PREGNANCY RESULTING FROM MILITARY SEXUAL TRAUMA

Kristen Zaleski

PREGNANCY RESULTING FROM MILITARY SEXUAL TRAUMA

A dissertation submitted to
The Sanville Institute
in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy in Clinical Social Work

By

KRISTEN ZALESKI

March 15, 2013

CERTIFICATE OF APPROVAL

I certify that I have read **The Effects of Pregnancy Resulting from Military Sexual Trauma** by Kristen Zaleski, LCSW and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Judith R Schore, PhD Judith R Schore 1-26-13
[chair's name, academic degree], Chair, Date

Kathryn Basham PhD. January 25 2013
[committee member's name, academic degree], Faculty, Date

Samaan Barish PhD Jan. 26 2013
[external committee member's name, academic degree], Date
[Professor / Program Director / Faculty] [School affiliation]

[illegible] PhD March 15, 2013
[Academic Dean's name, academic degree], Academic Dean, Date

ABSTRACT

PREGNANCY RESULTING FROM MILITARY SEXUAL TRAUMA

KRISTEN ZALESKI

This study explored the experience of pregnancy from military sexual trauma on enlisted US service women, applying attachment and trauma theory as scaffolding for exploring the women's experiences. A qualitative, grounded theory research methodology was used to analyze single-session interview data with seven self-selected participants. Five major themes emerged from the data. The discussion addresses the implications of military culture and its traumatic impact on attachment security and trauma enactments as well as of future research regarding how medical providers and psychotherapists can begin to address the traumatic impact of this silent epidemic of pregnancy resulting from rape.

DEDICATION

This study is dedicated to all of the women who serve and have served in the US military and have silently suffered sexual harassment and abuse from the very colleagues who have taken an oath to protect them. May this study be the beginning of having their voices heard, particularly the seven women who bravely sat with me and shared some of their deepest and most painful memories.

ACKNOWLEDGEMENTS

This dissertation would not have been possible without the generosity and hard work of many people in the institute, my family, and my workplace. To begin, I would like to thank Gail Abarbanel, LCSW. Her commitment to victims of sexual assault not only spawned my interest in the topic, but also inspired me to be an outspoken advocate, psychotherapist, and teacher in this field. She has supported my growing interest and education tremendously, and I owe her so much for both introducing me to The Sanville Institute and for hiring me to work in her amazing program, which began my training as a sexual assault psychotherapist and advocate. She is not just a director of a program, she is a beloved colleague for whom I feel deep admiration.

Second, I would like to acknowledge Lori Katz, PhD. She hired me at the Veterans Administration in Long Beach and generously allowed me to conduct research in her clinic. Without her support, this dissertation research would not have been possible.

Third, to my amazing mentors at The Sanville Institute. Alexandra Kivowitz, my mentor for three years, worked tirelessly throughout the school year—even through summer vacation—to help me edit my papers for the Sanville curriculum. Her humor, sensitivity, and honest guidance have helped me become a more confident clinician and writer. She had her work cut out for her, and I deeply respect her for that. Next, Samoan Barish, PhD. The conversations we had at her home about this dissertation and the woman experience were both profound and exhilarating. I feel very lucky to have her on my dissertation committee. And last, but not least, Judith Schore, PhD. Her guidance shaped me tremendously when I was a student in her colloquia and later when she served as chair of my dissertation committee. She has literally and figuratively taught me about secure

attachment and embodied its essence in her mentoring professionalism throughout my dissertation writing. She handled my rapprochement strategies like a confident right brain container, and if she had not been my instructor and chair, I question whether I would be the clinician and researcher I have grown to be. And, thank you, as well, Allan Schore, PhD, whom Judy would call during our attachment-based conversations and who often had a good article suggestion that influenced my writing.

