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Higher Self-Stigma is Related to Lower Likelihood of Disclosing Military Sexual Trauma During Screening in Female Veterans

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Objective: Recent prevalence estimates indicate 38% of female service members/veterans (SM/Vs) report military sexual trauma (MST). This estimate is higher than Veterans Affairs estimates, which suggest 28% report MST during screening. The discrepant estimate suggests possible barriers to disclosing MST, which are not well-identified in the literature. The current study examined whether being assaulted by a fellow unit member and stigma for seeking help to treat the sequelae of MST from self, unit leader/command, and romantic partners were correlates of MST nondisclosure among 209 female SM/Vs. **Method:** Participants completed a self-report questionnaire assessing MST nondisclosure, MST assailant characteristics, and stigma from the aforementioned sources as well as demographic, military, and mental health characteristics. Logistic regression analyses adjusting for military rank, MST severity, age, marital status and satisfaction, and probable mental health diagnoses determined whether being assaulted by a fellow unit member (yes/no) or stigma from various sources were associated with MST nondisclosure. **Results:** Thirty-seven (17.70%) participants did not disclose MST during a previous screening. At the bivariate level, participants who did not disclose MST reported higher self-stigma and anticipated enacted stigma from unit leader/command and romantic partner. After adjusting for covariates, only higher self-stigma was associated with MST nondisclosure. **Conclusions:** Female veterans who report higher self-stigma were less likely to disclose their MST during screening. Such findings are consistent with previous literature demonstrating that self-stigma, relative to other forms of stigma, relates to lower help-seeking behaviors. Efforts to increase the disclosure of MST during screening should focus on reducing self-stigma.

Clinical Impact Statement

Military sexual trauma (MST) is associated with poor mental health outcomes. There are discrepant prevalence rates of MST suggesting possible barriers to disclosure in some settings. Barriers to MST disclosure are not well studied. The current study observed that higher self-stigma was associated with MST nondisclosure during a previous screening. Given these findings, it may be helpful to assess for the presence of self-stigma when screening for MST as it might help identify those at greater risk for nondisclosure. Nondisclosure of MST during screening can delay the provision of services to treat the sequelae of MST.

Keywords: disclosure of trauma, stigma, veterans, military sexual trauma, females

According to the Department of Veterans Affairs (VA), military sexual trauma (MST) refers to experiences of sexual assault or repeated, threatening sexual harassment that a service member experienced during his or her military service (Department of

Veterans Affairs, 2015). MST is associated with several postdeployment mental health concerns including increased risk for posttraumatic stress disorder (PTSD) and depression diagnoses (Kimerling, Gima, Smith, Street, & Frayne, 2007; Kimerling et al., 2010; Maguen et al., 2012), eating disorder diagnoses (Blais, Brignone, Maguen, et al., 2017), increased risk for suicide mortality (Kimerling, Makin-Byrd, Louzon, Ignacio, & McCarthy, 2016), and lower satisfaction with interpersonal relationships (Katz, Cojucar, Beheshti, Nakamura, & Murray, 2012). A recent meta-analysis revealed 38.4% of female service members and veterans reported assault or harassment MST (Wilson, 2016). This estimate is higher than VA MST screening data, which indicate that 28% of female veterans reported MST (Department of Veterans Affairs, 2017). These discrepant prevalence rates may be due to the underreporting of MST. Indeed, a non-VA study describing self-reported disclosure rates indicates that 25% of female veterans

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The methods reported here were approved by the Institutional Review Board at Utah State University. The views expressed are those of the authors and do not necessarily represent the views or policy of Utah State University.

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did not disclose their MST during screening (Blais, Brignone, Fargo, Galbreath, & Gundlapalli, 2017), and only 21% of female active duty service members filed an official report of their sexual assault (Morrall, Gore, & Schell, 2014). Among VA-enrolled veterans, disclosure of MST during mandated screenings can initiate contact with a local MST coordinator, who can facilitate timely referrals for assessment and treatment to address the sequelae of MST. Thus, nondisclosure of MST can potentially delay access to mental health resources. At present, barriers to disclosure of MST are not well identified. The purpose of the current study was to examine correlates of MST nondisclosure among female veterans who reported a history of MST and a previous MST screening.

