselor), and currently providing psychotherapy or counseling. Therapists were designated a military-affiliation status within this study if they (a) currently or previously served in military service, (b) currently or previously served as a military psychologist or therapist, (c) currently or previously worked as a Department of Defense (DOD) psychologist or therapist, (d) currently or previously worked as a psychologist or therapist for the Department of Veteran Affairs, or (e) self-identify as currently or having previously worked largely with military populations (at least 50% of caseload). Therapists that do not meet the criteria for a military-affiliated status were designated as civilian therapists.

The final sample size was 108 participants, after management of outliers and missing data. This sample size is sufficient for the planned analyses within this study. Power analysis for a 2 x 2 MANOVA with two independent variables and two dependent variables was conducted in G*Power to determine a sufficient sample size of 98 participants using an alpha of .05, a power of .80, and an effect size of $f^2 = .0625$ (Faul, Erdfelder, Buchner, & Lang, 2013).

Research Design

An analogue quasi experimental design was used in this study. The study comprised five independent variables including therapist participant gender, military-status (military versus civilian) of the therapist participant, multicultural competence (MCKAS-R; Lu, 2017), military cultural competence (AMCC; Meyer et al., 2015), and MST client gender. Gender of an MST client was an independent analogue experimental variable manipulated to create two conditions of exposure through a vignette. The client being either male or female and having experienced sexual harassment and assault while serving within the U.S. military. The dependent variables were therapists' expectations as measured by the Working Alliance Inventory (Hatcher &

Gillaspy, 2006) and therapist hope as measured by the Therapist Hope for Clients Scale (Bartholomew et al., 2020).

Materials

A total of two vignettes were created with each adhering to each gender condition. The vignettes were written to create a realistic scenario. Vignettes were created emphasizing the subjective experience of being personally immersed in the situation with the use of second-person pronouns directed at the participant from the vignette client (Aguinis & Bradley, 2014; Brauer et al., 2009). Each vignette included descriptions of a military veteran (male or female) arriving for counseling and reporting an experience of military sexual trauma (harassment and assault) while serving 5 years ago. The clinical screen items for military sexual trauma used by the Department of Veteran Affairs (Wilson, 2018) were be used to confirm in both vignette stories of having experienced (a) uninvited or unwanted sexual attention including touching, cornering, pressure for sexual favors, and inappropriate verbal remarks and (b) having experienced threat of force and force to have sex against their will. Descriptions of the client included sadness, crying, a request for help, a statement conveying trust in the therapist, and positive indicators of client motivation to allow the therapist details by which to evaluate working alliance with the client. The vignettes differed only in the identification of gender. Three expert raters familiar with military sexual trauma, having extensive knowledge of MST, and experience working with victims of MST reviewed the vignettes. The feedback received was used to edit the vignettes. The edited vignettes were reviewed by the expert raters until an agreement rating of 95% was achieved. Expert ratings involved consensus that the vignettes met an appropriate degree of realism, equivalence, and clinical appropriateness. Please see Appendix B for a copy of clinical vignettes used within this study.

Measures

Assessment of Military Cultural Competence

The Assessment of Military Cultural Competence (AMCC) is a 36-item measure that comprises three subscales assessing 1) culturally competent skills, 2) attitudes towards the military, and 3) military cultural knowledge (Meyer et al., 2015). The subscales of culturally competent skills and attitudes toward the military each comprise eight items. Each item of the cultural competent skills subscale is scored on a 5-point Likert scale ranging from 1 (*never*) to 5 (*always*) and the attitudes towards the military subscale is scored on a Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The third subscale of the AMCC comprises 20 multiple-choice questions with four possible options and one correct answer each, totaling a possible 20 points. The subscale of military knowledge was developed through expert panel and review by faculty from the San Antonio Uniformed Services Health Education Consortium (SAUSHEC), Uniformed Services University of the Health Sciences (USUHS), University of Texas Health Science Center at San Antonio (UTHSCSA) psychiatry, and Veteran Administration Medical Center psychiatrists. Pilot testing was conducted on a small cohort of civilian and military residents (n= 34) and discrimination indices were reported to improve the quality of each question (Meyer et al., 2015). The AMCC has a possible range of total scale scores between 16 and 100. Participants obtaining higher total scores of the AMCC represent having higher competence in understanding the military culture and environment that affects members of the US Armed Forces. The internal reliability of the AMCC within this study was $\alpha = .74$.

Multicultural Counseling Knowledge and Awareness Scale- Revised

The Multicultural Counseling Knowledge and Awareness Scale- Revised (MCKAS-R; Lu, 2017) is a 28-item self-report measure of perceived multicultural counseling knowledge and awareness. Each item of the MCKAS-R is scored on a 7-point Likert scale ranging from 1 (*not at all true*) to 7 (*totally true*) with select items being reversed scored due to negative wording. Possible total scale scores range from 7 to 196, with greater total scores indicating greater multicultural competence. The original measure, the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996), was framed in relation to the Multicultural Counseling Model established by Sue et al. (1982) comprising the three dimensions of attitudes and beliefs, knowledge, and skills within the field of psychology and mental health counseling. The full MCKAS-R scale comprises items from all three dimensions of Sue et al.'s (1982) multicultural competence conceptualization but obtains only two subscales including knowledge and awareness due to attitude and belief items corresponding to the knowledge scale by factor analysis (Lu, 2017). The Knowledge subscale (17 items) assesses general knowledge and skills related to multicultural counseling, which are positively worded resulting in higher scores representing more knowledge. The Awareness subscale (11 items) measures subtle Eurocentric worldview bias that may be held by the therapist of the counseling relationship and treatment goals (Ponterotto, 2002). Nine of the 11 items within the Awareness subscale are negatively worded, indicating lower scores means more awareness, and require reverse scoring. Item responses for both subscales are summed to create a total score where higher total scores of the MCKAS-R represent therapist self-perceptions of higher multicultural competence.

The MCKAS-R is refined from its original version, the Multicultural Counseling Awareness Scale (MCAS; Ponterotto, 2002). The revision and re-evaluation of the MCKAS-R

scale was intended to improve construct validity which resulted in the deletion of four items (Lu, 2017). Psychometric properties of the MCKAS-R indicated coefficient alphas for the total scale and subscales Knowledge and Awareness as .90, .91, and .86, respectively, for a sample of mental health professionals spanning four professional role categories from master's-level counseling students to counselor educators (Lu, 2017). Correlation between the two subscales was .33.

In refining the scale, Lu (2017) confirmed three items within the Knowledge subscale were consistent with Sue and colleagues (1982) description of beliefs and attitudes. Inter-rater agreement of three raters provided a mean Cohen's kappa of .74 which indicated overall agreement and retainment of the items within the measure but exclusion from follow-up factor analyses. The remaining 29 items underwent an exploratory factor analysis that indicated a 2-factor structure consistent with the past measure version. Principal factor analyses with Promax rotation, confirmed a two-factor model explaining 44% of the variance (Lu, 2017). The continued presence of two factors confirmed the two domain/subtest structures of Knowledge and Awareness in the pre-existing MCKAS scale. The MCKAS-R has been refined from its initial version, the Multicultural Counseling Awareness Scale (MCAS; Ponterotto et al., 1996), which demonstrated good internal consistency, test-retest reliability, convergent validity, and criterion validity with other scales (Ponterotto et al., 2002). The internal reliability of the MCKAS-R within this study was $\alpha = .82$

Working Alliance Inventory- Short Form Revised- Therapist

The Working Alliance Inventory-Short Form Revised- Therapist (WAI-SRT; Hatcher & Gillaspy, 2006) is a 10-item self-report measure based on Bordin's (1979) conceptualization of alliance. The scale is scored on a 5-point Likert scale ranging from 1 (*seldom*) to 5 (*always*), with

a possible range of total scale scores between 10 and 50. Some items are reversed scored due to negative wording. Item responses to all three subscales are summed to create a total score where higher total scores of the WAI-SRT represent therapists' perception of higher therapeutic alliance. The WAI-SRT was developed from the original Working Alliance Inventory (Horvath & Greenberg, 1989) to more specifically assess the therapist's perceptions of working alliance in therapy. The WAI-SRT inventory is comprised of 10 items and three subscales: the Goal subscale (three items), the Task subscale (three items), and the Bond subscale (four items). The Goal subscale is a measure of shared agreement between the therapist and client on the goals of therapy (Hatcher & Gillaspy, 2006). The Task subscale assesses the therapist's ability to use established tasks in therapy to help the client achieve their therapeutic goals in treatment (Hatcher & Gillaspy, 2006). The Bond subscale measures the therapist's perception of the quality of the interpersonal bond between the therapist and client (Hatcher & Gillaspy, 2006).

Reliability estimates of the scores for the WAI-SRT subscales ranged from .85 to .90 and total score alphas were .91 and .92 for two samples of adults receiving outpatient psychotherapy (Hatcher & Gillaspy, 2006) and .94 in follow-up psychometric evaluation (Hatcher, Lindqvist, & Falkenström, 2020). For the subscales of Goal, Task, and Bond, reliability estimates of the scores ranged from .85 to .87, .85 to .87, and .85 to .90, respectively (Hatcher & Gillaspy, 2006). Test-retest reliability was not reported. Hatcher and Gillaspy (2006) conducted an exploratory principal axis factor analysis with direct oblimin rotation, identifying a six-factor solution accounting for 56% of the variance. The three factors associated with negatively worded items were excluded as the authors focused on the three factors comprising positively worded items (Hatcher & Gillaspy, 2006). The three positively worded factors aligned with the theoretical sub-constructs of goals, tasks, and bond (Hatcher & Gillaspy, 2006). The three-factor solution

reported correlations ranging .42 to .46 (Hatcher & Gillaspy, 2006). Confirmatory factor analysis found a three-factor model as the best fit compared to one- and two-factor models (Hatcher & Gillaspy, 2006). For the three-factor model, the root mean square error of approximation (RMSEA) was .08, the Tucker-Lewis index (TLI) was .94 and the comparative fit index (CFI) was .95; all of which support adequate or good fit (Hatcher & Gillaspy, 2006). With regard to construct validity, the WAI-SRT has been found to correlate with other measures of therapeutic alliance, including the California Psychotherapy Alliance Scale (CALPAS; Gaston, 1991) and the Helping Alliance Questionnaire (HAQ; Alexander & Luborsky, 1986) with correlations of .80 and .74, respectively (Hatcher & Gillaspy, 2006). As evidence of discriminant validity, WAI-SRT scores had low correlations of .29 to .33 with a measure of patient change self-ratings of the Group Health Patient Experience Survey (GHPES; Agency for Health Care Research and Quality, 2008). Convergence validity is supported with low correlations of .22 between the WAI-SRT and a clinician form of the Aphasia and Stroke Therapeutic Alliance Measure (A-STAM; Lawton, Conroy, Sage, & Haddock, 2019). The internal reliability of the WAI-SRT within this study was $\alpha = .85$.

Therapist Hope for Clients Scale (THCS)

The Therapist Hope for Clients Scale (THCS; Bartholomew et al., 2019) is a 10-item measure to assess a therapist's perceptions of agency, pathways, and goals in working with clients. The THCS is an adaption from Snyder's Hope Theory (Snyder, 2002), whereby hope is operationalized as an integration of goals, agency, and pathways. The THCS comprises three subscales including Goal (three items), Agency (three items), and Pathways (four items). The Goal subscale is a measure of identification of goals with a client (Bartholomew et al., 2020). The Agency subscale assesses the belief and energy to help a client achieve change

(Bartholomew et al., 2020). The Pathways subscale measures the ability to envision future possibility for change with a client (Bartholomew et al., 2020). The scale is scored on an 8-point Likert scale ranging from 1 (*definitely false*) to 8 (*definitely true*), with a possible range of total scale scores between 10 and 80. Item responses to all three subscales are summed to create a total score where higher total scores of the THCS represent therapists' perception of higher hope in the client.

Reliability estimates of the scores for the THCS subscales ranged from .81 to .85 and total score alphas were .89 for a sample of adults receiving outpatient psychotherapy (Bartholomew et al., 2020). For the subscales of (Goals Identification) Goal, (Commitment to the Client) Agency, and (Beliefs in the Client) Pathways, reliability estimates of the scores were .84, .81, and .85, respectively (Bartholomew et al., 2020). Test-retest reliability was not available.

Bartholomew et al. (2020) conducted an exploratory principal axis factor analysis with direct oblimin rotation, identifying a three-factor solution accounting for 61.63% of the variance. The first factor (3 items) contained only goal items accounting for 48.26% of the variance (eigenvalue = 6.76). The second factor (four items) comprised three agency items and one pathways item, accounting for 9.15% of the variance (eigenvalue = 1.28). The third factor (three items) included two pathway items and one agency item, accounting for 4.22% of the variance (eigenvalue = .59). Internal consistency reliability estimates for the total scale was .89 and each of the three factors were .84, .81, and .85, respectively (Bartholomew et al., 2020). The scale developers note that while the factors did not fully replicate the components of hope theory (Snyder, 2002), the factors do comprise pathways and agency items which is consistent with qualitative findings about therapists' hope for their clients (Bartholomew, 2019).

Confirmatory factor analysis found a three-factor model as the best fit compared to a four-factor model (Bartholomew et al., 2020). For the three-factor model, the root mean square error of approximation (RMSEA) was ≤.06, the comparative fit index (CFI) was ≥.95, and standardized root mean square residual (SRMR) was ≤.08; all of which support adequate or good fit (Bartholomew et al., 2020). With regard to construct validity, the THCS has been found to correlate with other measures of therapeutic alliance, including the Adult Hope Scale (AHS; Snyder et al., 1991), Inventory of Therapist Work with Client Assets (IT-WAS; Harbin et al., 2013) and the Working Alliance Inventory, Therapist Version (WAI-SRT; Hatcher & Gillaspy, 2006) with correlations of .84, .95, and .84, respectively (Bartholomew et al., 2020). Discriminant and convergence validity estimates are not available, which is likely related to the recency of measure development. The internal reliability of the THCS within this study was $\alpha = .84$.

Military Sexual Trauma

The VA MST clinical screen used to identify veterans that have experienced MST includes two-items: (a) "When you were in the military… Did you ever receive uninvited or unwanted sexual attention (e.g., touching, cornering, pressure for sexual favors, inappropriate verbal remarks)"; and (b) "When you were in the military… Did anyone ever use force or the threat of force to have sex with you against your will?" (Wilson, 2018, p. 384). For the purposes of the present study, the vignettes created adhered to the clinical screening items in defining military sexual harassment and military sexual assault. The clinical screening items were also included in the demographic information questionnaire to determine the number of victims of MST participating in the study. Please see Appendix B for a copy of the clinical vignettes used within this study.

Demographic Information

Therapist demographic information was collected including gender, age, race, degree type, professional licensing, years of clinical practice, whether therapist served in prior military service, whether the therapist is or was serving as a military psychologist or therapist, whether the therapist is or was serving as a Department of Defense (DOD) psychologist or therapist, whether the therapist is or was serving as a Department of Veteran Affairs psychologist or therapist or other mental health service provider, or whether the therapist is or was working largely with military populations (at least 50% of caseload). Participants were asked if they are currently providing psychotherapy or counseling, what type of master's or doctoral level degree in a mental health related field they hold, as well as the type of license they hold in a mental health-related field (e.g., licensed psychologist, licensed social worker, licensed professional counselor). Participants were also asked whether they have experienced military sexual trauma. A total of 3 participants of the total 108 sample endorsed having experienced military sexual trauma. Please see Appendix A for a copy of demographic questions used within this study.

Procedures

Participants were therapists from the across the United States having access to a computer and internet access. Therapists were recruited by purposive sampling via internet recruitment. An email was sent through the APA Division 19, Society of Military Psychology list-serv, inviting military-affiliated therapists to participate. A separate email was sent through the APA Division 17, Society of Counseling Psychology list-serv, American Counseling Association list-serv, National Association of Social Workers list-serv, as well as the Michigan Psychological Association list-serv to obtain a sample of civilian-based counselors. Additional recruitment requests were placed with list-servs and provider forums through Division 17

(Counseling Psychology), Division 18 (Psychologists in Public Service), Division 19 (Military Psychology), Division 29 (Advancement of Psychotherapy), Division 51 (Psychological Study of Men and Masculinities), American Counseling Association, National Association of Social Workers, the Michigan Psychological Association, the International Society for Traumatic Stress Studies, and email invitations through counseling psychology, clinical psychology, and social work graduate programs. Participants were encouraged to forward recruitment information to colleagues and professionals that met the study's recruitment criteria. All therapist participants were provided access to a web link for the study via Qualtrics. The study was approved by Western Michigan University's IRB.