Finally, my family. Thank you to my mother and father for supporting my pursuit of a PhD not only emotionally but also financially for most of this journey. Without their assistance, I would not be finishing today. Thank you to my daughter, Sagan, who does not know but who has had a tremendous influence on this work. I was one who questioned whether motherhood was something I wanted. Being pregnant with Sagan while working with sexual assault victims and coming home to her after hearing such heart-breaking stories allowed me to realize a deeper love than I ever thought possible. My pregnancy with her has shaped my view of the woman archetype. I know she is going to be the greatest contribution I could ever give to this world.

My final acknowledgement is to my husband and champion, Jonathan. As most dissertation students understand, he has suffered as a result of my decision to pursue a PhD. Despite the long nights and days away for classes and study time, we also had a beautiful daughter in the middle of it all. He has valiantly taken night shifts with the baby, created daddy-daughter weekends, and supported my writing and research without any hesitation. Being the husband of a PhD student is not easy. Being the husband of a sexual trauma psychotherapist is probably harder. Combine the two, and I can only assume he will go down in history as the most supportive husband a woman has ever known. I only wish the

women I interviewed in this study could have been shaped by the kind of love I have in my life. I feel lucky and guilty about my luck of love. He embodies and teaches me true attachment security. Jonathan Zaleski, I love you more than the written word can record.

TABLE OF CONTENTS

CHAPTER ONE

INTRODUCTION

This qualitative study grew out of the author's interest in how women cope with a sexual assault when they thought they were in a secure and safe environment, such as the US military. With an even more specific concern, the author explored psychological adaptation to a sexual assault during military service that resulted in pregnancy. Currently, a large gap exists in the psychological literature focused on civilian or military pregnancy resulting from rape. Though rape occurrence has been documented throughout military training and during wartime, the government has been slow to respond or even to acknowledge its existence. In fact, according to a 2011 *Newsweek* article, "It wasn't until 1992 that the Defense Department even acknowledged such incidents as an offense, and initially only female victims were recognized" (Ellison, 2011). In January 2011, the Air Force created a task force to uncover the extent of sexual violence in its culture—a step prompted by "one of the most comprehensive studies undertaken by the US military," which reported that one in five Air Force women was a victim of sexual assault (Mulrine, 2011). Recently, Lackland Air Force base in San Antonio was being investigated for sexual misconduct with over 31 female trainees, and a staff sergeant was sentenced in July 2012 for 20 years in prison "for crimes that included rape and sexual assault" on the base (Weissert, 2012).

Statistics from the US Department of Defense in 2005 indicated that one in four women soldiers would be victim of a sexual assault during the course of her service time. Moreover, according to a 2000 report, 4.7% of rapes result in pregnancy. An estimated 32,000 pregnancies from rape occurred in 2000 alone (Stewart & Trussell, p. 228). A

study of pregnancy in the military, not specifically from rape, "found an unintended pregnancy rate of 97 per 1,000 women in the prior 12 months" (Grindlay, Yanow, Jelinska, Gomperts, & Grossman, 2011, p. 259). Grindlay et al. have stated that the military rate for unintended pregnancy is higher than the civilian rate, a finding attributed to the higher percentage of women in the military that are of child-bearing age. Grindlay et al. (2000) calculated that there were "between 19,200 & 23,100 unintended pregnancies in the military each year" (p. 259).

Based on a review of the mental health literature, despite increased attention to the epidemic of sexual assault in military culture, substantial investigation into the psychological impact of military sexual trauma upon our nation's service women remains lacking. And, that the majority women in the military is of child-bearing age increases the statistics for pregnancy from sexual assault— a major problem that has long lacked public awareness or acknowledgement within the military culture. This dissertation is designed to investigate this phenomenon at a depth heretofore not explored.

Theoretical Framework

The following research incorporated both trauma and modern attachment theories (Schore, 2012) as the lens through which to view the experiences of raped women soldiers who became pregnant from the assailant. Focusing on trauma and attachment behaviors will inform our understanding of how the sexual assault impacted them in the moment, as well as in their lives following the traumatic experience.