One factor that may relate to decisions to not disclose MST during screening is the relationship of the assailant to the MST survivor. That is, it is possible that being assaulted by a fellow unit member may be a barrier to MST disclosure during screening. This is consistent with the premise of *Betrayal Trauma Theory* (Freyd, 1994; Freyd, DePrince, & Gleaves, 2007), which states that a betrayal of trust occurs when the individual suffers abuse from the people they depend on for survival. Following enlistment into the military, service members are encouraged to function on a foundation of trust, of both their fellow service members and the military organization itself (United States Department of Defense, 2014). Findings from the 2014 RAND Military Workplace Survey revealed that 85% of survivors were assaulted by a fellow service member and 65% indicated that the assault occurred within a military setting. Of those women who reported, 52% perceived professional or social retaliation. Unfortunately, as many as 15% choose *not* to report a sexual assault because of fears of retaliation (Morrall et al., 2014).

Betrayal Trauma Theory also posits that trauma survivors, perpetrators, and witnesses may all exhibit betrayal blindness as they are reluctant to acknowledge that a betrayal occurred at the hands of a trusted individual (Freyd, 1996, 1999). Betrayal blindness may serve a protective role by attempting to preserve relationships, harmonious organizations, and social systems in which the survivors depend on, which is critical within the military organization. According to the 2014 RAND Military Workplace Survey, 44% of active duty service members who reported their sexual assault to someone in their chain of command were “encouraged to drop the issue” (Morrall et al., 2014, p. 50), and 41% of active duty sexual assault survivors indicated that “the person to whom they reported the events took no action” (Morrall et al., 2014, p. 50). Finally, 54% of women who filed a report perceived negative career consequences resulting from the assault (Morrall et al., 2014). As such, perceptions that reporting did not result in any action against the assailant coupled with concerns about retaliation and negative career consequences may make service members reticent to disclose MST. Given that these findings were limited to active duty service members, who do not undergo routine MST screenings, it is critical to further study these variables in discharged veterans who are screened for MST when accessing services through the VA (Kimerling et al., 2007).

Another factor that may relate to decisions to not disclose MST during screening is stigma. There are various forms of stigma including self-stigma and anticipated enacted stigma.

Self-stigma is defined as negative attitudes regarding mental illness and its treatment that are held by the individual with the stigmatized condition (Manos, Rusch, Kanter, & Clifford, 2009). Anticipated enacted stigma represents beliefs that others will act in a hostile or discriminatory manner if their stigmatized status is made known (Blais & Renshaw, 2013). A mixed method study by Blais, Brignone, Fargo, et al. (2017) examined MST nondisclosure in 289 MST survivors. Of those, 143 reported a prior screening and 35 indicated that they did not disclose their MST status during screening. Of those 35, 18 (51.43%) identified stigma as a barrier to their disclosure. These results are consistent with a qualitative study by Burns and colleagues (2014), which studied experiences and perceptions of MST in 22 female service members deployed overseas between 2002 and 2011. Of these participants, seven (32%) experienced MST and stigma was cited as one of the barriers to disclosure. Moreover, Holland, Rabelo, and Cortina (2016) examined perceived barriers to help-seeking for MST after accounting for covariates of sex and deployment status. Participants included 1,558 male and female active duty service members who were compared based on sexual assault survivor status (sexual assault survivor vs. nonvictim). Of the 542 assault survivors, 56% reported fears that others would treat them differently, 52% reported fears they would be viewed as weak, and 43% reported concerns that others would have less confidence in them.

Although these extant studies of MST nondisclosure in female service members and veterans revealed that stigma and the survivor/assailant relationship were barriers to MST disclosure, this literature has limitations. For example, research conducted by Blais, Brignone, Fargo, et al. (2017) and Burns et al. (2014) were both small qualitative studies that did not use validated measures of stigma to distinguish between different stigma sources. Indeed, previous research using military samples shows that self-stigma is related to lower help-seeking intentions, but stigma perceived from leaders or unit members was unrelated to help-seeking (Blais, 2016). Such findings suggest that it is critical to distinguish between sources of stigma when studying barriers to disclosure. Moreover, participants in the Burns et al. (2014) study included women who had indirect experiences with MST, such as knowing a fellow service member who had experienced MST. Lastly, Holland et al. (2016) assessed for MST experiences only within the past year. Therefore, it is possible that some participants who were categorized as not having a history of sexual trauma actually had experienced MST but did not fit the identified study time period.