The participants were provided with a brief introduction to the study noting that therapist's perceptions were to be assessed in the context of working with a simulated military sexual trauma client by vignette. An anonymous informed consent document was presented noting voluntary status of participant, confidentiality of all responses, and minimal to no anticipated risks for participants. Contact information for national mental health resources as well as the principal investigator (Patrick Munley, Ph.D.) and co-investigator (Alishia Salyer, M.A.) was also provided. Following consent to participate in the study, the participants were asked to complete a brief survey consisting of demographic information. Participants were asked to complete the Multicultural Counseling Knowledge and Awareness Scale and the Assessment of Military Cultural Competence followed by the case vignette. The participants were then presented with one of the two vignettes describing a client that is either male or female and having experienced sexual harassment and sexual assault while serving in the U.S. military. Only a single vignette of the possible two vignettes was presented to each participant, and the vignette presented to the participant was randomly selected through Qualtrics.

After having read the vignette, the participants were asked to complete the Working Alliance Inventory and Therapist Hope for Client Scale, with instruction to think of the individual described in the vignette as a real client. After responding to the final study measures of working alliance and therapist hope for clients, the participants were asked two final questions. The questions asked the participants to rate how realistic and believable the vignette of the client was. The questions were scored on a 7-point Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). Higher scores on these questions reflected higher levels of perceived realism and believability in the participant mentally imagining to work with the client depicted in the clinical vignette. The large majority of participants agreed or strongly agreed that the vignettes of the clients were believable (93.6%) and realistic (88.9%). Please see Appendix C to review the questions used within this study.

The average length of time to complete the online study was approximately 26 minutes. An original 173-person sample was initially recruited to participate. Fifty-eight people began the survey measures, and either discontinued the survey early or skipped full measures within the study and were therefore not included in the study. An additional 4 participants were excluded because they did not meet the recruiting requirements of the study, which was due to participants not being licensed. One outlier was also removed, and two additional cases were excluded due to distortion of data with small N gender comparison (1 non-binary; 1 prefer not to say), resulting in a final sample of 108.

Analyses

SPSS statistical software was utilized to perform all statistical analyses. Descriptive data analysis of all the study variables was conducted. Preliminary analyses were conducted to ensure basic assumptions of independence of observations, multicollinearity, normality, and

homogeneity of variance were met. Pearson's product-moment correlation coefficients were calculated for continuous variables and point-biserial correlations for dichotomous outcomes to determine the associations between each study variable (Field, 2013).

To consider the first study hypothesis, "It is hypothesized that there will be significant effects associated with therapist type (military vs. civilian), and client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma," a 2 x 2 MANOVA was conducted. Therapist type (military vs civilian) and client gender were entered as independent variables and therapist perceptions of working alliance and therapist hope as the dependent variables. The three multivariate effects associated with the model were tested, i.e., main effect therapist type, main effect client gender, and interaction effect. There were no statistically significant multivariate effects obtained, therefore follow-up univariate ANOVAs were not conducted. The MANOVA used total scale scores of the WAI-SRT and THCS.

To consider the second study hypothesis, "It is hypothesized that that there will be significant effects associated with therapist gender, client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma." A 2 x 2 MANOVA was conducted with therapist gender and client gender as the independent variables and therapist expectations of working alliance and therapist hope as the dependent variables. The three multivariate effects associated with the model were tested, i.e. main effect therapist gender, main effect client gender, and interaction effect. There were no statistically significant multivariate effects obtained. However, there was a near significant interaction effect for therapist gender and client gender on therapist hope. Given the possible importance of a therapist gender and client gender interaction, cell means for therapist gender by client gender with working alliance and

with therapist hope were reviewed. A follow-up exploratory 2 x 2 ANOVA for therapist gender, client gender and hope was conducted with pairwise comparisons.

To address the third study hypothesis, “It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute significant unique variance to predicting the criterion variable of therapist perception of the working alliance.” A multiple regression analysis was conducted. The variables of therapist gender, therapist type, and client gender were not statistically significant in the MANOVAs conducted to test hypothesis 1 and hypothesis 2, and they were not entered in the multiple regression analysis. Multicultural competence and military cultural competence were entered simultaneously in the regression model. The null hypothesis was tested to determine if multicultural competence and military cultural competence contribute significant unique variance to predicting therapist expectations of the working alliance.

The final hypothesis, “It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, that multicultural competence and military cultural competence, will contribute significant unique variance to predicting the criterion variable of therapist hope with victims of military sexual trauma,” was tested with a multiple regression analysis. The variables of therapist gender, therapist type, and client gender were not statistically significant in the MANOVAs conducted to test hypothesis 1 and hypothesis 2. Therefore, they were not entered in the multiple regression analysis. Multicultural competence and military cultural competence were entered simultaneously in the regression model. The null hypothesis was tested to determine if multicultural competence and military cultural competence

contribute significant unique variance to predicting therapist perception of hope with victims of military sexual trauma.

CHAPTER IV

RESULTS

Chapter IV presents the research findings of this study. First, descriptive statistics, correlations among the variables, and review of assumptions are reported. This is followed by the results of the main statistical analysis for each research question. An original 173-person sample was initially recruited to participate. Fifty-eight people began the survey measures, and either discontinued the survey early or skipped full measures within the study and were therefore not included in the study. An additional 4 participants were excluded because they did not meet the recruiting requirements of the study, which was due to participants not being licensed. One outlier was also removed, and two additional cases were excluded due to distortion of data with small N gender comparison (1 non-binary; 1 prefer not to say), resulting in a final sample of 108.

Descriptive Statistics and Correlations among The Variables

Descriptive Statistics

Descriptive statistics including the means, standard deviations, range, and Pearson *r* correlations were calculated and are provided in Tables 1 and 2. The possible total scale scores for multicultural competence range from 7 to 196. The mean total scale score for multicultural competence was 160.96 with a standard deviation of 14.92. Therefore, it appears that the current sample of participants endorsed relatively high levels of perceived multicultural competence. The possible total scale scores for military cultural competence range from 16 to 100. The mean total scale score for military cultural competence was 73.25 with a standard deviation of 8.16. Participants endorsed relatively high levels of perceived military cultural competence within this

study. The possible total scale scores for working alliance range from 10 to 50. The mean total scale score for working alliance was 41.78 with a standard deviation of 5.20. Participants endorsed relatively high levels of perceived working alliance with the client depicted in the clinical vignette within this study. The possible total scale scores for therapist hope for client range from 10 to 80. The mean total scale score for working alliance was 65.01 with a standard deviation of 8.24. Participants endorsed relatively high levels of perceived therapist hope for the client depicted in the clinical vignette within this study.

The distribution of the scores for scales of multicultural competence, military cultural competence, working alliance, and therapist hope for client were normal as evidenced by the values of skew and kurtosis. Correlations between variables ranged from |.019| to |.561| and 5 correlations were statistically significant. Therapist gender showed a statistically significant linear relationship with multicultural competence ($r = .218$; $p = .024$) with female therapists tending to score higher than male therapists on multicultural competence. Therapist military status also indicated a statistically significant linear relationship with military cultural competence ($r = .244$; $p = .011$) with military affiliated therapists tending to report higher military cultural competence than civilian therapists. Military cultural competence indicated a statistically significant linear relationship with working alliance ($r = .305$; $p = .001$) with those therapists endorsing higher military cultural competence also reporting greater working alliance. Military cultural competence indicated a statistically significant linear relationship with therapist hope for clients ($r = .263$; $p = .006$) with those therapists endorsing higher military cultural competence also reporting greater therapist hope in client. Working alliance and therapist hope for the client were also statistically significantly correlated ($r = .561$; $p < .001$) indicating a significant linear relationship with those therapists reporting stronger working alliances also

reporting more hope for clients.

Table 1

Descriptive Statistics for Therapist Gender, Client Gender, Therapist Type, Multicultural Competence, Military Cultural Competence, Working Alliance, and Therapist Hope for Client

	M	SD	Range	Skew	Kurtosis	Cronbach α
Multicultural Competence	160.95	14.92	105-196	-.74	.10	.74
Military Cultural Competence	73.24	8.16	53-87	-.51	.74	.82
Working Alliance	41.77	5.19	26-50	-.52	.26	.85
Therapist Hope for Client	65.00	8.23	38-80	-.61	.65	.84

Note. N=108 for all study variables. Possible total scale score ranges for multicultural competence is 7 to 196, military multicultural competence is 16 to 100, working alliance is 10 to 50, and therapist hope for client is 10 to 80.

Table 2

Correlations for Therapist Gender, Client Gender, Therapist Type, Multicultural Competence, Military Cultural Competence, Working Alliance, and Therapist Hope for Client

Variable	1	2	3	4	5	6	7
1. Therapist Gender	—	.043	-.032	.218*	-.064	.127	.115
2. Client Gender		—	-.048	-.091	-.160	.048	.086
3. Therapist Type			—	-.019	.244*	.078	.138
4. Multicultural Competence				—	.150	.126	.032
5. Military Cultural Competence					—	.305**	.263**
6. Working Alliance						—	.561**
7. Therapist Hope for Client							—

*$p<.05$ **$p<.01$.

Note. N=108 for all study variables. Gender was coded as 1 for men and 2 for women. Therapist Type is defined as Civilian Therapist (coded as 0) compared with Military-Affiliated Therapist (coded as 1).

Prior to testing research questions 1 and 2 of the study, the dataset was examined to determine if the assumptions of MANOVA were met including multivariate normality, homogeneity of covariance matrices, independence of observations, and no multivariate outliers. First, the data was assessed for potential outliers using the Mahalanobis distance statistic. One outlier was identified with a reported Mahalanobis distance value of 15.81, which exceeds the critical value threshold of 13.82 (Barnett & Lewis, 1994). The outlier was removed by list-wise deletion and subsequent Mahalanobis testing resulted in an acceptable value of 12.72. Second, multivariate normality was examined with review of histograms, normal Q-Q plots, and detrended normal Q-Q plots. The multivariate normality assumption was not met as a Shapiro-Wilk's test showed a significant departure from normality for both dependent variables of Working Alliance $W(108) = .966$, $p = .007$ and Therapist Hope for Client $W(108) = .971$, $p = .020$. A squared logarithm transformation was conducted to potentially improve normality within the dataset. However, the data continued to not meet the assumption of normality with Shapiro-Wilk's test results of Working Alliance $W(108) = .955$, $p = .001$ and Therapist Hope for Client $W(108) = .975$, $p = .040$. Due to the lack of improvement for normality following transformation of the data, the original dataset was used to complete the main analyses. It is noteworthy that the Shapiro-Wilk's test is often sensitive to small deviations from normality in large data sets (Field, 2013). Review of the histograms, Q-Q plots, and detrended plots indicate relative support for normal distribution of the scores. The histograms did reflect a condensed range of scores which is consistent with observed means and standard deviations. Points within Q-Q plots appeared to lie within a straight diagonal line with minimal deviations. Detrended Q-Q plots similarly displayed a relatively normal distribution of scores; however, there appeared to be a ceiling effect for outcomes variables of working alliance and therapist hope where the plots

depicted clustering of scores at or near the maximum range value for the dependent variables.

Despite the data not meeting the assumption of normality, the MANOVA is known as a robust statistical analysis and non-normality among large datasets has been shown to have only a small effect on increasing the risk for a Type I error (Grimm & Yarnold, 2001). Third, the Box's Test for equivalence of covariance matrices was examined for homogeneity of covariance matrices. For Therapist Type X Client Gender, the *Box's M* (2.80) was not significant, p (.009) > α (.001) and Therapist Gender X Client Gender also had a non-significant *Box's M* (14.75) of p = (.12). These results indicate that the assumption was met as there are no significant differences between the covariance matrices (Field, 2013). Fourth, independence of observations is assumed to have been met. It is expected that participants presented as honest and without misrepresentation due to the population comprising mental health professionals being recruited across primarily professional list-serv platforms. The quasi-experimental design of this study aided in bolstering independence of observations due to the random presentation of either a male or female client to each study participant. Participants were only allowed to be presented with one version of the vignette (male vs. female). The observations within the study are also likely to be independent of each other in that the study design involved between subject analyses and repeated assessment was not implemented.

Prior to testing research question 3 of the study, the dataset was examined to determine whether the assumptions of multiple regression were met including linearity of relationships, absence of multicollinearity, independence of observations, heteroscedasticity, and multivariate normality. First, normal Q-Q plots and standardized residual partial plots were examined to detect evidence for violations to linearity and homogeneity of variance. Neither plot type indicated that these assumptions were violated. Second, multicollinearity was evaluated with

review of variance inflation factor (VIF) between the predictors. All independent variables were found to have VIF values ranging between 1.03 and 1.12, well below the recommended threshold of < 10 (Field, 2013). These results indicate that the independent variables are not highly correlated, and the assumption of absence of multicollinearity was met. These results show that the assumption of multivariate normality was met. Third, heteroscedasticity was assessed with review of standardized residual versus predicted values plots. Plots for working alliance and therapist hope for client demonstrated scattered points without a clear pattern indicative of a trademark “cone” shape of heteroscedasticity. Fourth, the assumption of independence was evaluated by the Durbin-Watson test comparing independent variables to the dependent variables of working alliance (1.87) and therapist hope for client (1.89) demonstrating acceptable values of correlation. Similar to assumption testing for MANOVA, a review of histograms, normal Q-Q plots, and detrended normal Q-Q plots was conducted to evaluate normality for multiple regression testing. Additional assessment was also completed including review of residual statistics with values within +/-3 and Cook’s distance statistics below 1.0 supporting the absence of confounding outliers. With review of all assumptions, it appears appropriate to continue with study main analyses of MANOVA and multiple regression.

Hypothesis Testing

Research Question 1

Is there a relationship between therapist type (military vs. civilian), client gender, and therapist expectations of working alliance and therapist hope with victims of military sexual trauma?

Hypothesis 1

It is hypothesized that that there will be significant effects associated with therapist type

(military vs. civilian) and client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma.

To address the first research question, a 2 x 2 MANOVA was conducted where therapist type (military vs civilian) and client gender were entered as independent variables and therapist expectations of working alliance and therapist hope for client as the dependent variables. The MANOVA and subsequent analyses used total scale scores of the WAI-SRT and THCS for working alliance and therapist hope for client, respectively. The three multivariate effects associated with the model were tested to include main effect therapist type, main effect client gender, and interaction effect. The results of this MANOVA are presented in Table 3. Findings did not indicate a statistically significant main multivariate effect for type of therapist type on working alliance and therapist hope for client, *Wilk's* $\Lambda = .98$, $F(2, 103) = .99$, $p = .37$. The results of the MANOVA also did not indicate a statistically significant main multivariate effect for client gender on working alliance and therapist hope, *Wilk's* $\Lambda = .99$, $F(2, 103) = .24$, $p = .79$. Similarly, there was not a statistically significant multivariate interaction effect for therapist type and client gender on working alliance and therapist hope, *Wilk's* $\Lambda = .99$, $F(2, 103) = .43$, $p = .65$. In the absence of any significant multivariate effects, no follow up univariate ANOVAs were completed. Hypothesis 1 was not supported.

Table 3.

MANOVA of Therapist Type and Client Gender on Working Alliance and Therapist Hope for Client

Variable	Λ	F	df	p	η^2
Therapist Type	.981	.995	2, 103	.373	.019
Client Gender	.995	.237	2, 103	.790	.005
Therapist Type X Client Gender	.992	.434	2, 103	.649	.008

Note. N= 108. *p <.05

Research Question 2

Is there a relationship between therapist gender and client gender, with therapist expectations of working alliance and therapist hope with victims of military sexual trauma?

Hypothesis 2

It is hypothesized that that there will be significant effects associated with therapist gender, client gender, and therapist expectations of working alliance and therapist hope with victims of military sexual trauma.