Trauma theory has shown that victims who are attacked by a person with whom they had some attachment security (such as a family member, close friend, or colleague) are "prone to respond to assaults with increased dependence and with paralysis in their

decision making processes" (Van Der Kolk, 2007, p. 171). The diagnosis of Post Traumatic Stress Disorder (PTSD) was included in the DSM-III in 1980 to explicate the psychopathology of adults after surviving a traumatic event. PTSD can be a lifelong psychological disorder and may mean that the victim relives the traumatic event in daily life and experiences disruptions to the nervous system, which can chronically alter sleep/wake states, appetite, and biological rhythms. To cope with these psychological and biological changes, victims of violence may engage avoidance strategies and emotional numbing, thus putting themselves at higher risk for substance abuse, suicide, and other self-destructive behaviors.

John Bowlby (1976), the so-called "father" of attachment theory, has stated that a person's attachment behavior plays a vital role throughout that person's life cycle. Along these lines, Feeney (2007) explained that "infant attachment bonds involve 'proximity maintenance' and 'separation protest'" and the "establishment of a 'secure base' (using the attachment figure as a base from which to explore the environment); and using another person as a 'safe haven' (turning to an attachment figure for comfort in times of threat)" (p. 456). Adult attachment theory considers early infant care-giving experiences and the subsequent intimate relationships that developed over that person's lifespan and how those affects his/her expectations. Feeney explained, "Bowlby proposed that during the years of 'immaturity' (infancy to adolescence), individuals gradually build up expectations of attachment figures based on experiences with these individuals" (p. 456). Modern attachment theory adds an understanding of the affect-regulating aspect of one's attachment. Thus, for purposes of this dissertation, using both trauma theory and modern

day attachment theory will scaffold our understanding of the subjective life experiences of the participants.

Statement of the Problem

The researcher made the critical assumption that being a member of the military means that one is engaged in an attachment relationship. Research has begun to explore the correlation between the attachment security of the leader in a military setting and the mental health of the people he or she leads (Davidovitz, Mikulincer, Shaver, Izsak, & Popper, 2007; Solomon, Mikulincer, & Hobfall, 1986). That is, how the person in charge reacts to potential attachment disruptions, such as traumatic events, can affect the people whom he or she leads. Consequently, if a member of a unit such as the US military is sexually assaulted, would the resultant interpersonal trauma have the potential to be more life altering than other events in wartime or peacetime?

Prior attachment relationships with family and friends are a crucial factor in predicting attachment security in the future (Feeney & Collins, 2001; NCIHD Early Child Care Research Network, 2001). Attachment relationships are the people to whom a person will turn to in the wake of a sexual assault among civilians. However, the nature of military service often isolates victims of sexual violence making attachment relationships difficult to access immediately following a traumatic event.

Women service members are twice as likely as their male counterparts to get PTSD due to double trauma exposure to combat and sexual harassment and abuse. Furthermore, if a rape results in pregnancy, the psychological health of the child and the mother can be jeopardized when the mother has a PTSD diagnosis.

The good news is that most people do not develop PTSD following a trauma. In fact, Friedman, Keane, and Resnick (2007) have estimated that among females, approximately 54% do not develop PTSD from rape as measured three months after the trauma, and approximately 91% of female accident survivors never develop PTSD. However, a gender distinction exists, in that females are still more likely to be diagnosed with PTSD than men, as has been documented in the civilian as well as the military literature (Corbett, 2007; Friedman et al. (2007); Harman, 2008). Some researchers into this phenomenon have argued that women are at a greater exposure rate to trauma than men, specifically in terms of sexual violence. In wartime, though women have not been allowed to serve on the "front lines," until very recently, they often serve as mechanics and truck drivers and are thus exposed to roadside bombs and ambushings on a daily basis. Coupling those hostilities with the sexual predation that women experience during their nonshift hours on base means that women must be on high alert for an entire tour of duty, whereas a male soldier may experience the same biological alert engagement just a few hours a week. This distinction will be addressed in greater detail in the discussion of military culture.