The purpose of the current study was to address these aforementioned limitations in our understanding of factors related to nondisclosure of MST during screening. In particular, we sought to determine whether self-stigma, anticipated enacted stigma from unit leader/command and romantic partners, and being assaulted by a fellow unit member were associated with MST nondisclosure after accounting for covariates of nondisclosure identified in previous research. Relative to those who disclosed their MST during routine screening, we hypothesized that survivors who did not disclose their MST would (1) endorse higher levels of stigma, particularly self-stigma, and (2) have reported being assaulted by a fellow unit member versus a non-fellow unit member.

Method

Inclusion and Exclusion

Participants for the current study were drawn from a larger cross-sectional parent study that was conducted to better understand the association of MST with sexual dysfunction and romantic relationship satisfaction among 832 partnered female SM/Vs. The parent study included questions about MST history and severity, prior MST screening and disclosure, and assailant, demographic, military, and mental health characteristics, which were used as primary study variables in the current investigation. To be included in the current study, participants must report (a) being discharged from the military, (b) a positive history of MST, and (c) a prior MST screening. We selected out individuals who did not report being discharged as those in active duty do not undergo routine MST screenings. We opted to include those who identified as single, as partnered status was not a main outcome of the study. Of the 832 participants in the parent study, 679 (81.61%) reported a history of MST. Of those, 231 (27.76%) reported a prior screen for MST, and 209 (25.12%) reported being discharged from the military. These 209 comprise the current sample.

Participants

Participants were female veterans who self-reported service in the military. The majority of participants self-identified as White (72.25%, $n = 151$), married (72.72%, $n = 152$), and enlisted rank (97.13%, $n = 203$). Nearly half reported service in the Army (47.85%, $n = 100$). The average age of participants was 32.88 ($SD = 7.13$) and the majority had completed at least some college (91.87%; $n = 192$).

Procedures

Participants were recruited into the parent study through targeted advertisements on Facebook and through electronic listservs for female SM/Vs. Advertisements targeted partnered English-speaking women aged 18–65 with a history of military service. Individuals interested in participating advanced to a Qualtrics platform where they completed initial screening items confirming female sex, history of military service, and consenting age. Those that passed screening questions were provided with a Letter of Information and all study-related measures. This study was approved by the Institutional Review Board at Utah State University.

Measures

Outcome. Nondisclosure of MST during a previous screen was asked using the following question, which was designed for the parent study: *If you have been asked about experiencing MST from a health or mental health care provider, did you respond to the questions truthfully?* Participants could respond either “yes” (disclosed MST dummy code = 0) or “no” (did not disclose MST dummy code = 1).

Independent variables. Self-stigma for seeking help for the sequelae of MST was assessed using the 10-item *Self-Stigma of Seeking Help* (SSOSH; Vogel, Wade, & Haake, 2006) scale. A sample item from the SSOSH included “It would make me feel

inferior to ask a therapist for help.” Using a Likert scale of 1 (*strongly disagree*) to 5 (*strongly agree*), respondents rated their agreement with each statement. After five items were reverse scored, all 10 items were summed for a total score. The scale had a possible range of 10–50, with higher scores indicating greater self-stigma. The SSOSH showed high internal consistency (Cronbach’s α of .86 to .90) and good test–retest reliability (Vogel et al., 2006) in the norm sample. In the present sample, Cronbach’s $\alpha = .88$.

Anticipated enacted stigma for seeking help for the sequelae of MST was assessed with the 5-item *Perceptions of Stigmatization by Others for Seeking Help* (PSOSH; Vogel, Wade, & Ascherman, 2009) scale. The PSOSH instructions can be modified to measure anticipated enacted stigma from different sources. The instructions were altered for the present sample to measure anticipated enacted stigma from both unit leader/command and romantic partner. A sample item includes “To what degree do you believe that your romantic partner would think of you in a less favorable way?” The PSOSH allows respondents to rate their level of agreement with each statement using a Likert scale of 1 (*not at all*) to 5 (*a great deal*). All five items are summed to create a total score. The scale has a possible range of 5–25, with higher scores indicating greater anticipated enacted stigma. The scale demonstrates good internal reliability (Cronbach’s α of .78 to .91) and validity (Vogel et al., 2009). In the present sample, Cronbach’s $\alpha = .95$ and .96 for romantic partner and unit leader/command, respectively.