To address the second research question, a 2 x 2 MANOVA was conducted where therapist gender and client gender were entered as independent variables and therapist: expectations of working alliance and therapist hope for client as the dependent variables. The three multivariate effects associated with the model were tested to include main effect therapist gender, main effect client gender, and interaction effect. The results of this MANOVA are presented in Table 4. Findings did not indicate a statistically significant main multivariate effect for therapist gender on working alliance and therapist hope for client, *Wilk's* $\Lambda = .98$, $F(2, 103) = .97$, p = .38. The results of the MANOVA also did not indicate a statistically significant main multivariate effect for client gender on working alliance and therapist hope for client, *Wilk's* $\Lambda = .99$, $F(2, 103) = .29$, p = .75. Similarly, there was not a statistically significant multivariate interaction effect for therapist gender and client gender on working alliance and therapist hope for client, *Wilk's* $\Lambda = .95$, $F(2, 103) = 2.88$ p = .06. There were no statistically significant multivariate effects obtained at the p = .05 level. Hypothesis 2 was not supported.

Table 4.

MANOVA of Therapist Gender and Client Gender on Working Alliance and Therapist Hope for Client

Variable	*Λ*	*F*	*Df*	*p*	*Ƞ²*
Therapist Gender	.982	.965	2, 103	.384	.018
Client Gender	.994	.293	2, 103	.747	.006
Therapist Gender X Client Gender	.947	2.883	2, 103	.060	.053

Note. N= 108. *p <.05

Since there was a near significant interaction effect for therapist gender and client gender, with p =.06, partial eta squared = .053, the means for therapist gender by client gender for working alliance and the means for therapist hope were reviewed and are presented in Table 5.

Table 5.

Means of Therapist Gender and Client Gender on Working Alliance and Therapist Hope for Client

Variable	*Therapist Gender*	*Client Gender*	*Mean*	*N*
Working Alliance	Male	Male	40.07	15
		Female	41.36	14
	Female	Male	42.11	37
		Female	42.24	42
Therapist Hope	Male	Male	64.87	15
		Female	61.93	14
	Female	Male	64.03	37
		Female	66.94	42

Note. Total N= 108.

After reviewing the means, a 2 x 2 ANOVA for therapist gender, client gender and therapist hope was conducted with pairwise comparisons to explore for significant differences related to a possible interaction effect. Results for the 2 X 2 ANOVA indicated, as expected, the main effects for therapist gender and client gender were not significant ($p = .24$, $p = .99$ respectively). The interaction effect for therapist gender and client gender and therapist hope was also not significant ($F(3,1) = 2.71$, $p = .103$). However, pairwise comparison analyses indicated a significant mean difference for female client gender and therapist gender. Female therapists endorsed greater therapist hope for the female client as compared to male therapists with a statistically significant mean difference of 5.01 points on the therapist hope for client scale ($p = .049$). This suggests that female therapists endorsed more hope in working with the female client as compared to male therapists. Pairwise comparison did not indicate a significant mean difference between male and female therapists (.834 mean point difference, $p = .739$) in hope for the male client.

After conducting the analysis for research questions 1 and 2, it was found that therapist type (military vs. civilian), therapist gender, client gender, and their interactions did not demonstrate statistically significant multivariate effects on working alliance and therapist hope for the client. Therefore, the variables of therapist type (military vs. civilian), therapist gender, and client gender were not entered as variables to be controlled for in the multiple regression analyses for research question 3. Only the independent variables of multicultural competence and military cultural competence were used in the regression analysis for answering research question 3.

Research Question 3

What is the nature of the relationship between the variables of therapist gender, therapist

type (military vs. civilian), multicultural competence, military cultural competence, client gender, and the variables of therapist expectations of working alliance and therapist hope with victims of military sexual trauma?

Hypothesis 3a.

It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for Hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute statistically significant unique variance to predicting the criterion variable of therapist expectations of the working alliance.

After conducting the analysis for research questions 1 and 2, it was found that therapist type (military vs. civilian), therapist gender, client gender, and their interactions did not demonstrate statistically significant multivariate effects on working alliance and therapist hope for the client. Therefore, the variables of therapist type (military vs. civilian), therapist gender, and client gender were not entered as variables to be controlled for in the multiple regression analyses for research questions 3. Only the independent variables of multicultural competence and military cultural competence were used in the regression analysis for answering research question 3.

To address the first portion of the third research question and hypothesis 3a concerning therapist expectations of working alliance, a multiple regression analysis was conducted where multicultural competence and military cultural competence were entered as independent variables and therapist expectations of working alliance as the dependent variable. Multicultural competence and military cultural competence were entered simultaneously in this regression model. Table 6 presents the results of this regression analysis.

Table 6

Multiple Regression Analysis Predicting Working Alliance from Multicultural Competence and Military Cultural Competence

	Unstandardized Coefficients		Standardized Coefficients Beta	T	*p*
	B	Std. Error			
Constant	23.484	6.324		3.713	<.001
Multicultural Competence	.029	.033	.083	.882	.380
Military Cultural Competence	.187	.060	.293	3.128	.002**

Note. Multiple R = .316; R^2 = .100; Adjusted R^2 = .083; R^2 Change = .100; F_{Change} (2, 105) = 5.826; p = .004.

*p < .05. **p < .01.

The overall regression model was statistically significant (R = .316, R^2 =.100, Adjusted R square = .083, F(2, 105) = 5.83, p = .004). It was found that military cultural competence significantly predicted working alliance in the model (β = .293, p = .002). However, multicultural competence did not significantly predict working alliance (β = .083, p = .38). The model accounted for 10% of the variance in working alliance. Hypothesis 3 was supported as military cultural competence emerged as a statistically significant unique predictor of therapist expectations of the working alliance.

Hypothesis 3b.

It is hypothesized that after controlling for therapist gender, therapist type (military vs. civilian) and client gender, as may be necessary after testing for Hypotheses 1 and 2, that multicultural competence and military cultural competence, will contribute statistically significant unique variance to predicting the criterion variable of therapist hope with victims of

military sexual trauma.

To address the second portion of the third research question and hypothesis 3b, a multiple regression analysis was conducted where multicultural competence and military cultural competence were entered as independent variables and therapist expectations of therapist hope in the client as the dependent variable. Since the variables of therapist gender, therapist type, and client gender did not demonstrate statistical significance in the MANOVAs conducted in hypothesis 1 and 2, they were not included in this multiple regression analysis. Multicultural competence and military cultural competence were entered simultaneously in this regression model. Table 7 presents the results of this regression analysis.

Table 7

Multiple Regression Analysis Predicting Therapist Hope in Client from Multicultural Competence and Military Cultural Competence

	Unstandardized Coefficients		Standardized Coefficients Beta	t	*p*
	B	Std. Error			
Constant	46.158	10.192		4.529	<.001
Multicultural Competence	-.004	.053	-.007	-.076	.939
Military Cultural Competence	.266	.096	.264	2.770	.007**

Note. Multiple R = .263; R^2 = .069; Adjusted R^2 = .051; R^2 Change = .069; F_{Change} (2, 105) = 3.894; p = .023.

*$p < .05$. **$p < .01$.

The overall regression model was statistically significant (R = .263, R^2 = .069, Adjusted R2 = .051, R Square Change = .069, F(2, 105) = 3.89, p = .023). It was found that military cultural competence emerged as a significant unique predictor of therapist hope for the client (β = .266, p = .007). However, multicultural competence did not significantly predict therapist hope

for the client ($\beta = -.007$, $p = .94$). Hypothesis 3b was supported as military cultural competence was a statistically significant unique predictor of therapist expectations of therapist hope for the client.

Summary

In review of the study results, statistically significant correlations were found between variables of interest. Specifically, therapist gender showed a statistically significant linear relationship with multicultural competence, with female therapists tending to score higher than male therapists. Therapist military status showed a statistically significant linear relationship with military cultural competence with military affiliated therapists tending to report higher military cultural competence than civilian therapists. Working alliance and therapist hope for the client were also statistically significantly correlated.

Results of two 2 X 2 MANOVA analyses found that there were no statistically significant multivariate effects associated with therapist gender, client, gender, or type of therapist (military vs. civilian) in reported expected working alliance and therapist hope for the client.

Follow up multiple regression analyses indicated that therapists who endorsed higher levels of military cultural competence tended to report higher levels of expected working alliance and therapist hope for the client. In comparison, there was not a significant unique predictor relationship for therapist reported multicultural competence and therapist expectations for working alliance and therapist hope for the client.

CHAPTER V

DISCUSSION

Propelled by the U.S. Congressional mandate in 1992, mental health providers have worked to provide treatment to specifically meet the needs of victims of military sexual trauma (Allard et al., 2011). In pursuit of developing efficacious treatment for victims of military sexual assault, numerous considerations have been evaluated to bolster treatment outcomes including improved systems of reporting and assessing military sexual assault, standardized screening methods, and evidence-based trauma-focused treatment protocols (Allard et al., 2011; Kimerling et al., 2007; Turchik et al., 2012; U.S. Commission on Civil Rights, 2013). While a substantial amount of graduate and professional training emphasizes the importance of multicultural competence when working with special populations, military populations and their unique needs are often unaddressed. Although consensus exists regarding the importance of tailoring trauma-focused therapy to unique populations, little is known about therapist expectations working with victims of military sexual trauma. Furthermore, there appears to be little research evaluating the potential impact of therapist's multicultural competence, military cultural competence, and expectations of working alliance and therapist hope with victims of military sexual trauma, and how these may differ by gender or between civilian and military-affiliated therapists. This study sought to provide empirical data and quantitative data analyses to help answer specific questions regarding therapist's expectations working with victims of military sexual assault. This chapter will review interpretations of findings, limitations, recommendations for future research, and implications of this study.

Research Questions and Hypotheses

Therapist Type, Client Gender, and Therapist Expectations of Working Alliance and Therapist Hope for Clients

The study's first research question hypothesized that there would be significant effects associated with therapist type (military vs. civilian) and client gender and therapist expectations of working alliance and therapist hope with victims of military sexual trauma. This hypothesis was not supported.

The Pearson *r* correlations between therapist type, client gender, and measures of working alliance and therapist hope were not statistically significant. Additionally, all three Wilk's Λ test results assessing for the main effect of therapist type, main effect of client gender, and the interaction effect were not significant. This indicates that there were similar therapist expectations of working alliance and therapist hope for clients across types of therapists, client gender, or interaction between therapist type and client gender.

The results of the current study are not fully consistent with previous research. In the absence of quantitative research evaluating potential therapist's expectations of working alliance and therapist hope for male and female clients who are victims of military sexual trauma, a broader review of the literature is considered. Specifically, the results of the current study are not fully consistent with previous research that found qualitative differences of therapist's expectations working with male victims of sexual trauma. Yarrow and Churchill (2009) reported that within a sample of 32 clinicians (22 female, 7 male, 3 unknown gender), 16 of them endorsed discomfort working with male victims of sexual trauma due to fear of being perceived as an abuser. Four therapists were also reported to have experienced anxiety for the client's embarrassment, two clinicians feared eliciting client anger, and another two therapists were uncertain if they wanted to hear about the abuse (Yarrow & Churchill, 2009). However, this

contrasts with a broader scoped qualitative study conducted by Fisher (1989) that found that gender differences in causal explanations for patient experience in psychotherapy were not due to the effect of the patient's gender. It was noted that no significant therapist gender biases were observed for patient-presenting problems early in treatment; but therapists were observed to report gendered differences in explaining difficulties later in treatment after 5-6 sessions. Specifically, female therapists tended to perceive themselves as responsible for difficulties, regardless of client gender. Whereas male therapists perceived patients as responsible for treatment difficulties. Fisher stated, "In either case, when a woman and a man were in a therapy relationship together, the causes of these difficulties in treatment, attributed to women, were perceived as longer-lasting and unlikely to change" (1989). While the results of this study do not indicate any support for gender differences in therapist expectations working with victims of military sexual trauma, these results are consistent with previous research. While therapists do not perceive gender differences at the start of treatment, gender-based differences may occur later in mental health treatment.

There is an absence of quantitative studies comparing working alliance between civilian versus military-affiliated therapist working with victims of military sexual trauma. But there has been a substantial amount of research to encourage civilian based providers to gain increased knowledge and competence in advance of working with military members and veterans (Coll et al., 2012; Culbreth, Newsome, & Whiting, 2013; Nedegaard & Zwilling, 2017; Smith, 2014; Stebnicki, 2016).

Bell and Reardon (2011) noted that therapists may perceive that it takes longer to establish a working alliance with victims of MST due to difficulties establishing trust (Bell & Reardon, 2011). But differentiation between therapist expectations between civilian and military-

affiliated therapists are relatively unknown.

A possible explanation for the results within this study is that therapists, regardless of association with military clients or victims of military sexual assault, endorse similar levels of working alliance and therapist hope for clients. Clinical training also emphasizes the importance of addressing potential gender bias in treatment and how to work effectively across gender differences. Therapists are trained to develop strong working alliances with clients as it is understood that working alliance is a core component of common factors and serves as one of the strongest predictors of treatment success (Norcross, 2011). Similarly, therapists endorsing high working alliance are expected to similarly report high therapist hope due to the recognized relational nature between the outcome measures (Bartholomew et al., 2019; Bartholomew et al., 2017).

In a qualitative study reviewing therapist's views of sexual assault, Ullman (2014) noted the likely bias within her sample that volunteered to participate. Ulman observed that those therapists that volunteered for the study were more likely to enjoy working with victims of sexual trauma and likely had more experience and training in trauma, as compared to other non-participating therapists. Thus, the sample may have reflected a skewed group of therapist participants and how they positively perceive victims of sexual violence. Similarly, participants in this study may also reflect more positive therapist expectations regardless of therapist type or client gender due to the individual interest and decision to self-select into this study. It is also important to note that therapists may have endorsed different expectations of working alliance within this analogue study as compared to working with a real client in a clinical context.

Therapist Gender, Client Gender, and Therapist Expectations of Working Alliance and Therapist Hope for Clients

The study's second research question hypothesized that there would be significant effects

associated with therapist gender, client gender, and therapist expectations of working alliance and therapist hope with victims of military sexual trauma. This hypothesis was not supported.

The Pearson *r* correlations between therapist gender, client gender, and measures of working alliance and therapist hope were not statistically significant. Additionally, all three Wilk's Λ test results assessing for the main effect therapist type, main effect client gender, and interaction effect were not significant. This indicates that there were similar therapist expectations of working alliance and therapist hope for clients across therapist gender, client gender, and there was not a unique interaction effect between therapist gender and client gender. However, there was a near significant interaction effect for therapist gender and client gender on therapist hope. Given the possible importance of evaluating therapist gender and client gender within this study, a follow-up 2 x 2 ANOVA for therapist gender, client gender and therapist hope was conducted with pairwise comparisons. Results revealed that there was not a statistically significant interaction between the effects of therapist gender and client gender on therapist hope. However, pairwise comparison analyses indicated a significant mean difference for female client gender and therapist gender. Female therapists endorsed greater therapist hope for female clients as compared to male therapists.

There is presently no literature assessing therapist's expectations of working alliance and therapist hope for clients working with victims of military sexual trauma. However, there is existing literature suggesting that gender is important from the client's perspective and may impact therapy working with victims of military sexual trauma. The follow-up finding of a significant pairwise comparison of therapist gender, female client gender, and therapist hope for clients reflect that there may be a trend related to gender regarding therapist gender, female gender, and expectations of therapist hope for clients. Future research with larger samples of men

may be helpful in continuing to explore the possible influence of interactions of therapist gender and gendered expectations of working with victims of MST.