The American Diagnostic and Statistical Manual (IV edition) currently divides diagnoses of PTSD into three categories: intrusion of the trauma, avoiding and numbing symptoms, and autonomic hyper arousal. For a person to be eligible for diagnosis, s/he must have been exposed to one of two "stressors," defined as: (a) The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. (b). The person's response involved intense fear, helplessness, or horror. To be diagnosed

with this condition, the patient must have experienced these symptoms for a minimum of three months. Prior to three-month cutoff, the patient can be diagnosed with Acute Stress Disorder, which, as its name implies, is a shorter reaction and more of a biological adjustment to the trauma occurrence.

The year 2012 saw significant criticism of the current DSM criteria for a diagnosis of PTSD. As Scaer (2005) has stated, "[T]he DSM-IV does not address the subtle end of the bell curve of life trauma, an area of experiences that might be called 'negative life events'" (p. 91). Although he has concurred that the "stressors" the DSM outlines can cause PTSD, Scaer has argued in his book *The Trauma Spectrum* that smaller traumas such as birth trauma, betrayal trauma, motor vehicle accidents, and media exposure to violence can also induce a diagnosis of PTSD within individuals.

A 2012 *Washington Post* article described the current debate around changing the name of Post Traumatic Stress Disorder to Post Traumatic Stress Injury (Jaffe, 2012). As the author has explained, "[PTSD] is so overwhelming that it alters the physiology of the brain. In this sense, PTSD is more like a bullet wound or a broken leg than typical mental disorder or disease" (p. 121). However, the opposing side has argued that PTSD in fact has more commonalities with depression and bipolar disorder, adding that using the term "injury" indicates a discrete time period rather than a disorder that can "stretch on for decades" (p. 122). It is believed that the newest version of the DSM, Version V—set to be released in 2013—will alter the stressor criteria for a PTSD diagnosis to include smaller traumas that can accumulate over a lifespan.

Rationale for the Study

The present study was designed to explore the emotional experience and impact of rape and pregnancy on women serving in the military. This study explored both the experiences themselves and the decisions these women made about their resultant pregnancies. It also investigated how their long-term relationships were affected both at the time of the incident and subsequent to the assault. Attachment and trauma theories serve as the theoretical base upon which these matters are considered.

Research Design

The method used by this study is grounded theory as developed by Strauss and Corbin (1998). By collecting data in a systematic, informed, and organized way—and then applying the constant comparative method of data analysis (Conrad-Wragg, 1978) —the researcher hoped to secure a deeper understanding of how servicewomen who were raped and became pregnant were affected during and subsequent to the trauma by applying the lens of attachment theory and subjective narrative. For the women participants, this study involved a retrospective analysis. Due to the average age of the clients who engaged the services at the Women's Mental Health Center, the retrospective will be greater than 20 years.

Study participants self-selected by responding to advertising at the VA Long Beach and was substudy from a larger investigation at the Women's Mental Health Center. Criteria for participating in the research study were that the women must have been enlisted in the military when the assault and resultant pregnancy took place.

Significance of the Study

This study will contribute to the current gap in both psychodynamic theory of military veterans as well as awareness of the impact a pregnancy can have upon a rape victim. Today, women are enlisted in the military in larger numbers than ever before, and many served in Iraq and Afghanistan, where sexual assault statistics for the US military climbed year after year. The present research study attempts to illustrate how the assault, the culture of the military, and the subsequent treatment—or lack thereof—contributed to the psychological state of the participants. The author hopes to publicize the research results and thus inform the American public of this silent psychological health crisis afflicting our US women veterans.

Limitations of the Study

This study was conducted with women who lived in one geographic location of Southern California and thus may reflect a particular cultural and political undercurrent that cannot be generalized to the larger population. In addition, the women who were interviewed were low-income, and many were experiencing life stressors, such as lack of stable housing, economic challenges, and limited social support. Some of the participants had undergone prior psychological services around issues of sexual violence, which may have shaped their retrospective narratives. Finally, this sample was a small group of women who were mostly of menopausal age and had experienced the assault over 20 years previous to the study. Subjective memories of the assault that was experienced 20 years ago can affect the historical accuracy of the assault narratives.