Being assaulted by a fellow unit member was assessed using a question designed for the parent study that asked participants to indicate whether the assailant of their MST was a member of their unit (yes: dummy code = 1; no: dummy code = 0). Nonunit member assailant options included a civilian, a member of the U.S. military but not in their unit, a foreign military service member, or other (with a write-in option to describe this individual).

Covariates. Covariates were selected based on theoretical or empirical evidence suggesting an association of the covariate with disclosure of sexual trauma. Covariates included age (Bicanic, Hehenkamp, van de Putte, van Wijk, & de Jongh, 2015), MST severity (scoring described below; Blais, Brignone, Fargo, et al., 2017), rank (officer class [dummy code = 0]; enlisted class [dummy code = 1]), and probable PTSD and depression diagnoses (scoring described below; Ullman & Filipas, 2005). As previous literature shows that military service members who reported a history of sexual assault experience lower concurrent relationship satisfaction (e.g., Miller, Schaefer, Renshaw, & Blais, 2013), we included relationship satisfaction and marital status (married [dummy code = 1]; not married but partnered [dummy code = 0]) as covariates in the model examining anticipated enacted stigma from partners as a correlate of MST nondisclosure. A self-report questionnaire designed for the parent study assessed these covariates (with the exception of MST severity, probable PTSD and depression diagnoses, and couples’ satisfaction—measures are described below). Other demographic information used solely for the purpose of describing the sample was also collected and included branch of service, race, and education.

A modified version of the *VA MST Screening Questionnaire* was used to assess MST severity. To assess for harassment MST, participants were asked whether they experienced touching, cornering, pressure for sexual favors, or verbal remarks. A response of “yes” to any of the experiences indicated the presence of harassment MST. Assault MST was assessed using the following ques-

tion: *When you were in the military, did someone ever use force or threat of force to have sexual contact with you against your will?*" An affirmative response indicated the presence of assault MST. In analyses, harassment MST was coded "0" and assault MST was coded "1."

Romantic relationship satisfaction was assessed with the 4-item *Couples Satisfaction Index* (CSI-4; Funk & Rogge, 2007). A sample item includes "In general, how satisfied are you in your relationship?" Participants responded to the four items using a variable anchor Likert scale. Total scores are calculated by summing all four items. The scale has a possible range of 0–21, with higher scores indicating greater levels of relationship satisfaction. CSI-4 scores below 13.5 indicate relationship dissatisfaction (Funk & Rogge, 2007). The CSI-4 demonstrates strong convergent validity and high internal consistency (Cronbach's α of .94; Funk & Rogge, 2007). In the present sample, Cronbach's α = .92.

A probable PTSD diagnosis was assessed with the 20-item *PTSD Checklist for the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (PCL-5; Weathers et al., 2013). The PCL-5 is a self-report measure used to assess PTSD symptoms corresponding to the *Diagnostic and Statistical Manual for Mental Disorders-Fifth Edition* (DSM-5) symptom criteria for PTSD. A sample item includes "In the past month, how much were you bothered by: Blaming yourself or someone else for the stressful experience or what happened after it?" Respondents rated their agreement with each statement using a 5-point Likert scale of 0 (*not at all*) to 4 (*extremely*). All 20 items are summed to create a total symptom severity score. The scale has a possible range of 0–80, with scores of 31 or greater indicating a probable PTSD diagnosis (yes = 1; no = 0; Bovin et al., 2016). In the current sample, Cronbach's α = .97.

A probable depression diagnosis was assessed with the 2-item *Patient Health Questionnaire-2* (PHQ-2; Kroenke, Spitzer, & Williams, 2003). The PHQ-2 measured how bothered a respondent was during the past 2 weeks by depressed mood and anhedonia, which are the two cardinal symptoms of depression (Kroenke & Spitzer, 2002). A sample item includes "Over the past 2 weeks, how often have you been bothered by any of the following problems: Little interest or pleasure in doing things?" Respondents rated their agreement with either statement using a 4-point Likert

scale of 0 (*not at all*) to 3 (*nearly every day*). Total scores are calculated by summing the two items. The scale has a possible range of 0–6, with scores of 3 or greater indicating a probable depression diagnosis (yes = 1; no = 0; Kroenke et al., 2003). The PHQ-2 has adequate acceptability as an initial screening tool for identifying possible depression among individuals seen in primary care settings (see meta-analysis, Mitchell, Yadegarfar, Gill, & Stubbs, 2016). In the current sample, Cronbach's α = .88.