In qualitative studies of veterans having experienced military sexual trauma, women (N=9) were reported to endorse a predominant gender preference of a female provider (Turchik, Bucossi, & Kimerling, 2014), while 50% of men (N=20) preferred a female provider, 25% preferred a male provider, and 25% did not endorse a gender preference (Turchik et al., 2013). Similarly, in a study conducted by McBain, Garneau-Fournier, and Turchik (2020), a sample of 1,591 veterans having experienced military sexual trauma reported specific gender preferences working with Veterans Health Administration providers in mental health treatment. McBain and colleagues found that in instances of provider preference mismatch (patients assigned to work with providers of less desired gender), female patients endorsed greater perceived barriers in treatment, less comfort with providers, and lower perceived provider competency. Male patients mismatched with their preferred provider preference endorsed greater perceived barriers in treatment and less comfort with providers (McBain et al., 2020). Therefore, patients endorsing a gender preference working with a mental health provider, and not having their preferences met, may experience effects in mental health treatment including effects to working alliance. In reviewing data of a national cohort of veterans (N= 506,471), researchers found, contrary to their prediction, that gender match between therapists and patient with PTSD was not a positive predictor of retention in therapy (Shiner, Westgate, Harik, Watts, & Schnurr, 2017). Rather, women were more likely to be retained in therapy in the case of gender matching and the opposite was true for men. Matching male therapists with male patients with PTSD was reported as a negative predictor of psychotherapy retention (Shiner et al., 2017).

Additional comparisons are drawn from more generalized research. The results of the current study are relatively consistent with previous research of broad gender comparisons. Within a study conducted by Behn, Davanzo, & Errázuriz (2018), a sample of 28 therapists and 547 adult clients receiving individual psychotherapy for depressive symptoms were found to demonstrate no significant differences in therapeutic alliance across variables of client and therapist gender. Behn and colleagues delineated results indicating that pairing therapists and clients at different levels of gender, age, and income combinations did not contribute to positive assessment of therapeutic alliance beyond the first session. Similarly, Cottone, Drucker, & Javier (2002) evaluated client gender, therapist gender, and client/therapist gender types and did not find significant differences in actual treatment outcomes across psychological symptoms of anxiety and depression. In most of the analysis results reported, variables that demonstrated a consistent statistically significant relationship with gender were related to duration in therapy and not change in psychological symptoms (Cottone et al., 2002).

The results of the current study may be explained by therapists obtaining graduate training to understand and respect gender differences in client, recognizing potential gender biases one may hold, as well as regular exposure to working with both male and female clients. However, the lack of differences may also be attributable to this study's methodology. Specifically, the use of clinical vignettes may have allowed for experimental manipulation of client gender, but gender and gender pronouns were the only differentiating characteristics between each vignette. With the absence of more gender-specific characteristics or responses, the saliency of client gender may have been less consequential. Additionally, the generalizability of an analogue model versus working with or seeing actual clients may limit the results of this study. This is discussed within this study's limitations.

Multicultural Competence, Military Cultural Competence, and Therapist Expectations of Working Alliance and Therapist Hope for Clients

The study's first part of the third research question hypothesized that multicultural competence and military cultural competence would contribute significant unique variance to predicting therapist expectations of the working alliance. This hypothesis was partially supported.

The study's second part of the third research question hypothesized that multicultural competence and military cultural competence would contribute significant unique variance to predicting therapist expectations of therapist hope for clients. This hypothesis was also partially supported.

Findings from the multiple regression model with military cultural competence and multicultural competence serving as predictors together of expected working alliance was significant. However, only military cultural competence emerged as a significant unique predictor in the model for working alliance. And multicultural competence did not emerge as a significant unique predictor in the model. The full model accounted for 10% of the variance in therapists with military cultural competence as the only significant predictor of expectations of working alliance. Therapists who endorsed higher levels of military cultural competence were more likely to expect greater working alliance with military sexual assault victims.

There is presently no current literature assessing military cultural competence or multicultural competence predicting therapist's expectations of working alliance when working with victims of military sexual trauma. However, a substantial amount of literature has emphasized the importance of multicultural competence when working with special populations (Sue, Arrendondo & McDavis, 1992; Sue & Sue, 2012; Weiss & Coll, 2011). However, it is unknown how therapists' multicultural competence without specific knowledge, skills, or

training related to the military culture affects psychotherapy with victims of military sexual trauma.

Military cultural competence is recognized as a specific type of competence held under the larger umbrella of multicultural competence. Some research and clinical recommendations have attempted to separate military cultural competence from the general literature of multiculturalism, highlighting the unique facets of the military community in competency training and education (Atuel & Castro, 2018; Price et al., 2015). The results of the current study are consistent with previous research on military cultural competence. For example, Brommelsiek, Peterson, and Amelung (2018) reported that following an immersion course, students who gained increased understanding and knowledge of military culture and veteran's health reported significantly improved positive attitudes towards veterans and military members. They were also found to endorse positive attitudes relating to knowledge, increased comfort with military culture, higher expectations of their own professional capacity and intention to provide evidence-based and culturally competent services to veterans, as well as more positive views towards issues pertaining to veteran health. Concerning the impact to victims of military sexual assault, the importance of military cultural competence may be even more critical. However, no existing literature demonstrates comparisons between therapists of high versus low military cultural competence treating MST victims.

It was surprising that the results within this study did not demonstrate multicultural competence as a predictor of therapist expectations working alliance with military sexual assault victims. However, military cultural competence alone was found to be a significant predictor of therapist expectations of working alliance with military sexual assault victims. This is consistent with literature emphasizing the importance of military cultural competence when working with

military services members and veterans (Carter & Watson, 2018; Convoy & Westphal 2013; Hall-Clark et al., 2019; Leppma et al., 2016; Meyer et al., 2016; Yamada et al., Zwiebach et al., 2019). Military cultural competence has also been stressed as a critical component within a 2014 RAND report recommending increased training in graduate education programs, a launch of a national certificate program, and making high-quality mental health care a national priority in treating military veterans and their families (Tanielian et al., 2014). As victims of military sexual trauma pursue mental health treatment, it is therefore essential that providers increase their military cultural competence to promote the working alliance and hope working with these patients.

Important to note, however, is that working alliance and therapist hope for clients is not conditional upon military cultural competence. For example, a qualitative study of 23 military veterans reported their perceptions of civilian psychologists' competency in military culture and its impact on the therapeutic alliance (Hart, 2020). The results were noted as mixed because some respondents endorsed a desire for their mental health providers to have competence of military culture, while other participants endorsed appreciation of the therapist's objectivity and disconnection from the military. Hart (2020) also noted that veterans described both positive and negative therapeutic alliance in mental health treatment as influenced by other factors including perceptions of clinical competence, professionalism, caring, feeling loved by the provider, feeling hated by the provider, disingenuousness, distrust, distant demeanor, and bias.

Strong working alliance is a significant predictor of improved treatment outcomes. A study comprising 25 therapists delivering the same trauma-focused treatment (CPT) to 192 veterans found that 12% of the variance for patient outcomes were due to therapist factors (Laska, Smith, Wislocki, Minami, & Wampold, 2013). The authors suggested that characteristics

and actions of effective therapists promoted strong working alliance with veterans. Howard, Berry, and Haddock (2021) also presented meta-analysis results emphasizing the importance of strong working alliance in predicting positive PTSD treatment outcomes (r = -.34) in civilian, military, and veteran samples.

Understanding that increased military cultural competence is associated with therapist's endorsing higher expectations of working alliance and therapist hope for clients, it is therefore recommended that mental health providers promote positive patient outcomes with attentiveness to the patient's unique culture and worldview.

Limitations of the Current Study

This study has several limitations. One limitation of the current study was the means of recruitment by purposive sampling and participant self-selection into the study. Mental health providers were invited to participate through professional list-servs, email listings, and email forwarding of the invitation web link to potentially interested colleagues. This resulted in a non-randomized sample of participants due to the goals of the current study to obtain only practicing mental health providers. Additionally, the sample was overly represented by participants identifying as female (73.1%), White/Caucasian (78.7%), those holding a doctoral degree (clinical psychology 60.2%; counseling psychology 21.3%), licensed psychologists (70.4%), and military-affiliated mental health providers (62.9%). However, this sample comprising predominantly White American, female therapists is reflective of previous response rates to psychological research via online recruitment as well as known demographics of mental health providers (Casler, Bickel, & Hackett, 2013). Unfortunately, the results of this study may not be generalizable to therapists identifying as a gender minority or racial minority. The over-representation of military-affiliated therapists may be attributable to the perceived relevance of

the study to providers having familiarity or experience working with victims of military sexual trauma. The over-representation of doctoral level providers as compared to master's level providers may be due to the larger number of requests on American Psychological Association list-servs which are geared towards psychologists as compared to social workers or licensed clinical counselors. Future research may benefit from including more varied list-serv platforms to include greater exposure to social workers and licensed clinical counselors.

A second possible limitation was that the data was obtained by participant self-report. Self-report measures are at risk of distorted data due to possible dishonesty, exaggeration, or a participants desire to appear in a socially desirable manner. To reduce the risk associated with self-report measures, instruments used within this study were selected due to their reported reliability and validity. Additionally, the between-subject design of this study with randomized presentation of only one gender of vignette served to increase the independence of variables (Field, 2013) and reduce the participants awareness of client gender comparison.

A third limitation of this study may be the implementation of an analogue study using a clinical vignette and requesting participants to visualize and imagine working with the described client as a real client. Furthermore, participants were then asked to rate their perceived working alliance and therapist hope for the client. Requesting participants to imagine working with a client does not necessarily generalize to real practice and allows for bias in participant response. However, the use of clinical vignettes and expected rating of working alliance has been used in other research including one study where student clinicians reported their perceived working alliance and therapist attachment style in response to vignettes of fictional therapeutic encounters (Christopher, 2012). Hatcher and Favorite (2005) also demonstrate use and support of analogue study designs, as they noted particular benefit in using the approach to focus on unique aspects

of complex human interaction such as their study of therapist empathy where participants viewed vignettes and imaged themselves to work with the depicted clients. The implementation of analogue study designs has also been promoted in research that may otherwise involve potential ethical difficulties in a clinical setting (Kazdin, 2015). Potential ethical difficulties that may have arisen had this current study been conducted with real clients include concerns about randomly assigning a victim of military sexual trauma to a provider with less military cultural competence and less experience working with MST as compared to a provider with higher military cultural competence and more clinical experience treating MST. This current study appears to have successfully used clinical vignettes to elicit statistically significant relationships in therapist participant expectations of working alliance and therapist hope for clients. The large majority of participants also agreed or strongly agreed that the vignettes of the clients were believable and realistic.

A fourth limitation within this study includes the relatively small Pearson product-moment correlation coefficients observed between most of the variables. Only 5 statistically significant correlations were observed ranging from small effect size (.218) to large effect size (.561) according to standards within social science research (Cohen, 1988; Field, 2013). Therefore, it appears that many of the relationships between variables within this study demonstrate low strength in linear relationship to one another. The outcomes of this study should be replicated to validate the findings and promote further research evaluating therapists' expectations working with victims of military sexual trauma.

Implications of the Current Study

Recognizing the limitations discussed above, the findings of this study have implications for mental health providers working with victims of military sexual trauma.

First, therapists may want to develop or increase military cultural competence if they intend to work with victims of military sexual assault. Having a broad understanding of diversity and multicultural competence does not replace the importance of gaining specific knowledge pertaining to a client's culture and worldview (Atuel & Castro, 2018). Therapists perceiving themselves to have military cultural competence may engage clients with greater confidence in building working alliance and may view their work with greater hope in anticipating that they can understand and provide effective treatment (Brommelsiek et al., 2018). Therapists demonstrating military cultural competence may also increase the client's perceived working alliance with the provider, which has been identified as the strongest predictor of positive treatment outcomes (Hart, 2020).

Therapists may seek to increase military cultural competence by pursuing education and training specifically for working with military members and veterans. Mental health providers may also utilize relationships with military-affiliated agencies and veteran mental health supporting organizations at local, state, and national levels. Many web-based resources are available for military cultural competence training including but not limited to the a) Community Providers Toolkit from Department of Veterans Affairs Mental Health (U. S. Department of Veteran Affairs, n.d.), b) Military Culture Course Modules from the Uniformed Services University of the Health Sciences (Center for Deployment Psychology, n.d.), and c) Department of Veterans Affairs Veteran Cultural Competence Training (U. S. Department of Veteran Affairs, 2023).

Results of this study may be useful to promote military cultural competence in graduate training programs. At present, very few graduate programs offer specialized training to work with the military population. A study conducted by Leppma and colleagues (2016) reviewed the

graduate training received by military psychologists treating veterans and military families. The results obtained indicated that almost half of the participants reported that their graduate training programs did not prepare them to address military culture or work with the military population. Carter and Watson (2018) suggest that therapists in training intending to work with the military population may benefit from integrating military issues into coursework and existing counseling curriculum. Educators may support military cultural competence education by infusing military cultural issues into existing curriculum and coursework as a means of exposing students to an otherwise unaddressed special population.

Results from the current study revealed that therapist type (military-affiliated versus civilian) was not related to therapist expectations of working alliance and therapist hope for clients. Due to the absence of previous studies comparing military-affiliated to civilian providers, this study is the first of its kind. This finding has implications for therapists concerned with building working alliance and desiring to have increased hope for clients. Therapists pursuing or having higher levels military cultural competence may function to enhance one's expectations in working with victims of military sexual trauma. However, it is important to clarify that this study reviewed expectations and therefore actual treatment outcomes for victims of military sexual trauma may differ between military-affiliated to civilian therapists. Further research is needed to explore potential differences and similarities between military-affiliated to civilian providers when working with victims of military sexual trauma.

Results from the current study revealed that therapist gender was not related to therapist expectations of working alliance and therapist hope for clients. There is a lack of research pertaining to therapist expectations of working alliance and therapist hope for clients comparing men and women providers. This study suggests that there may be no differences between the

gender of therapists in their expectations working with victims of military sexual trauma. Ideally, this may represent that men and women generally have comparative expectations of working alliance and therapist hope. However, the finding of a significant pairwise comparison for male and female therapists hope for the female client vignette suggests more research may be needed. Also, findings do not rule out that some therapists may hold substantially different expectations due to individualized experiences, but the differences are not attributable to therapist gender alone. This may be an area for further exploration to review. In addition, therapists identifying as a gender minority may report potentially different or similar expectations working with victims of military sexual trauma.

Results from the current study revealed that client gender was not related to therapist expectations of working alliance and therapist hope for clients. There is no present research pertaining to therapist expectations of working alliance and therapist hope for clients comparing male and female victims of military sexual trauma. This finding has implications that therapists do not endorse different expectations of working alliance and therapist hope for clients based upon gender. Rather, they lack any expected gender bias working with victims of military sexual trauma. Due to the between-subjects design of this study where a participant was exposed to only one gender of a client, it is more challenging to identify frequency of potential gender bias among participants as compared to a within-subjects repeated design. Further research is needed to explore potential differences and similarities of expected therapist expectations of working alliance and therapist hope for clients who identify as a gender minority.

Summary and Conclusions

In review of the results of this study, several conclusions may be drawn. First and foremost, this study served to help fill a gap in the research literature pertaining to therapists'

expectations working with victims of military sexual trauma. Second, this study found no differences in therapists' expectations of working alliance and therapist hope for clients, comparing military-affiliated and civilian therapists. Third, there were similar therapist expectations of working alliance and therapist hope for clients across therapist gender, client gender, and there was not a unique interaction effect between therapist gender and client gender. This suggests the absence of gender bias in how therapists expect to work with victims of military sexual trauma. However, it is advisable to remember that these results are based on analogue research using clinical vignettes instead of real clients. Further research and replication are encouraged to confirm the results of this study.

An important finding within this study is the unique role of military cultural competence in predicting therapists' expectations of working alliance and therapist hope for clients. Multicultural competence alone did not predict therapists' expectations of working alliance and therapist hope for clients. These results appear to support the "call to the profession" made by Sue, Arrendondo, McDavis (1992) outlining multicultural counseling competencies for the field of mental health providers. They emphasized the importance of gaining specific knowledge, acquiring skills and techniques, and learning appropriate evidence-based treatments working with a unique population. Therefore, having a broad knowledge base of diversity and multicultural competence, but lacking specific knowledge to work with unique military populations may be insufficient. The study provided empirical support for the theorized notion that military cultural competence increases working alliance expectations and therapist hope in treating victims of military sexual trauma. Given this finding, therapists should be encouraged to pursue training and learning of military cultural competence to bolster the potential effectiveness working with military clients.