CHAPTER TWO

REVIEW OF THE LITERATURE: PSYCHOLOGICAL UNDERSTANDING OF RAPE-INDUCED TRAUMA

A 2012 review of the literature on psychological trauma yielded a high number of references. The research studies ranged from inductive research and application (such as treatment strategies and therapeutic interventions to treat the trauma of rape) to deductive analysis, whereby the phenomena had been observed and discussed but not theorized upon. Notably, the deductive aspect of rape-related pregnancy had not been explored in the psychological literature.

The following review will not focus on the numerous therapies that researchers have devised to treat rape trauma. Instead, this literature review will attempt to understand how the psychological community has understood the effects of rape-related pregnancy on the victims themselves. This researcher found a dearth of research studies exploring the psychological effects of this phenomenon, so intersecting literature from psychoanalysis and modern-day attachment theorists, incidence reports from OB/GYN research articles, and societal analysis of military and rape will be consulted to understand the occurrence of pregnancy from a sexual assault.

Psychological Review of the Sexual Trauma Literature

Psychoanalytic Contributions

The study of sexual trauma began with Sigmund Freud when he concluded, "in every case he had analyzed, a passive sexual experience before puberty generally accompanied by indifference, disgust, or fear was the cause of hysteria" (Westerlund, 1986, p. 299). In his personal letters, Freud made further assertions, stating, "[T]here was

the astonishing thing that in every case . . . blame was laid on perverse acts by the father" (Westerlund, p. 299). After studying neurosis for many years, Freud courageously announced to a conservative Viennese society that sexual trauma had residual effects on women, causing them to suffer psychological disturbance or "hysteria." However, this assertion was not well received by Freud's colleagues, and he was criticized publically and privately for his claims.

Even as Viennese society was reacting negatively to his assertion that hysteria was a product of sexual trauma, Freud was developing his own theory of the unconscious and conducting analysis of a woman who accused one of Freud's own colleagues of sexual misconduct. Because of his collegial knowledge of the accuser's whereabouts at the time of the alleged sexual abuse, Freud discovered that his analysand was not being honest about the nature of her assault. As such, Freud interwove his observations about her dishonesty and his understanding of her motivation into his theory of unconscious fantasy. Within a year, Freud rejected his "seduction theory" entirely and proceeded to develop his theory that the Oedipal Complex explained why so many women indicted their fathers for sexual perversions. That is, the seduction itself, was all unconscious fantasy, not factual event (Kupfersmid, 1993; Tabin, 1993).

Elsewhere, Pierre Janet, who ran the psychological laboratory at the *Hopital du Salpêtrière* in 1887, proposed "that when people experience 'vehement emotions,' the mind may not be able to match what is going on with existing cognitive schemas." (Janet, 1924, p.45) Similarly, Van Der Kolk (2007) has asserted that memories of the violent experiences cannot be integrated into personal awareness, as "patients become 'phobic'

of their memory and therefore place it into the subconscious to avoid dealing with its difficult integration (p. 53).

In his 1924 book addressing principles of psychotherapy, Janet discussed his observations of "provoked somnambulism" (hypnosis) and began to describe the various traumatic memories that involved "violent emotions" as life events that linger in the subconscious (a term that he—not Freud—coined). In this writing, Janet noted a "foreign physician, Dr. S. Freud of Vienna" who, he explained:

> changed first of all the terms that I was using. . . . but above all he transformed a clinical observation and a therapeutic treatment with a definite and limited field of use into an enormous system of medical philosophy. In this system all neuropathic disorders result from some traumatic memory concealed in the subconscious, and every treatment demands the search for such memories. (pp. 39–43)

Further, Janet (1924) argued against the "generalized" notion that traumatic memories are part of neurosis and are therefore a symptom or false event, instead advocating for patients who recalled traumatic memories as having experienced factual events.