Data Analysis

Sample characteristics were assessed using descriptive statistics. Bivariate associations between MST disclosure status, stigma from different sources, being assaulted by a fellow unit member, and covariates were tested using *t* tests or χ^2 tests where appropriate. To determine whether stigma source and unit member assailant were associated with MST nondisclosure, four separate adjusted binary (disclosed = 0/did not disclose = 1) logistic regression analyses were conducted, one for each source of stigma and unit member assailant. Unstandardized β s and standard errors are reported. Missing data was handled using listwise deletion. All statistical analyses were conducted in IBM SPSS Version 24 (IBM Corporation, 2016).

Results

Thirty-seven (17.70%) participants who reported a previous MST screening did not disclose their MST. Table 1 presents differences between stigma sources, being assaulted by a unit member, and demographic characteristics of those who did and did not disclose their MST during screening. Compared with those who disclosed MST, those who did not disclose reported significantly higher levels of self-stigma, anticipated enacted stigma from unit leader/command, and anticipated enacted stigma from romantic partner ($ps \leq .05$). Those who did not disclose MST were also more likely to have a history of assault MST. There were no significant differences observed between those who did and did not disclose their MST with regard to assailant identity, enlisted rank, marital status, and age ($ps > .05$). Ninety-three (44.50%) participants reported scores on relationship satisfaction that fell

Table 1
Demographic Characteristics and Differences Between MST Nondisclosure (Dummy Code = 1) and MST Disclosure (Dummy Code = 0) Groups

Variables	MST nondisclosure ($n = 37$) <i>N(%)</i> / <i>M(SD)</i>	MST disclosure ($n = 171$) <i>N(%)</i> / <i>M(SD)</i>	<i>t</i> test/ χ^2
Self-stigma ^a	28.69 (9.59)	24.09 (9.02)	$t(173) = -2.69, p = .008$
Leader-stigma ^a	20.09 (5.90)	17.17 (7.30)	$t(171) = -2.18, p = .03$
Partner-stigma ^a	10.08 (6.76)	7.34 (4.60)	$t(43.59) = -2.30, p = .03$
Unit member assailant	33 (89.19%)	132 (77.19%)	$\chi^2(1) = 2.67, p = .10$
Probable PTSD	27 (77.14%)	109 (66.87%)	$\chi^2(1) = 1.41, p = .23$
Probable depression	21 (58.33%)	79 (51.30%)	$\chi^2(1) = .58, p = .45$
Couple satisfaction ^b	12.32 (5.25)	13.65 (4.77)	$t(201) = 1.50, p = .14$
Assault MST	30 (81.08%)	91 (53.22%)	$\chi^2(1) = 9.71, p = .002$
Enlisted rank	35 (94.59%)	167 (98.24%)	$\chi^2(1) = 1.71, p = .19$
Married	28 (75.68%)	123 (71.93%)	$\chi^2(1) = .22, p = .64$
Age	31.89 (6.96)	33.08 (7.19)	$t(205) = .91, p = .37$

Note. PTSD = posttraumatic stress disorder; MST = military sexual trauma.

^a Higher scores equal more severe symptoms/functioning. ^b Lower scores equal worse functioning.

within the distressed range, 136 (65.07%) and 100 (47.85%) participants reported scores indicative of a probable PTSD or depression diagnosis, respectively. However, no significant differences were observed between those who did or did not disclose with regard to probable PTSD diagnosis, probable depression diagnosis, or relationship satisfaction (see Table 1).