REFERENCES

Agency for Health Care Research and Quality. (2008). *ECHO Experience of Care and Health Outcomes Survey*. Rockville, MD: U. S. Department of Health and Human Services. https://www.cahps.ahrq.gov/content/products/ECHO/PROD_ECHO_Intro.asp

Aguinis, H., & Bradley, K. J. (2014). Best practice recommendations for designing and implementing experimental vignette methodology studies. *Organizational Research Methods, 17,* 351-371. https://doi.org/10.1177/1094428114547952

Alexander, L. B., & Luborsky, L. (1986). The Penn Helping Alliance Scales. In L. S. Greenberg & W. M. Pinsoff (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York, NY: Guilford Press.

Allard, C. B., Nunnink, S., Gregory, A. M., Klest, B. K., & Platt, M. (2011). Military sexual trauma research: A proposed agenda. *Journal of Trauma & Dissociation, 12,* 324-345. https://doi.org/10.1080/15299732.2011.542609

American Psychological Association. (2003). Guidelines for multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*(5), 377-402. https://doi.org/10.1037/0003-066X.58.5.377

American Psychological Association. (2017). *Clinical practice guideline for the treatment of PTSD*. https://www.apa.org/ptsd-guideline/ptsd.pdf

Anderson, R. S., & Levitt, D. H. (2015). Gender self-confidence and social influence: Impact on working alliance. *Journal of Counseling & Development, 93*, 280-288. https://doi.org/10.1002/jcad.12026

Andresen, F. J., Monteith, L. L., Kugler, J., Cruz, R. A., & Blais, R. K. (2019). Institutional betrayal following military sexual trauma is associated with more severe depression and

specific posttraumatic stress disorder symptom clusters. *Journal of Clinical Psychology, 75*, 1305-1319. https://doi.org/10.1002/jclp.22773

Arredondo, P., & Perez, P. (2006). Historical perspectives on the multicultural guidelines and contemporary applications. *Professional Psychology: Research and Practice, 37*(1), 1-5. https://doi.org/10.1037/0735-7028.37.1.1

Atuel, H. R., & Castro, C. A. (2018). Military cultural competence. *Clinical Social Work Journal, 46*, 74-82. https://doi.org/10.1007/s10615-018-0651-z

Baltrushes, N., & Karnik, N. S. (2013). Victims of military sexual trauma- you see them, too. *The Journal of Family Practice, 62*(3), 120-125. https://www.researchgate.net/publication/236072497

Barlow, M. R., Goldsmith Turow, R. E., & Gerhart, J. (2017). Trauma appraisals, emotion regulation difficulties, and self-compassion predict posttraumatic stress symptoms following childhood abuse. *Child Abuse & Neglect, 65*, 37-47. https://doi.org/ 10.1016/j.chiabu.2017.01.006

Barnett, V., & Lewis, T. (1994). *Outliers in statistical data*. 3rd edition. New York: J. Wiley & Sons. https://doi.org/10.1002/bimj.4710370219

Barth, S. K., Kimerling, R. E., Pavao, J., McCutcheon, S. J., Batten, S. V., Dursa, E., Peterson, M. R., & Schneiderman, A. I. (2015). Military sexual trauma among recent veterans. *American Journal of Preventative Medicine, 50*(1), 77-86. https://doi.org/10.1016/j.amepre.2015.06.012

Bartholomew, T. T., Gundel, B. E., Li, H., Joy, E. E., Kang, E., & Scheel, M. J. (2019). The meaning of therapists' hope for their clients: A phenomenological study. *Journal of Counseling Psychology, 66*(4), 496-507. https://doi.org/10.1037/cou0000328

Bartholomew, T. T., Gundel, B. E., & Scheel, M. J. (2017). The relationship between alliance ruptures & hope for change through counseling: A mixed methods study. *Counselling Psychology Quarterly, 30*, 1-19. http://dx.doi.org/10.1080/09515070.2015.1125853

Bartholomew, T. T., Gundel, B. E., Scheel, M. J., Kang, E., Joy, E. E., & Li, H. (2020). Development and initial validation of the therapist hope for clients scale. *The Counseling Psychologist, 48*(2), 191-222. https://doi.org/10.1177/0011000019886428

Bedard-Gilligan, M., Marks, E., Graham, B., Garcia, N., Jerud, A., & Zoellner, L. A. (2016). In L. Katz (Ed.), *Treating Military Sexual Trauma* (pp. 67-74). New York, NY: Springer Publishing Company, LLC.

Behn, A., Davanzo, A., & Errázuriz, P. (2018). Client and therapist match on gender, age, and income: Does match within the therapeutic dyad predict early growth in the therapeutic alliance? *Journal of Clinical Psychology, 74*(9), 1403-1421. https://doi.org/10.1002/jclp.22616

Bell, M. E., & Reardon, A. (2011). Experiences of sexual harassment and sexual assault in the military among OEF/OIF veterans: Implications for health care providers. *Social Work in Health Care, 50*, 34-50. https://doi.org/10.1080/00981389.2010.513917

Bell, M. E., Street, A. E., & Stafford, J. (2014). Victims' psychosocial well-being after reporting sexual harassment in the military. *Journal of Trauma Dissociation, 15*(2), 133-152. https://doi.org/10.1080/15299732.2014.867563

Bell, M. E., Turchik, J. A., & Karpenko, J. A. (2014). Impact of gender on reactions to military sexual assault and harassment. *Health & Social Work, 39*(1), 25-33. https://doi.org/10.1093/hsw/hlu004

Bernal, G., & Domenech Rodriguez, M. M. (Eds.). (2012). *Cultural adaptations: Tools for evidence-based practice with diverse populations.* Washington, DC: American Psychological Association.

Blais, R. K., Brignone, E., Maguen, S., Carter, M. E., Fargo, J. D., & Gundlapalli, A. V. (2017). Military sexual trauma is associated with post-deployment eating disorders among Afghanistan and Iraq veterans. *International Journal of Eating Disorders, 50*(7), 808-816. https://doi.org/10.1002/eat.22705

Bordin, E. S. (1979). The generalizability of the psychanalytic concept of the working alliance. *Psychotherapy: Theory, Research, & Practice, 16*, 252-260. https://doi.org/10.1037/h0085885

Bowman, D. G., Scogin, F., Floyd, M., & McKendree-Smith, N. (2001). Effect of therapist sex on outcome of psychotherapy: A meta-analysis. *Psychotherapy, 38*, 142-148. https://doi.org/10.1037/0033-3204.38.2.142

Brauer, P. M., Hanning, R. M., Arocha, J. F., Royall, D., Goy, R., Grant, A., Dietrich, L., Martino, R., & Horrocks, J. (2009). Creating case scenarios or vignettes using factorial study design methods. *Journal of Advanced Nursing 65*(9), 1937-1945. https://doi.org/10.1111/j.1365-2648.2009.05055.x

Breiding, M. J., Smith, S. G., Basile, K. C., Walters, M. L., Chen, J., & Merrick, M. T. (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization: National intimate partner and sexual victimization survey, United States, 2011 (NIH Publication No. 745990). Centers for Disease Control and Prevention, *MMWR Surveillance Summary, 63*(8), 1-18. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4692457/pdf/nihms745990.pdf

Brignone, E., Gundlapalli, A. V., & Blais, R. K. (2016). Differential risk for homelessness among US male and female veterans with a positive screen for military sexual trauma. *JAMA Psychiatry, 73*(6), 582-589. https://doi.org/10.1001/jamapsychiatry.2016.0101

Brommelsiek, M., Peterson, J. A., & Amelung, S. K. (2018). Improving cultural competency: A patient-centered approach to interprofessional education and practice in a veterans healthcare facility. *International Journal of Higher Education, 7*(4), 157-165. https://doi.org/10.5430/ijhe.v7n4p157

Burns, B., Grindlay, K., Holt, K., Manski, R., & Grossman, D. (2014). Military sexual trauma among U.S. servicewomen during deployment: A qualitative study. *American Journal of Public Health, 104*(2), 345-349. https://doi.org/10.2105/AJPH.2013.301576

Campbell, R. & Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences with military and civilian social systems. *Psychology of Women Quarterly, 29*(1), 97-106. https://doi.org/10.1111/j.1471-6402.2005.00171.x

Carrola, P., & Corbin-Burdick, M. F. (2015). Counseling military veterans: Advocating for culturally competent and holistic interventions. *Journal of Mental Health Counseling, 37*(1), 1-14. https://doi.org/10.17744/mehc.37.1.v74514163rv73274

Carter, T. T., & Watson, T. I. (2018). Infusing military culture into counselor education. *Journal of Military and Government Counseling, 6*(3), 155-170. http://mgcaonline.org/wp-content/uploads/2018/10/JMGC-Vol-6-Is-3.pdf

Casler, K., Bickel, L., & Hackett, E. (2013). Separate but equal? A comparison of participants and data gathered via Amazon's mTurk, social media, and face-to-face behavioral testing. *Computers in Human Behavior, 29,* 2156-2160. https://doi.org/10.1016/j.chb.2013.05.009

Castro, C.A., Kintzle, S., Schuyler, A.C., Lucas, C.L., & Warner, C. H. (2015). Sexual assault in

the military. *Current Psychiatry Reports, 17*(54), 1-13. https://doi.org/ 10.1007/s11920-015-0596-7

Center for Deployment Psychology. (n.d.). *Military culture course modules.* Uniformed Services University. Retrieved October 8, 2023, from https://deploymentpsych.org/military-culture-course-modules

Center for Deployment Psychology (2020). *Military culture: Core competencies for healthcare professionals*. Uniformed Services University. https://deploymentpsych.org/military-culture-course-modules

Christopher, Colin Warren (2012). *Therapist attachment and perceived working alliance among student clinicians* [Doctoral dissertation, Pacific University]. http://commons.pacificu.edu/spp/381

Clearly, A., & Dowling, M. (2009). Knowledge and attitudes of mental health professionals in Ireland to the concept of recovery in mental health: A questionnaire survey. *Journal of Psychiatric and Mental Health Nursing, 16,* 539-545. https://doi.org/10.1111/j.1365-2850.2009.01411.x

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Coll, J. E., Weiss, E. L., Draves, P. R., & Dyer, D. L. (2012). The impact of military cultural awareness, experience, attitudes and education on clinician self-efficacy in the treatment of veterans. *Professional Development: The International Journal of Continuing Social Work Education, 15*(1), 39-48. https://www.researchgate.net/publication/266475972

Comas-Diaz, L. (2012). *Multicultural care: A clinician's guide to cultural competence.* Washington DC: American Psychological Association.

Constantine, M. G., Miville, M. L., & Kindaichi, M. M. (2008). Multicultural competence in counseling psychology practice and training. In S. D. Brown, & R. W. Lent (Eds.). *Handbook of counseling psychology* (4th ed., pp. 141-158). Hoboken, NJ: John Wiley & Sons, Inc.

Convoy, S., & Westphal, R. J. (2013). The importance of developing military cultural competence. *Journal of Emergency Nursing, 39*(6), 591-594. http://dx.doi.org/10.1016/j.jen.2013.08.010

Cook, J. M., Dinnen, S., Thompson, R., Simiola, V., & Schnurr, P. P. (2014). Changes in implementation of two evidenced-based psychotherapies for PTSD in VA residential treatment programs: A national investigation. *Journal of Traumatic Stress, 27*, 137-143. http://doi.org/10.1002/jts.21902

Coppock, T. E., Owen, J. J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. *Psychotherapy Research, 20*, 619-626. https://doi.org/10.1080/10503307.2010.497508

Cottone, J. G., Drucker, P., & Javier, R. A. (2002). *Psychotherapy: Theory/Research/Practice/Training, 39*(4), 297-308. https://doi.org/10.1037/0033-3204.39.4.297

Crowley, K., & Sandhoff, M. (2017). Just a girl in the Army: U.S. Iraq war veterans negotiating femininity in a culture of masculinity. *Armed Forces & Society, 43*(2), 221-237. https://doi.org/10.1177/0095327X16682045

Culbreth, M. L., Newsome, G., & Whiting, P. P. (2015). *Bridging the gap between veterans and civilian clinicians* (Article 78). Ideas and Research You Can Use: VISTAS Online, American Counseling Association. https://www.counseling.org/knowledge-

center/vistas/by-subject2/vistas-veterans/docs/default-source/vistas/article_7839cd23f16116603abcacff0000bee5e7

Dardis, C. M., Reinhardt, K. M., Foynes, M. M., Medoff, N. E., & Street, A. E. (2018). “Who are you going to tell? Who’s going to believe you?”: Women’s experiences disclosing military sexual trauma. *Psychology of Women Quarterly, 42*(4), 414-429. https://doi.org/10.1177/0361684318796783

Davis, L., & Grifka, A. (2017a). Introduction. In L. Davis, A. Grifka, K. Williams, & M. Coffey (Eds.), *2016 Workplace and gender relations survey of active duty service members: Overview report* (pp. 1-18). Office of People Analytics (OPA). https://www.sapr.mil/public/docs/reports/FY16_Annual/Annex_1_2016_WGRA_Report.pdf

Davis, L., & Grifka, A. (2017b). Estimated sexual assault prevalence rates. In L. Davis, A. Grifka, K. Williams, & M. Coffey (Eds.), *2016 Workplace and gender relations survey of active duty service members: Overview report* (pp. 31-50). Office of People Analytics (OPA). https://www.sapr.mil/public/docs/reports/FY16_Annual/Annex_1_2016_WGRA_Report.pdf

Davis, L., & Grifka, A. (2017c). Reporting the one situation of sexual assault. In L. Davis, A. Grifka, K. Williams, & M. Coffey (Eds.), *2016 Workplace and gender relations survey of active duty service members: Overview report* (pp. 103-142). Office of People Analytics (OPA). https://www.sapr.mil/public/docs/reports/FY16_Annual/Annex_1_2016_WGRA_Report.pdf

Ditchter, M. E., & True, G. (2015). “This is the story of why my military career ended before it should have”: Premature separation from military service among U.S. women veterans. *Journal of Women and Social Work, 30*(2), 187-199. https://doi.org/10.1177/0886109914555219

Do, J. J., & Samuels, S. M. (2020). I am a warrior: An analysis of the military masculine-warrior narrative among U.S. Air Force officer candidates. *Armed Forces & Society, 47*(1), 1-23. https://doi.org/10.1177/0095327X20931561

Eckerlin, D. M., Kovalesky, A., & Jakupcak, M. (2016). Military sexual trauma in male service members: How to assess and care for men with this less visible wound. *The American Journal of Nursing, 116*(9), 34-43. https://doi.org/10.1097/01.NAJ.0000494690.55746.d9

Elder, W. B., Domino, J. L., Rentz, T. O., & Mata- Galán, E. L. (2017). Conceptual model of male military sexual trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 9*(1), 59-66. http://dx.doi.org/10.1037/tra0000194

Exum, H. A., Coll, J. E., & Weiss, E. L. (2011). *A civilian counselor's primer for counseling veterans* (2nd Ed.). Deer Park, NY: Linus Publications.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2013). G*Power Version 3.1.7 [computer software]. Uiversität Kiel, Germany. http://www.psycho.uni-duesseldorf.de/abteilungen/aap/gpower3/download-and-register

Fenell, D. L. (2008). A distinct culture. *Counseling Today, 50*(12), 8-35. https://ct.counseling.org/2008/06/a-distinct-culture/

Fenell, D. L. (2014). Counseling stoic warriors: providing therapy to military men. In M. Englar-Carlson, M. P. Evans, & T. Duffy (Eds.), *A counselor's guide to working with men* (pp. 227-246). Alexandria, VA: American Counseling Association.

Field, A. (2013). *Discovering statistics using SPSS* (4th ed.). Thousand Oaks, CA: Sage.