In 1933 (on Freud's 75th birthday celebration) more than 30 years after Freud had proposed his "seduction theory"—Sandor Ferenczi presented his own paper, entitled "Confusion of Tongues between Adult and Child," in which he repudiated Freud's rejection of his own seduction theory. Ferenczi conflicted with Freud's notion idea that sexual abuse was always an unconscious fantasy, stating clearly to his audience:

> Even children of very respectable, sincerely puritanical families, fall victim to real violence or rape much more often than one had dared to suppose . . . The

> immediate explanation—that these are only sexual phantasies of the child, a kind of hysterical lying—is unfortunately made invalid by the number of such confessions, e.g. of assaults upon children, committed by patients actually in analysis. (p. 227)

Ferenczi was not able to flesh out his trauma theory publically because he died shortly after presenting "Confusion of Tongues." In his article, "Ferenczi's Trauma Theory," psychoanalytic author Jay Frankel (1998) outlined the evolution of Ferenczi's trauma observations, beginning with his experience as a soldier and later as a psychoanalyst. Frankel asserted Ferenczi's belief that traumas that were "incomprehensible" and "without warning" (p. 43) were the most damaging and that sexual trauma was more damaging "than simple violence" (p. 44). According to Frankel, Ferenczi concluded his writings around the understanding of interpersonal trauma by asserting "that there were two basic forms: influence through love and tenderness, which he said was a maternal form of suggestion, and influence through authority or power, which he considered paternal" (p. 46).

Contemporary Contributions

Jennifer Freyd (1994) coined the term "betrayal trauma" as the adaptive function a child utilizes in the wake of sexual assault by a known, trusted other. She suggested that:

> [P]sychogenic amnesia is an adaptive response to childhood abuse. When a parent or other powerful figure violates a fundamental ethic of human relationships, victims may need to remain unaware of the trauma not to reduce

> suffering but rather to promote survival. Amnesia enables the child to maintain an attachment with a figure vital to survival, development, and thriving. (p. 307)

Freyd's contribution is similar to that of Ferenczi: that the betrayal of trust and safety by someone with whom the victim has had a sense of security can be more traumatizing than assault by a stranger. Though Freyd's ideas are focused on the repressed memories themselves, and how they came to consciousness later in life, how the relationship betrayal is a trauma in itself does apply to this research. In the case of sexual trauma, relationship betrayal would exist in the majority of rape cases, as people are more often assaulted by an acquaintance than by a stranger. Thus the betrayal of the assault itself induces post trauma symptoms as victims try to make sense of their experiences. In the *Handbook of PTSD,* Vogt, Kind, and King (2007) have stated that "with respect to post trauma characteristics, researchers have generally focused on two categories that may increase the likelihood of an adverse response to trauma: lack of social support and exposure to additional life stressors" (p. 1010).

In working with his patients, Ferenczi (1933) noted the concept of social support following a trauma, explaining that two traumas could exist from one exposure: The event itself and the response that the patient received when recounting the trauma. This characterization continues to be associated with various trauma conditions including sexual assault as well as in cases of natural disaster and combat stress. As Benight (2012) has explained: "Social support is defined in very broad terms relating to aspects of the individual's social world that are engaged in helping during a significant stressor or trauma" (p. 4).

Research conducted following the 9/11 terrorist attacks and other catastrophic events showed that the levels at which individuals felt supported by family and friends affected their overall recovery from the disasters themselves. In a research article following the Polish flood disaster that occurred in 1997, Kaniasty (2012) found that the "indicators of post-disaster social bitterness, operationalized as dissatisfaction with aid and interpersonal and community animosities and disagreements, were predictive of lower levels of subsequent social psychological well being" (p. 22).