Table 2 presents adjusted binary logistic regressions of MST nondisclosure on stigma sources, being assaulted by a unit member, and covariates. The overall regressions of self-stigma ($\chi^2[6] = 19.43, p = .003$; Hosmer & Lemeshow $\chi^2 [8] = 6.14, p = .63$; Nagelkerke's $R^2 = .18$), anticipated enacted stigma from romantic partner ($\chi^2[8] = 15.93, p \leq .05$; Hosmer & Lemeshow $\chi^2[8] = 9.81, p = .28$; Nagelkerke's $R^2 = .15$), and being assaulted by a unit member ($\chi^2[6] = 14.46, p \leq .05$; Hosmer & Lemeshow $\chi^2[8] = 11.41, p = .18$; Nagelkerke's $R^2 = .13$) were significant, whereas anticipated enacted stigma from unit leader/command ($\chi^2[6] = 12.10, p = .06$; Hosmer & Lemeshow $\chi^2 [8] = 12.12, p = .15$; Nagelkerke's $R^2 = .12$) was not. However, after adjusting for covariates, only higher self-stigma was associated with MST nondisclosure (see Table 2). MST nondisclosure was unrelated to unit member assailant and anticipated enacted stigma from unit leader/command and romantic partner ($ps > .05$). Experiencing assault MST, compared with harassment only MST, was associated with nondisclosure in models assessing the relationship of MST nondisclosure with unit member assailant, self-stigma, and anticipated enacted stigma from romantic partner.

Discussion

The purpose of the current study was to determine whether self-stigma, anticipated enacted stigma from unit leader/command or romantic partner, and being assaulted by a fellow unit member were associated with MST nondisclosure during screening in female veterans. The results of the current study indicate that stigma source is differentially associated with the disclosure of MST among survivors, such that those reporting higher self-stigma were less likely to disclose their MST during screening. Higher anticipated enacted stigma from unit leader/command and romantic partners were associated with nondisclosure of MST during

screening at the bivariate level but not after adjusting for covariates. This finding suggests that when seeking help for the sequelae of MST, survivors may be more concerned with what MST implies about them as an individual rather than what others will think of them for needing help.

One explanation for the observed association between self-stigma and nondisclosure of MST observed in the current study originates from Goffman's (1963) theory of stigma, which states that individuals are motivated to deliberately conceal a stigmatized condition if possible. Goffman's theory further asserts that stigmatized individuals are reduced "from a whole and usual person to a tainted, discounted one" (Goffman, 1963, p. 11). Thus, by not disclosing one's MST experience, survivors may perceive themselves to remain strong veterans rather than being viewed as a "weak victim." Unfortunately, extant civilian literature indicates that individuals reporting higher self-stigma for sexual assault report increased trauma symptom severity (Deitz, Williams, Rife, & Cantrell, 2015). Thus, the individuals who may most benefit from receiving care may experience stigma that prevents them from disclosing their trauma, in turn, delaying the provision of mental health services. This is consistent with previous research in service members and veterans with histories of sexual assault who identified stigma as a primary barrier to treatment seeking (Blais, Brignone, Fargo, et al., 2017; Zinzow et al., 2015). Collectively, these findings suggest that it is critical to develop targeted strategies to identify those who might experience self-stigma during the screening process.

Consistent with the findings of Morral et al. (2014), nearly 90% of survivors who did not disclose their MST indicated that their assailant was a fellow unit member. Contrary to hypotheses, however, unit member assailant was not related to MST disclosure. These results are somewhat inconsistent with *Betrayal Trauma Theory* (Freyd, 1994; Freyd et al., 2007) and existing literature on the survivor relationship to the perpetrator, which found that those who were assaulted by a known other were less likely to disclose (Morral et al., 2014; Ullman, 2007b). The lack of association between MST disclosure and being assaulted by a fellow unit member observed in the current study may be an artifact of our

Table 2
Adjusted Regressions (Unstandardized β s [SE]) of MST Disclosure Status on Stigma Source, Being Assaulted by a Unit Member Assailant, and Covariates (N = 209)