Fisher, E. H. (1989). Gender bias in therapy? An analysis of patient and therapist causal explanations. *Psychotherapy, 26*(3), 389-401. http://dx.doi.org/10.1037/H0085451

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316-340. http://dx.doi.org/10.1037/pst0000172

Forziat, K. E., Arcuri, N. M., & Erb, C. (2018). Counseling the military population: The factor of prior military exposure for counselors-in-training. *The Journal of Counselor Preparation and Supervision, 10*(1). https://repository.wcsu.edu/jcps/vol10/iss1/6

Frank, J. D. (1995). Psychotherapy as rhetoric: Some implications. *Clinical Psychology: Science and Practice, 2*(1), 90-93. https://doi.org/10.1111/j.1468-2850.1995.tb00030.xFraser, C. (2011). Family issues associated with military deployment, family violence, and military sexual trauma. *Nursing Clinics, 46*(4), 445-455. https://doi.org/10.1016/j.cnur.2011.08.011

Galovski, T. E., Street, A. E., Creech, S., Lehavot, K., Kelly, U. A., & Yano, E. M. (2022). State of the knowledge of VA military sexual trauma research. *Journal of General Internal Medicine, 37*(3), 825-832. https://doi.org/10.1007/s11606-022-07580-8

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*: *Theory, Research, Practice, Training, 27*, 143-153. https://doi.org/10.1037/0033-3204.27.2.143

Gaston, L. (1991). Reliability and criterion-related validity of the California Psychotherapy Alliance Scales-patient version. *Psychological Assessment, 3*, 68-74. http://dx.doi.org/10.1037/1040-3590.3.1.68

Gibbons, S. W., Migliore, L., Convoy, S. P., Greiner, S., & DeLeon, P. H. (2014). Military mental health stigma challenges: Policy and practice considerations. *The Journal for Nurse Practitioners, 10*(6), 365-372. http://dx.doi.org/10.1016/j.nurpra.2014.03.021

Grantham-Philips, W. (2020, July 7). *Fort Hood soldier's death sparks online outcry: 'The military hasn't had their #MeToo movement yet'*. USA Today. https://www.usatoday.com/story/news/nation/2020/07/06/vanessa-guillens-death-spotlights-sexual-assault-harassment-military/5383313002

Grimm, L. G., & Yarnold, P. R. (2001). *Reading and understanding multivariate statistics*. American Psychological Association: Washington D.C.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531-548. https://doi.org/10.1037/0033-3204.43.4.531

Gross, G. M., Cunningham, K. C., Moore, D. A., Naylor, J. C., Brancu, M., Wagner, H. R., Elbogen, E. B., Calhoun, P. S., VA Mid-Atlantic MIRECC Workgroup, & Kimbrel, N. A. (2019). Does deployment-related military sexual assault interact with combat exposure to predict posttraumatic stress disorder in female veterans? *Traumatology, 25*(1), 66-71. https://doi.org/10.1037/trm0000165

Gurung, S., Ventuneac, A., Rendina, J., Savarese, E., Grov, C., & Parsons, J. T. (2018). Prevalence of military sexual trauma and sexual orientation discrimination among lesbian, gay, bisexual, and transgender military personnel: A descriptive study. *Sexuality Research and Social Policy, 15*, 74-82. https://doi.org/10.1007/s13178-017-0311-z

Hall-Clark, B. N., Wright, E. C., Fina, B. A., Blount, T. H., Evans, W. R., Carreño, P. K., Peterson, A. L., Foa, E. B., & STRONG STAR Consortium. (2019). Military culture

considerations in prolonged exposure therapy with active-duty military service members. *Cognitive and Behavioral Practice, 26*(2), 335-350. https://doi.org/10.1016/j.cbpra.2018.07.009

Hall, K. G., Garland, A., Charlton, G. P., & Johnson, M. (2018). Military culture and the civilian therapist: Using relational-cultural theory to promote the therapeutic alliance. *Journal of Creativity in Mental Health, 13*, 451-466. https://doi.org/10.1080/15401383.2018.1470951

Harbin, J. M., Gelso, C. J., & Perez Rojas, A. E. (2013). Therapist work with client strengths: Development and validation of a measure. *The Counseling Psychologist, 42*, 345-373. https://doi.org/10.1177/0011000012470570

Harned, M., Ormerod, A. J., Palmieri, P. A., Collinsworth, L. L., & Reed, M. (2002). Sexual assault by workplace personnel and other types of sexual harassment: A comparison of antecedents and consequences. *Journal of Occupational Health Psychology, 7*(2), 174-188. https://doi.org/10.1037//1076-8998.7.2.174

Hart, J. (2020). *Military veterans' perception of civilian psychologists' competency in military culture and its impact on the therapeutic alliance* (Publication No. 28091039). [Doctoral dissertation, Adler University] ProQuest Dissertations and Theses database.

Hatcher, S. L. & Favorite, T. (2005). An analogue study of therapist empathic process: Working with difference. *Psychotherapy: Theory, Research, Practice, Training, 42*(2), 198-210. https://doi.org/10.1037/0033-3204.42.2.198

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research, 16*, 12-25. https://doi.org/10.1080.10503300500352500

Hatcher, R. L., Lindqvist, K., & Falkenström, F. (2020). Psychometric evaluation of the Working Alliance Inventory - Therapist version: Current and new short forms. *Psychotherapy Research, 30*(6), 706-717. https://doi.org/10.1080/10503307.2019.1677964

Hembree, E. A., Foa, E. B., Dorfan, N. M., Street, G. P., Kowalski, J., & Tu, X. (2003). Do patients drop out prematurely from exposure therapy for PTSD? *Journal of Traumatic Stress, 16*(6), 555-562. https://doi.org/10.1023/B:JOTS.0000004078.93012.7d

Herbert, M. S. (1998). *Camouflage isn't only for combat: Gender, sexuality, and women in the military*. New York, NY: New York University Press.

Holder, N., Holliday, R., Williams, R.C., & Surís, A. (2018). Differences in posttraumatic stress disorder symptom severity for military veterans with combat vs. military sexual trauma. *The Military Psychologist, 33*, 6-10.

Holland, K. J., Caridad Rabelo, V., & Cortina, L. M. (2016). Collateral damage: Military sexual trauma and help-seeking barriers. *Psychology of Violence, 6*(2), 253-261. http://dx.doi.org/10.1037/a0039467

Holliday, R., Holder, N., & Surís, A. (2018). Reductions in self-blame cognitions predict PTSD improvement with cognitive processing therapy for military sexual trauma-related PTSD. *Psychiatry Research, 263*, 181-184. http://dx.doi.org/10.1016/j.psychres.2018.03.007

Holliday, R. & Monteith, L. L. (2019). Seeking help for the health sequelae of military sexual trauma: a theory-driven model of the role of institutional betrayal. *Journal of Trauma & Dissociation, 20*(3), 340-356. http://dx.doi.org/10.1080/15299732.2019.1571888

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*(2), 223-233. https://doi.org/10.1037/0022-0167.36.2.223

Howard, R., Berry, K., & Haddock, G. (2021). Therapeutic alliance in psychological therapy for posttraumatic stress disorder: A systematic review and meta-analysis. Clinical *Psychology & Psychotherapy, 29,* 373-399. https://doi.org/10.1002/cpp.2642

Hoyt, T., Klosterman Rielage, J., & Williams, L. F. (2011). Military sexual trauma in men: A review of reported rates. *Journal of Trauma & Dissociation, 12*(3), 244-260. https://doi.org/10.1080/15299732.2011.542612

Hunter, K. (2018). Warrior culture: Ancient roots, new meaning. In K. Hendricks Thomas & D. Albright (Eds.), *Bulletproofing the psyche: Preventing mental health problems in our military and veterans* (p. 29-42). Santa Barbara, CA: ABC-CLIO, LLC

Hunter, M. (2007). *Honor betrayed: Sexual abuse in America's military*. Fort Lee, NJ: Barricade Books.

Jonas D. E., Cusack, K., Forneris, C. A., Wilkins, T. M., Sonis, J., Middleton, J. C., Feltner, C., Meredith, D., Cavanaugh, J., Brownley, K. A., Olmstead, K. R., Greenblatt, K. A., Weil, A., & Gaynes, B. N. (2013). *Psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD): Comparative effectiveness review No. 92.* (AHRQ Publication No. 13-EHC011-EF; pp. 140-141). Agency for Healthcare Research and Quality. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/ptsd-adult-treatment_research.pdf

Juan, M. J. D., Nunnink, S. E., Butler, E. O., & Allard, C. B. (2017). Gender role stress mediates depression among veteran men with military sexual trauma. *Psychology of Men & Masculinity, 18*(3), 243-250. https://doi.org/10.1037/men0000120

Katz, L. S. (2016a). Warrior renew: An integrative treatment for military sexual trauma with an emphasis on interpersonal factors. In L. Katz (Ed.), *Treating Military Sexual Trauma* (pp. 235-254). New York, NY: Springer Publishing Company, LLC.

Katz, L. S. (2016b). What is military sexual trauma? In L. S. Katz (Ed.), *Treating military sexual trauma* (pp. 3-23). New York, NY: Springer Publishing Company.

Kazdin, A. E. (2015). *Methodological issues and strategies in clinical research* (4th ed.). Washington, DC: American Psychological Association.

Kelly, U. A., Skelton, K., Patel, M., & Bradley, B. (2011). More than military sexual trauma: Interpersonal violence, PTSD, and mental health in women veterans. *Research in Nursing & Health, 34*(6), 457-467. https://doi.org/10.1002/nur.20453

Khan, A. J., Holder, N., Shiner, B., Madden, E. Seal, K., Neylan, T. C., & Maguen, S. (2020). How do gender and military sexual trauma impact PTSD symptoms in cognitive processing therapy and prolonged exposure? *Journal of Psychiatric Research, 130*, 89-96. https://doi.org/10.1016/j.jpsychires.2020.06.025

Kilpatrick, D. G., Best, C. L., Smith, D. W., Kudler, H., & Cornelison-Grant, V. (2011). *Serving those who have served: Educational needs of health care providers working with military members, veterans, and their families*. Medical University of South Carolina Department of Psychiatry, National Crime Victims Research and Treatment Center. https://www.mirecc.va.gov/docs/visn6/Serving_Those_Who_Have_Served.pdf

Kimerling, R., Gima, K., Smith, M. W., Street, A., & Frayne, S. F. (2007). The Veteran Health Administration and military sexual trauma. *American Journal of Public Health, 97*, 2160-2166. https://doi.org/10.2105/AJPH.2006.092999

Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R. V., & McCarthy, J. F. (2016). Military sexual trauma and suicide mortality. *American Journal of Preventive Medicine, 50*(6), 684-691. https://doi.org/10.1016/j.amepre.2015.10.019

Klingensmith, K., Tsai, J., Mota, N., Southwick, S. M., & Pietrzak, R. H. (2014). Military sexual trauma in US veterans: Results from the National Health and Resilience in Veterans Study. *Journal of Clinical Psychiatry, 75*(10), 133-139. https://doi.org/10.4088/JCP.14m09244

Koblinsky, S. A., Leslie, L. A., & Cook, E. T. (2014). Treating behavioral health conditions of OEF/OIF veterans and their families: A state needs assessment of civilian providers. *Military Behavioral Health, 2*(2), 162-172. https://doi.org/10.1080/21635781.2014.890884

Kulesza, M., Pedersen, E., Corrigan, P., & Marshall, G. (2015). Help-seeking stigma and mental health treatment seeking among young adult veterans. *Military Behavioral Health 3*(4), 230-239. https://doi.org/10.1080/21635781.2015.1055866

Laska, K. M., Smith, T. L., Wislocki, A. P., Minami, T. & Wampold, B. E. (2013). Uniformity of evidence-based treatments in practice? Therapist effects in the delivery of cognitive processing therapy for PTSD. *Journal of Counseling Psychology, 60*(1), 31-41. https://psycnet.apa.org/doi/10.1037/a0031294

Lawton, M., Conroy, P., Sage, K., & Haddock, G. (2019). Aphasia and stroke therapeutic alliance measure (A-STAM): Development and preliminary psychometric evaluation. *International Journal of Speech-Language Pathology, 21*(5), 459-469. https://doi.org/10.1080/17549507.2019.1648551

Leppma, M., Taylor, J. M., Spero, R. A., Leonard, J. M., Foster, M. N., & Daniels, J. A. (2016). Working with veterans and military families: An assessment of professional competencies. *Professional Psychology Research and Practice, 47*(1), 84-92. https://doi.org/10.1037/pro0000059

Lindsay, J. A., Keo-Meier, C., Hudson, S., Walder, A., Martin, L. A., & Kauth, M. R. (2016). Mental health of transgender veterans of the Iraq and Afghanistan conflicts who experienced military sexual trauma. *Journal of Traumatic Stress, 29*(6), 563-567. https://doi.org/10.1002/jts.22146

Lofgreen, A. M., Carroll, K. K., Dugan, S. A., & Karnik, N. S. (2017). An overview of sexual trauma in the U.S. military. *Focus, 15*(4), 411-419. https://doi.org/10.1176/appi.focus.20170024

Lu, J. (2017). Multicultural Counseling Knowledge and Awareness Scale: Re-Exploration and refinement. *International Journal for the Advancement of Counselling, 39*, 14-27. https://doi.org/10.1007/s10447-016-9279-2

Management of Posttraumatic Stress Disorder Work Group. (2017). *VA/DOD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder*. Veterans Health Administration, Department of Defense.

Marino, M. A., Wolgast, K. A., Speck, P. M., Kenny, D. J., & Moriarty, H. (2019). American academy of nursing policy brief: Military sexual trauma. *Nurse Outlook, 67*(4), 486-491. https://doi.org/10.1016/j.outlook.2019.06.002

Mattocks, K. M., Haskell, S. G., Krebs, E. E., Justice, A. C., Yano, E. M., & Brandt, C. (2012). Women at war: Understanding how women veterans cope with combat and military sexual trauma. *Social Science & Medicine, 74*, 537-545.

https://doi.org/10.1016/j.socscimed.2011.10.039

McBain, S. A., Garneau-Fournier, J., & Turchik, J. A. (2020). The relationship between provider gender preferences and perceptions of providers among veterans who experienced military sexual trauma. *Journal of Interpersonal Violence, 37*(5-6), 2868-2890. https://www.ptsd.va.gov/professional/articles/article-pdf/id40826.pdf

McKay, K. (2001). *Therapist responses to client who have been raped: The effect of rape myth acceptance and ambivalent sexism on therapist perceptions of treatment responses* (Publication No. 3029954). [Doctoral dissertation, University of Akron] ProQuest Dissertations and Theses database.

Mengeling, M. A., Booth, B. M., Tomer, J. C., & Sadler, A. G. (2014). Reporting sexual assault in the military: Who reports and why most servicewomen don't. *American Journal of Preventative Medicine, 47*(1), 17-25. http://dx.doi.org/10.1016/j.amepre.2014.03.001

Meyer, E. G., Hall-Clark, B. N., Hamaoka, D., & Peterson, A. L. (2015). Assessment of military cultural competence: A pilot study. *Academic Psychiatry, 39*, 382-388. https://doi.org/10.1007/s40596-015-0328-7

Meyer, E. G., Writer, B. W., & Brim, W. (2016). The importance of understanding military culture. *Academic Psychiatry, 39,* 1-8. https://doi.org/10.1007/s40596-015-0285-1

Monteith, L. L., Bahraini, N. H., Matarazzo, B. B., Soberay, K. A., & Parnitzke Smith, C. (2016). Perceptions of institutional betrayal predict suicidal self-directed violence among veterans exposed to military sexual trauma. *Journal of Clinical Psychology, 72*(7) 743-755. https://doi.org/10.1002/jclp.22292

Monteith, L. L., Gerber, H. R., Brownstone, L. M., Soberay, K. A., & Bahraini, N. H. (2019). The phenomenology of military sexual trauma among male veterans. *Psychology of Men & Masculinity, 20*(1), 115-127. http://dx.doi.org/10.1037/men0000153

Morral, A. R., Schell, T. L., Cefalu, M., Hwang, J., & Gelman, A. (2018). *Sexual assault and sexual harassment in the U.S. military: Volume 5. Estimates for installation- and command-level risk of sexual assault and sexual harassment from the 2014 RAND military workplace study* (10.7249/RR870.7), RAND Corporation. http://dx.doi.org/10.7249/RR870.7

Morris, E. E., Smith, J. C., Farooqui, S. Y., & Surís, A. M. (2014). Unseen battles: The recognition, assessment, and treatment issues of men with military sexual trauma (MST). *Trauma, Violence, & Abuse, 15*(2), 94-101. http://doi.org/10.1177/1524838013511540

Mueller, K. L. (2017). Understanding our military survivors of sexual assault. In J. Beder (Ed.), *Caring for the military: A guide for helping professionals* (pp. 132-142). New York, NY: Routledge.