Variables	Self-stigma model	AES leader model	AES partner model	Unit member assailant model
Self-stigma	.08 (.03)**	—	—	—
AES leader	—	.06 (.04)	—	—
AES partner	—	—	.07 (.04)	—
Unit member assailant (yes = 1)	—	—	—	1.03 (.61)
Probable PTSD (yes = 1)	.55 (.62)	.38 (.63)	.17 (.61)	.25 (.56)
Probable depression (yes = 1)	-.17 (.48)	-.39 (.49)	-.22 (.51)	-.23 (.45)
Assault MST (yes = 1)	-1.25 (.57)*	-1.06 (.58)	-1.17 (.58)*	-1.36 (.53)**
Enlisted rank (yes = 1)	.85 (1.26)	1.31 (1.07)	1.53 (1.15)	1.44 (1.05)
Age	-.02 (.04)	-.01 (.03)	-.01 (.03)	-.03 (.03)
Married (yes = 1)	—	—	-.43 (.51)	—
Couple satisfaction	—	—	-.02 (.05)	—

Note. SE = standard error; AES = anticipated enacted stigma; PTSD = posttraumatic stress disorder; MST = military sexual trauma.

* $p \leq .05$. ** $p \leq .01$.

sampling. That is, being assaulted by a fellow unit member may only serve as a barrier to disclosure among those that are still enlisted because of fears of retaliation (Morrall et al., 2014). As the current sample was comprised of veterans who have since separated from their unit and the military more generally, the relationship to the assailant may be a less salient barrier. At the same time, our measure of the relationship to the assailant did not examine how personally close the survivor was to the assailant. That is, we asked whether survivors were assaulted by a fellow unit member and did not query the nature of the quality or closeness of the relationship to the assailant. It is possible that those who had a closer relationship to the assailant may be less likely to disclose their MST than those who knew their assailant but did not consider them to be a close friend or confidante. Being assaulted by someone with whom they felt they had a stronger connection to would represent a greater betrayal according to *Betrayal Trauma Theory* (Freyd, 1994; Freyd et al., 2007), and as such, this betrayal may serve as a barrier.

Findings from the current study also demonstrated that experiencing assault MST was associated with MST nondisclosure relative to harassment only MST. It is possible that those who experienced more severe MST feel more shame and guilt, which may serve as a barrier to disclosure. Indeed, feelings of self-blame, guilt, and shame for being assaulted have been identified in previous studies of MST survivors (Burns et al., 2014; Monteith, Brownstone, Gerber, Soberay, & Bahraini, 2018) and civilian survivors of sexual assault (Donde, 2016; Sable, Danis, Mauzy, & Gallagher, 2006; Sigurvinsdottir & Ullman, 2015; Ullman, 2007a; Zinzow & Thompson, 2011). Future research in this area would be strengthened by examining the potential mediation of shame, self-blame, and guilt on the association of MST severity and disclosure.

Our findings also suggest that it may be helpful to distinguish between assault and harassment only MST during screenings. Most studies examining factors related to MST and its sequelae do not distinguish between harassment and assault MST, and current VA MST screening practices do not specify MST severity in the screening result that is documented in a veteran's chart. Emerging evidence suggests that those who experienced assault MST, versus harassment only MST, report poorer mental health outcomes and higher suicidal ideation (Blais, Brignone, Fargo, Livingston, & Andresen, 2018). Such findings indicate that MST severity might be a key indicator of risk for nondisclosure and risk for adverse outcomes.

The current study has limitations. First, causal inferences about the directionality of these relationships cannot be made as the study utilized a cross-sectional design. Second, the majority of the participants were White, married, and enlisted rank, which limits the generalizability to other ethnically diverse groups and commissioned military service members and veterans. Third, all data were collected via self-report and are subject to recall bias. Fourth, as this study focused on stigma related to disclosing MST, it is possible that those who experienced lower stigma were more likely to participate in this study and report on their experiences. Fifth, the anticipated enacted stigma measure instructions were altered for the present sample to assess stigma from "unit leader/command." Measuring "unit leader/command" as a single entity may have obscured the findings of anticipated enacted stigma from either of these military sources. That is, it is possible that partic-

ipants perceived higher stigma from command but not their direct leaders.

In conclusion, the current study broadens existing literature by demonstrating the significant positive relationship of self-stigma with MST nondisclosure in female veterans. These findings illustrate the importance of measuring the detrimental impact of self-stigma on survivors of MST. It may be helpful to assess for the presence of self-stigma when screening for potential MST survivors as it might help identify those at greater risk for nondisclosure. Given the negative sequelae of both MST and stigma, future research is needed to develop targeted strategies to reduce self-stigma in an effort to increase MST disclosure.

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