Mullen, K., Holliday, R., Morris, E., Raja, A., Surís, A. (2014). Cognitive processing therapy for male veterans with military sexual trauma-related posttraumatic stress disorder. *Journal of Anxiety Disorder, 28*, 761-764. http://dx.doi.org/10.1016/j.janxdis.2014.09.004

Nacasch, N., Foa, E. B., Huppert, J. D., Tzur, D., Fostick, L., Dinstein, Y., Polliack, M., & Zohar, J. (2010). Prolonged exposure therapy for combat- and terror-related posttraumatic stress disorder: A randomized control comparison with treatment as usual. *The Journal of Clinical Psychiatry, 72*(9), 1174-1180. http://doi.org/10.4088/JCP.09m05682blu

National Association of Social Workers. (2015). Standards and indicators for cultural competence in social work practice. http://www.socialworkers.org/LinkClick.aspx?fileticket=PonPTDEBrn4%3D&portalid=0

National Center for PTSD. (2019, October 17). *Military sexual trauma*. U.S. Department of Veteran Affairs. https://www.ptsd.va.gov/understand/types/sexual_trauma_military.asp

Nedegaard, R., & Zwilling, J. (2017). Promoting military cultural competence among civilian care providers: Learning through program development. *Social Sciences, 6*(13), 1-11. https://doi.org/10.3390/socsci6010013

Norcross, J. C. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy Relationships That Work: Evidence-Based Responsiveness*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199737208.001.0001

Northcut, T. B., & Kienow, A. (2014). The trauma trifecta of military sexual trauma: A case study illustrating the integration of mind and body in clinical work with survivors of MST. *Clinical Social Work Journal, 42*, 247-259. http://doi.org/10.1007/s10615-014-0479-0

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

O'Brien, C., Keith, J., & Shoemaker, L. (2015). Don't tell: Military culture and male rape. *Psychological Services, 12*(4), 357-365. http://dx.doi.org/10.1037/ser0000049

O'Brien, B. S., & Sher, L. (2013). Military sexual trauma as a determinant in the development of mental and physical illness in male and female veterans. *International Journal of*

Adolescent Medicine and Health, 25(3), 269-274. https://doi.org/10.1515/ijamh-2013-0061

O'Hara, D. J., & O'Hara, E. F. (2012). Towards a grounded theory of therapist hope. *Counselling Psychology Review, 27,* 42-55. https://shop.bps.org.uk/publications/publication-by-series/counselling-psychology-review.html

Owen, J., Wong, Y. J., & Rodolfa, E. (2009). Empirical search for psychotherapists' gender competence in psychotherapy. *Psychotherapy Theory, Research, Practice, Training, 46*(4), 448-458. https://doi.org/10.1037/a0017958

Pavao, J., Turchik, J. A., Hyun, J. K., Karpenko, J., Saweikis, M., McCutcheon, S., Kane, V., & Kimerling, R. (2013). Military sexual trauma among homeless veterans. *Journal of General Internal Medicine, 28*, 536-541. https://doi.org/10.1007/s11606-013-2341-4

Ponterotto, J. G., Gretchen, D., Utsey, S. O., Rieger, B. P., & Austin, R. (2002). A revision of the multicultural counseling awareness scale. *Journal of Multicultural Counseling and Development, 3*0(3), 153-180. https://doi.org/10.1002/j.2161-1912.2002.tb00489.x

Ponterotto, J. G., Rieger, B. P., Barrett, A., Sparks, R., Sanchez, C. M., & Magids, D. (1996). Development and initial validation of the multicultural counseling awareness scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247–282). Lincoln, NE: Buros Institute of Mental Measurements.

Price, E. W., Stickley, V., & Prosek, E. A. (2015). Fall in line with duty: Preparing counseling students to serve the military population. *Journal of Military and Government Counseling, 3*(2), 79-92. https://www.researchgate.net/publication/313836352

Prosek, E. A., & Holm, J. M. (2014). Counselors and the military: When protocol and ethics conflict. *The Professional Counselor, 4*(2), 93-102. https://doi.org/10.15241/eap.4.2.93

Redmond, S. A., Wilcox, S. L., Campbell, S., Kim, A., Finney, K., Barr, K., & Hassan, A. M. (2015). A brief introduction to the military workplace culture. *Work, 50*(1), 9-20. https://doi.org/10.3233/WOR-141987

Romaniuk, J. R., & Loue, S. (2017). Military sexual trauma among men: A review of the literature and a call for research. *Best Practices in Mental Health: An International Journal, 13*(1), 80-104. https://www.researchgate.net/publication/317672486

Ross, P. T., Ravindranath, D., Clay, M., & Lypson, M. L. (2015). A greater mission: Understanding military culture as a tool for serving those who have served. Journal of *Graduate Medical Education, 7*(4), 519-522. https://doi.org/10.4300/JGME-D-14-00568.1

Rothbaum, B. O., Astin, M. C., & Masteller, F. (2005). Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *Journal of Traumatic Stress, 18*(6), 607-616. https://doi.org/607-616. 10.1002/jts.20069

Ryan, G. L., Mengeling, M. A., Booth, B. M., Torner, J. C., Syrop, C. H. & Sadler, A. G. (2014). Voluntary and involuntary childlessness in female veterans: Associations with sexual assault. *Fertility and Sterility, 102*(2), 539-547. http://dx.doi.org/10.1016/j.fertnstert.2014.04.042

Sadler, A. G., Booth, B. M., Cook, B. L., & Doebbeling, B. N. (2003). Factors associated with women's risk of rape in the military environment. *American Journal of Industrial Medicine, 43*, 262-273. https://doi.org/10.1002/ajim.10202.

Scheel, M. J., Stabb, S. D., Cohn, T. J., Duan, C., & Sauer, E. M. (2018). Counseling psychology model training program. *The Counseling Psychologist, 46*(1), 6-49. https://doi.org/10.1177/0011000018755512

Scudder, H. R. (2017). *Premature termination in trauma-focused treatment from the perspective of military service members and veterans* (Publication No. 10191575) [Doctoral dissertation, William James College]. ProQuest Dissertations and Theses database.

Severance, L., Debus, J., & Davis, L. (2017). Analysis of men who indicated experiencing sexual assault. In L. Davis, A. Grifka, K. Williams, & M. Coffey (Eds.), *2016 Workplace and gender relations survey of active duty service members: Overview report* (pp. 313-344). Office of People Analytics (OPA). https://www.sapr.mil/public/docs/reports/FY16_Annual/Annex_1_2016_WGRA_Report.pdf

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy, 47*(4), 637-645. https://doi.org/10.1037/a0021175

Shepperson, K. (2018). *Lived experiences of civilian therapists managing care for survivors of military sexual trauma* (Publication No. 10975026) [Doctoral dissertation, University of Phoenix]. ProQuest Dissertations & Theses Global.

Shiner, B., Westgate, C. L., Harik, J. M., Watts, B. V., & Schnurr, P. P. (2017). Effect of patient-therapist gender match on psychotherapy retention among United States veterans with posttraumatic stress disorder. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(5), 642-650. https://doi.org/10.1007/s10488-016-0761-2

Silva, J. M. (2008). A new generation of women? How female ROTC cadets negotiate the

tension between masculine military culture and traditional femininity. *Social Forces, 87*(2), 937-960. https://doi.org/10.1353/sof.0.0138

Smith, A. J. (2014). Culturally competent therapy with military veterans: Identifying and overcoming issues facing providers. *Journal of Military and Government Counseling, 2*(2), 119-135. https://mgcaonline.org/wp-content/uploads/2013/02/JMGC-Vol-2-Is-2.pdf

Smith, C. P., & Freyd, J. J. (2013). Dangerous safe havens: Institutional betrayal exacerbates sexual trauma. *Journal of Traumatic Stress, 26*, 119-124. https://doi.org/10.1002/jts.21778

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., Yoshinobu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*(4), 570-585. https://doi.org/10.1037/0022-3514.60.4.570

Snyder, C. R. (2002). Hope theory: Rainbows in the mind. *Psychological Inquiry, 4*, 249-275. https://doi.org/10.1207/S15327965PLI1304_01

Soto, A., Smith, T. B., Griner, D., Domenech Rodríguez, M., & Bernal, G. (2018). Cultural adaptations and therapist multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology, 74*(11), 1907-1923. https://doi.org/10.1002/jclp.22679

Stebnicki, M. A. (2016). Military counseling. In I. Marini & M. A. Stebnicki (Eds.) *The Professional Counselor's Desk Reference* (2nd Ed.) (pp. 499-506). New York, NY: Springer Publishing Company.

Steenkamp, M. M., Litz, B. T., Hoge, C. W., & Marmar, C. R. (2015). Psychotherapy for military-related PTSD: A review of randomized clinical trials. *JAMA, 314*(5), 489-500. https://doi.org/10.1001/jama.2015.8370

Street, A. E., Gradus, J. L., Stafford, J., & Kelly, K. (2007). Gender differences in experiences of sexual harassment: Data from a male-dominated environment. *Journal of Consulting and Clinical Psychology, 75*(3), 464-474. https://doi.org/10.1037/0022-006X.75.3.464.

Street, A. E., Vogt, D., & Dutra, L. (2009). A new generation of women veterans: Stressors faced by women deployed to Iraq and Afghanistan. *Clinical Psychology Review, 29*, 685-694. https://doi.org/10.1016/j.cpr.2009.08.007

Strom, T. Q., Gavian, M. E., Possis, E., Loughlin, J., Bui, T., Linardatos, E., Leskela, J., & Siegel, W. (2012). Cultural and ethical considerations when working with military personnel and veterans: A primer for VA training programs. *Training and Education in Professional Psychology, 6*(2), 67-75. https://doi.org/10.1037/a0028275

Strong, J. D., Crowe, B. M., & Lawson, S. (2018). Female veterans: Navigating two identities. *Clinical Social Work Journal, 46*, 92-99. https://doi.org/10.1007/s10615-017-0636-3

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*(4), 440-448. https://doi.org/10.1037/0003-066X.53.4.440

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*(2), 64–88. https://doi.org/10.1002/j.2161-1912.1992.tb00563.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith, E. J., & Vasquez-Nuttall, E. (1982). Position paper: cross-cultural counseling competencies. *The Counseling Psychologist, 10*(2), 45-52. https://doi.org/10.1177/0011000082102008

Sue, D. W., & Sue, D. (2012). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: Wiley.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548. https://doi.org/10.1146/annurev.psych.60.110707.163651.

Surìs, A., & Lind, L. (2008). Military sexual trauma: A review of prevalence and associated health consequences in veterans. *Trauma, Violence, & Abuse, 9*(4), 250-269. https://doi.org/10.1177/1524838008324419

Surìs, A., Lind, L., Kashner, M., & Borman, P. D. (2007). Mental health, quality of life, and health functioning in women veterans: Differential outcomes associated with military and civilian sexual assault. *Journal of Interpersonal Violence, 22*(2), 179-197. https://doi.org/10.1177/0886260506295347

Tanielian, T., Farris, C., Epley, C., Farmer, C. M., Robinson, E., Engel, C. C., Robbins, M. W., & Jaycox, L. H. (2014). *Ready to Serve: Community-based provider capacity to deliver culturally competent, quality mental health care to veterans and their families*. RAND corporation. https://www.rand.org/content/dam/rand/pubs/research_reports/RR800/RR806/RAND_RR806.pdf

Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). *A meta-analysis of multicultural competencies and psychotherapy process and outcome, 62*(3), 337-350. http://dx.doi.org/10.1037/cou0000086

Taylor, B. J. (2006). Factorial surveys: Using vignettes to study professional judgement. *British Journal of Social Work, 36,* 1187-1207. https://doi.org/10.1093/bjsw/bch345

Tiet, Q. Q., Leyva, Y. E., Blau, K., Turchik, J. A., & Rosen, C. S. (2015). Military sexual assault, gender, and PTSD treatment outcomes of U.S. veterans. *Journal of Traumatic Stress, 28*, 92-101. https://doi.org/10.1002/jts.21992

Turchik, J. A., Bucossi, M. M., & Kimerling, R. (2014). Perceived barriers to care and gender preferences among veteran women who experienced military sexual trauma: A qualitative analysis. *Military Behavioral Health, 2*, 180-188. https://doi.org/10.1080/21635781.2014.892410

Turchik, J. A., & Edwards, K. (2012). Myths about male rape: A literature review. *Psychology of Men & Masculinity, 13*(2), 211-226. https://doi.org/10.1037/a0023207

Turchik, J. A., McLean, C., Rafie, S., Hoyt, T., Rosen, C. S., & Kimerling, R. (2013). Perceived barriers to care and provider gender preferences among veteran men who have experienced military sexual trauma: a qualitative analysis. *Psychological Services, 10*(2), 213-222. https://doi.org/10.1037/a0029959

Turchik, J. A., Pavao, J., Hyun, J., Mark, H., & Kimerling, R. (2012). Utilization and intensity of outpatient care related to military sexual trauma for veterans from Afghanistan and Iraq. *The Journal of Behavioral Health Services & Research, 39*(3), 220-233. https://doi.org/10.1007/s11414-012-9272-4

Turchik, J. A., & Wilson, S. M. (2010). Sexual assault in the U.S. military: A review of the literature and recommendations for the future. *Aggression and Violent Behavior, 15*(4), 267-277. https://doi.org/10.1016/j.avb.2010.01.005

Ullman, S. E. (2014). Interviewing therapists about working with sexual assault survivors: Research and therapist perspectives. *Violence Against Women, 20*(9), 1138-1156. https://doi.org/10.1177/1077801214549639

U. S. Army. (2011, January 5). *Warrior Ethos*. https://www.army.mil/article/50082/warrior_ethos

U. S. Commission on Civil Rights. (2013). *Sexual assault in the military: 2013 statutory enforcement report*. https://www.usccr.gov/pubs/docs/09242013_Statutory_Enforcement_Report_Sexual_Assault_in_the_Military.pdf

U. S. Department of Defense, Sexual Assault Prevention and Response Office (SAPRO). (2020a). *Appendix F: Sexual Harassment Assessment, Fiscal Year 2020*.

U. S. Department of Defense, Sexual Assault Prevention and Response Office (SAPRO). (2020b). *Department of Defense annual report on sexual assault in the military: Fiscal year 2019*. (RefID: D-A4BC881). https://www.sapr.mil/sites/default/files/1_Department_of_Defense_Fiscal_Year_2019_Annual_Report_on_Sexual_Assault_in_the_Military.pdf

U. S. Department of Defense, Sexual Assault Prevention and Response Office (SAPRO). (2020c). Directive number 6495.01. https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/649501p.pdf

U. S. Department of Defense. (2015). *Report to the president of the United States on sexual assault prevention and response* (Fiscal year 2014). https://www.army.mil/e2/c/downloads/374630.pdf

U. S. Department of the Army. (2017). *Army training and leader development* (Army Regulation 350-1). https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN18487_R350_1_Admin_FINAL.pdf

U. S. Department of Veteran Affairs. (n.d.). *Community provider toolkit.* Retrieved October 8, 2023, from https://www.mentalhealth.va.gov/communityproviders/index.asp

U. S. Department of Veterans Affairs. (2014, December 1). *VA expands eligibility for VA health care related to military sexual trauma*. Office of Public and Intergovernmental Affairs. https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2663

U. S. Department of Veterans Affairs. (2020a). *Military sexual trauma (MST) mandatory training and reporting requirements for VHA mental health and primary care providers (*VHA Directive 1115.01-1).

U. S. Department of Veteran Affairs. (2020b, August 11). *Military sexual trauma.* https://www.va.gov/health-care/health-needs-conditions/military-sexual-trauma/

U. S. Department of Veteran Affairs. (2023, April 10). *Veteran cultural competence training.* Retrieved October 8, 2023, from https://www.mirecc.va.gov/visn2/education/vcc.asp

U.S. Department of Veterans Affairs & U. S. Department of Defense. (2010). *The VA/DoD clinical practice guideline for management of post-traumatic stress*. Washington, DC. https://www.rehab.research.va.gov/jour/2012/495/pdf/VADODclinicalguidlines495.pdf

Vasquez, M. J. T. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8), 878–885. https://doi.org/10.1037/0003-066X.62.8.878

Vera, E. M., & Speight, S. L. (2003). Multicultural competence, social justice, and counseling psychology: Expanding our roles. *The Counseling Psychologist, 31*(3), 253-272. https://doi.org/10.1177/0011000002250634

Veteran's Benefits Act, 38 U.S.C. § 1720D (1992).

Voelkel, E., Pukay-Martin, N. D., Walter, K. H., & Chard, K. M. (2015). Effectiveness of cognitive processing therapy for male and female U.S. veterans with and without military sexual trauma. *Journal of Traumatic Stress, 28,* 174-182. https://doi.org/10.1002/jts.22006

Vonderhaar, R. L., & Carmody, D. C. (2015). There are no 'innocent victims': The influence of just world beliefs and prior victimization on rape myth acceptance. *Journal of Interpersonal Violence, 30*(10), 1615-1632. https://doi.org/10.1177/0886260514549196

Walsh, K., Fortier, M. A., & Dilillo, D. (2010). Adult coping with childhood sexual abuse: A theoretical and empirical review. *Aggression and Violent Behavior, 15*(1), 1-13. https://doi.org/10.1016/j.avb.2009.06.009

Wampold, B. E. (2015) How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270-277. https://doi.org/10.1002/wps.20238

Weiss, E. L., & Coll, J. E. (2011). Influence of military culture and veteran worldviews on mental health treatment. *The International Journal of Health, Wellness, & Society, 1*(2), 75-86. https://doi.org/10.18848/2156-8960/CGP/v01i02/41168

Wendt, D. C., Gone, J. P., & Nagata, D. K. (2015). Potentially harmful therapy and multicultural counseling: Bridging two disciplinary discourses. *The Counseling Psychologist, 43*(3), 334-358. https://doi.org/10.1177/0011000014548280.

Westphal, R. J., & Convoy, S. P. (2015). Military culture implications for mental health and nursing care. *The Online Journal of Issues in Nursing, 20*(1), Manuscript 4. https://doi.org/10.3912/OJIN.Vol20No01Man04

Wiblin, J., Holder, N., Hooliday, R., & Surís, A. (2018). Predictors of unbearability, unloveability, and unsolvability in veterans with military-sexual-trauma-related

posttraumatic stress disorder. *Journal of Interpersonal Violence, 14*(1), 1-17. https://doi.org/10.1177/0886260518777554

Williams, I., & Bernstein, K. (2011). Military sexual trauma among U.S. female veterans. *Archives of Psychiatric Nursing, 25*(2), 138-147. https://doi.org/10.1016/j.apnu.2010.07.003

Wilson, L. C. (2018). The prevalence of military sexual trauma: A meta-analysis. *Trauma, Violence, & Abuse, 19*, 584-597. https://doi.org/10.1177/1524838016683459

Wolfe-Clarke, A. L., Bryan, C. J., Bryan, A. O., Reynolds, M. L., Fuessel-Herrmann, D., White, K. L., & Harris, J. A. (2017). Child sexual abuse, military sexual trauma, and psychological distress among male military personnel and veterans. *Journal of Child & Adolescent Trauma, 10*, 121-128. https://doi.org/10.1007/s40653-017-0144-1

Wolff, K. B., & Mills, P. D. (2016). Reporting military sexual trauma: A mixed-methods study of women veterans' experiences who served from World War II to the War in Afghanistan. *Military Medicine, 181*(8), 840-848. https://doi.org/10.7205/MILMED-D-15-00404

Women Veterans Health Programs Act, 38 U.S.C. § 102-585. (1992).

Worthen, M. (2011). The relations between traumatic exposures, posttraumatic stress disorder, and anger in male and female veterans. *Journal of Feminist Family Therapy, 23*(3-4), 188-201. https://doi.org/10.1080/08952833.2011.604535

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

Yamada, A. M., Atuel, H. R., & Weiss, E. L. (2013). Military culture and multicultural diversity among military service members: Implications for mental health providers. In F. A. Paniagua & A. M. Yamada (Eds.), *Handbook of multicultural mental health* (2nd ed.; pp. 389-410). San Diego, CA: Elsevier. http://dx.doi.org/10.1016/B978-0-12-394420-7.00020-5

Yarrow, C., & Churchill, S. (2009). Counsellors' and psychologists' experience of working with male survivors of sexual trauma: A pilot study. *Counselling Psychology Quarterly, 22*, 267–277. https://doi.org/10.1080/09515070903171926

Zaleski, K. L. (2015). *Understanding and treating military sexual trauma*. Irvine, CA: Springer. https://link.springer.com/book/10.1007%2F978-3-319-73724-9

Zaleski, K., & Katz, L. S. (2014). Alice in Wonderland: Exploring the experiences of female service members with a pregnancy resulting from rape. *Social Work in Mental Health, 12*, 391-410. https://doi.org/10.1080/15332985.2014.893945

Zephyrin, L. (2016). Reproductive health management for the care of women veterans. *Obstetrics & Gynecology, 127*(2), 382-392. https://doi.org/10.1097/AOG.0000000000001252

Zimmerman, T., Castronova, M., & ChenFeng, J. (2016). Diversity and social justice in supervision In K. B. Jordan (Ed.), *Couple, marriage, and family therapy supervision* (pp. 121-150). New York, NY: Springer Publishing Company.

Zwiebach, L., Lannert, B. K., Sherrill, A. M., McSweeney, L. B., Spraing, K., Goodnight, J. R. M., … Rauch, S. A. M. (2019). Military cultural competence in the context of cognitive behavioural therapy, *The Cognitive Behavior Therapist, 12*(5), E5. https://doi.org/10.1017/S1754470X18000132

Appendices

Appendix A

Demographic Questionnaire

What is your gender?
- Male
- Female
- Nonbinary
- Transgender male
- Transgender female
- Intersex
- Prefer not to say

Age

____

Which origin do you closely identify yourself in – Hispanic, Latino or Spanish?
- Yes
- No
- Other (Please specify)
- Prefer not to say

How would you best describe yourself?
- American Indian or Alaska Native
- Asian
- Black or African American
- Biracial
- Native Hawaiian or Other Pacific Islander
- White
- Other (Please specify)
- Prefer not to say

Are currently providing psychotherapy or counseling for mental health treatment?
- Yes
- No

What type of master's or doctoral level degree in a mental health related field do you hold?
- Ph.D./Psy.D. Clinical Psychology
- Ph.D./Psy.D. Counseling Psychology
- M.A./M.S. in Clinical Psychology
- M.A./M.S. in Counseling Psychology
- Ph.D. Counselor Education
- M.A. Counseling/Counselor Education
- Ph.D. Social Work
- M.S.W Social Work
- M.D./D.O. with residency training in Psychiatry

Other (Please specify) ____________________

Please indicate what type of full license you hold in a mental health-related field (e.g., licensed psychologist, licensed social worker, licensed professional counselor)?

Licensed Marriage and Family Therapist
Licensed Physician
Licensed Professional Counselor
Licensed Psychologist
Licensed Social Worker
Other (Please specify) ____________________

Years of Clinical practice

______

Have you served in prior military service?

Yes
No

Are you currently serving in military service?

Yes
No

Were you or are you serving as a military psychologist or therapist?

Yes
No

Were you or are you serving as a Department of Defense (DOD) psychologist or therapist?

Yes
No

Were you or are you working as a Department of Veteran Affairs psychologist or therapist?

Yes
No

Were you or are you working largely with military populations (at least 50% of caseload)?

Yes
No

Have you ever experienced military sexual trauma?

Yes
No
Prefer not to say

Appendix B

Clinical Vignettes

Vignette 1

Instructions: **Please read the following case vignette as if this were a real client you are currently working with. Please visualize and imagine how you anticipate you might respond, ask further questions, conceptualize the client's distress, and provide treatment to this client.**

Mr. Johnson is a 24-year-old male veteran having previously served active-duty in the U. S. Army. His initial intake paperwork notes that he has long-standing trouble sleeping, difficulties managing stress, and notes vaguely "something terrible happened." He arrives on time, dressed in civilian clothes, appearing visibly anxious with his knee bouncing rapidly sitting in the waiting room. He introduces himself by his last name and remarks that he has never been to counseling before noting, "I don't know how this counseling thing works. I usually just keep things to myself." You discuss the process of counseling in which you help to identify difficulties, establish goals for wellness, and collaboratively work together to reach those goals. He appears uncomfortable and asks, "Who is going to know about this? What do you do with information told to you?" You outline the boundaries of confidentiality, reassuring him that you do not report to a superior, but guard his privacy. You indicate the limits of confidentiality regarding risk of harm to self, others, children, and vulnerable adults.
Mr. Johnson appears to relax a bit, although still alert. He begins to report feeling increased frustration and irritability at work. He notes difficulties transitioning back to civilian life 4 years ago with a history of poor relationships with friends and family, short-term dating relationships, chronic pain, headaches, and difficulties sleeping with trouble falling asleep and nightmares. He also notes drinking more alcohol to help him sleep but is "probably drinking more than he should" with approximately 4-6 drinks per night. You ask specifically about his nightmares and he cites that he has terrible dreams about "what happened me." You gently probe about this terrible event, and he looks blankly at you for a period of 30-seconds before slowly sharing details of being sexually harassed and assaulted during his time of service 5 years ago.
Mr. Johnson describes having been down range, clarifying that he was deployed overseas, when he and a group of five male soldiers in his platoon got together late one evening to have some drinks. Mr. Johnson notes that he had worked day-in and day-out with these guys for 6 months, building strong friendships and trust with each. He notes that there were times where "being in the sandbox made em' stir crazy" citing sexualized comments and hand gestures directed at him. Mr. Johnson describes "letting it go" and "not making a big deal out of it." However, the night of drinking escalated things. Mr. Johnson became visibly distressed describing events with pressured speech and elevated affect, although with restricted facial expressions and staring at the floor. He reported struggling to remember all the events that occurred as he had drunk a substantial amount of alcohol and was very inebriated. He shared his recalled events including the other soldiers ordering him to take off his pants and the pain of being raped. "I was told not to fight back, so I didn't." He described having blacked-out during the incident, having trouble recalling specific details but he was aware that the other soldiers were present.
Over the following weeks, Mr. Johnson feared rumors spreading of what had happened. However, the rape was not mentioned within his unit and platoon. He notes that "everyone acted

like nothing happened. Even the guys that did it." Mr. Johnson noted increased anxiety, hypervigilance, fear, and paranoia on the deployment as he no longer felt safe. Mr. Johnson described his anger and hurt that men he previously trusted and saw as brothers would do this to him. He indicated that he did not make an official report for fear of further reprisal from his platoon which could ruin his career. Following the event, he began to struggle completing assignments and duties which kept him from promotion. Two years later with multiple negative performance evaluations, he chose not to reenlist as he felt he was "no longer strong enough to serve." Mr. Johnson tearfully described the events of rape, hiding his face with his hands. "It's been five years, but I don't know what to do. I haven't been able to talk about this with anyone. This is the first time I've told anyone. I need help. I need to get past this, I just don't know how. I am not sure if anyone can help me."

Vignette 2

Instructions: **Please read the following case vignette as if this were a real client you are currently working with. Please visualize and imagine how you anticipate you might respond, ask further questions, conceptualize the client's distress, and provide treatment to this client.**

Ms. Johnson is a 24-year-old female veteran having previously served active-duty in the U. S. Army. Her initial intake paperwork notes that she has long-standing trouble sleeping, difficulties managing stress, and notes vaguely "something terrible happened." She arrives on time, dressed in civilian clothes, appearing visibly anxious with her knee bouncing rapidly sitting in the waiting room. She introduces herself by her last name and remarks that she has never been to counseling before noting, "I don't know how this counseling thing works. I usually just keep things to myself." You discuss the process of counseling in which you help to identify difficulties, establish goals for wellness, and collaboratively work together to reach those goals. She appears uncomfortable and asks, "Who is going to know about this? What do you do with information told to you?" You outline the boundaries of confidentiality, reassuring her that you do not report to a superior, but guard her privacy. You indicate the limits of confidentiality regarding risk of harm to self, others, children, and vulnerable adults.

Ms. Johnson appears to relax a bit, although still alert. She begins to report feeling increased frustration and irritability at work. She notes difficulties transitioning back to civilian life 4 years ago with a history of poor relationships with friends and family, short-term dating relationships, chronic pain, headaches, and difficulties sleeping with trouble falling asleep and nightmares. She also notes drinking more alcohol to help her sleep but is "probably drinking more than she should" with approximately 4-6 drinks per night. You ask specifically about her nightmares and she cites that she has terrible dreams about "what happened me." You gently probe about this terrible event, and she looks blankly at you for a period of 30-seconds before slowly sharing details of being sexually harassed and assaulted during her time of service 5 years ago.

Ms. Johnson describes having been down range, clarifying that she was deployed overseas, when she and a group of five male soldiers in her platoon got together late one evening to have some drinks. Ms. Johnson notes that she had worked day-in and day-out with these guys for 6 months, building strong friendships and trust with each. She notes that there were times where "being in the sandbox made em' stir crazy" citing sexualized comments and hand gestures directed at her. Ms. Johnson describes "letting it go" and "not making a big deal out of it." However, the night of drinking escalated things. Ms. Johnson became visibly distressed describing events with pressured speech and elevated affect, although with restricted facial expressions and staring at the floor. She reported struggling to remember all the events that occurred as she had drunk a substantial amount of alcohol and was very inebriated. She shared her recalled events including the other soldiers ordering her to take off her pants and the pain of being raped. "I was told not to fight back, so I didn't." She described having blacked-out during the incident, having trouble recalling specific details but she was aware that the other soldiers were present.

Over the following weeks, Ms. Johnson feared rumors spreading of what had happened. However, the rape was not mentioned within her unit and platoon. She notes that "everyone acted like nothing happened. Even the guys that did it." Ms. Johnson noted increased anxiety, hypervigilance, fear, and paranoia on the deployment as she no longer felt safe. Ms. Johnson described her anger and hurt that men she previously trusted and saw as brothers would do this to

her. She indicated that she did not make an official report for fear of further reprisal from her platoon which could ruin her career. Following the event, she began to struggle completing assignments and duties which kept her from promotion. Two years later with multiple negative performance evaluations, she chose not to reenlist as she felt she was “no longer strong enough to serve.” Ms. Johnson tearfully described the events of rape, hiding her face with her hands. “It’s been five years, but I don’t know what to do. I haven’t been able to talk about this with anyone. This is the first time I’ve told anyone. I need help. I need to get past this, I just don’t know how. I am not sure if anyone can help me.”

Appendix C

Vignettes Perceived as Believable and Realistic

Please rate the following statements in reference to the client you mentally imagined working with:

	Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
The vignette of the client is **realistic.**	1	2	3	4	5	6	7
The vignette of the client is **believable.**	1	2	3	4	5	6	7

Appendix D

Human Subjects Institutional Review Board Approval Letter

WESTERN MICHIGAN UNIVERSITY

Human Subjects Institutional Review Board

Date: February 17, 2022

To: Patrick Munley, Principal Investigator
Alishia Salyer, Student Investigator

Re: Initial - IRB-2022-52 An Analogue Study of Expected Working Alliance Working with Victims of Military Sexual Trauma Among Civilian and Military-Oriented Therapists

This letter will serve as confirmation that your research project titled An Analogue Study of Expected Working Alliance Working with Victims of Military Sexual Trauma Among Civilian and Military-Oriented Therapists has been **approved** under the **Exempt** Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording).
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects.
category of review by the Western Michigan University Institutional Review Board (WMU IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the approval submission.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., ***add an investigator, increase number of subjects beyond the number stated in your application, etc.***). Failure to obtain approval for changes will result in a protocol deviation.

In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB or the Associate Director Research Compliance for consultation.

The Board wishes you success in the pursuit of your research goals.

Sincerely,

Amy Naugle, Ph.D., Chair
WMU IRB

For a study to remain open after one year, a Post Approval Monitoring report (please use the continuing review submission form) is required on or prior to (no more than 30 days) February 15, 2023 **and each year thereafter until closing of the study.**
When this study closes, submit the required Final Report found at https://wmich.edu/research/forms.
Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.