In his seminal book *Traumatic Stress,* Van Der Kolk (2006) acknowledged the impact of trauma on a victim's support system. He described the creation of "scapegoats" as a way to deal with the intense emotion of trauma. One potential scapegoat is the victim him or herself: The social support systems "start shunning the victims and blame them for what has happened—a phenomenon that has been called 'the second injury'" (Van Der Kolk, 2007, p. 27). Symonds (1982) coined the term "second injury" to designate the impact that professional support can have on the outcome of trauma and its subsequent treatment in psychotherapy:

> The "second injury" is essentially a perceived rejection and lack of expected support from the community, agencies, treating personnel, society in general, as well as, family or friends to an individual who has been injured or victimized . . . all his past feelings of security, safety and feelings of invulnerability are shattered. In addition, his personal idealized image of himself as a self-sufficient, autonomous individual are damaged. (p. 32)

Although some of the traumatology field's most prominent authors and researchers—Solomon and Siegel (2003), Herman (1992), Gilligan (1982) to name a

few—discuss the importance of the psychological impact of trust building in a trauma survivor, they do not discuss or hypothesize about how the violation of trust can be a trauma itself. Trauma therapists and law enforcement officials have endorsed the importance of conveying to the trauma survivor that she was not at fault for the trauma. The psychological treatment literature has reached a consensus that a positive therapeutic alliance helps to heal post-trauma symptoms. However, little discussion exists on how important it is that the survivor not only be believed when recounting the story, but also be supported through the aftermath.

Attachment theory focuses extensively on the centrality of social supports in psychological development—whether there are traumatic events or not. Perspectives of attachment theory will be addressed as they inform our understanding of the effects of pregnancy following military sexual assault.

Modern-Day Attachment Theory

Modern-day attachment theory is now understood as a "theory of regulation" (Schore, 2003) between infant and caregiver or, in the clinical realm, between client and therapist. It posits that the ultimate goal for the first year of life is to form a secure relationship with one's caregiver. During this time, the cognitive part of the brain associated with logic, language development, and autobiographically "explicit" memory is not "online." Instead, the right hemisphere of the brain—associated with emotions, nervous system regulation, and Freud's "system unconscious"—begins to develop through person-to-person interaction. Most importantly, the right hemisphere benefits from continued interaction and eye-to-eye gaze episodes with the child's primary caregiver(s). As Schore has explained, "The attachment relationship mediates the dyadic

regulation of emotion, wherein the mother (primary caregiver) co-regulates the infant's postnatally developing central (CNS) and autonomic (ANS) nervous systems" (p. 4). As discussed earlier, the secure relationship enables infants to feel safe within their domains of experience, which results in further exploration of their external environment. As secure infants explore and interact with their primary attachment figure, their right brain experiences a rapid growth of neuronal development. The primary caregiver provides the child's undeveloped regulatory system a point of attribution. That is, if children sense fear, they reference their caregiver and, through nonverbal cues, deem a situation safe or unsafe. From this nonverbal attribution, children may choose to continue their play and stay in a state of homeostasis, or may begin to experience fear and become dysregulated biologically, entering a state of autonomic arousal in which their heart rate increases, they begin to cry, and they summon their caregiver to provide comfort. Once in the arms of a caregiver who can affectively attune to the child's distress, the child can return to homeostasis, experience parasympathetic nervous system and down regulate their agitation, eventually feel safe enough to play.

In contrast, if in the first year of infancy, the child is not attended by an attuned caregiver, he/she may experience high levels of arousal and dysregulation that are never repaired. This dynamic can cause the child to have higher levels of agitation and arousal, which in turn causes higher levels of the stress hormone cortisol to be released in the brain, and induces a pruning of neuronal growth. If a caregiver is unable to attend to an infant's distress from neglect, abuse, or prolonged absence, the child does not benefit from the affect attunement of another human. Infants thereby become ill equipped to handle stressful situations by themselves, and will not develop the regulatory structures to

assist them in affect regulation. That their brain does not receive optimal care giving nurturance leads to a maladjusted nervous system and poor auto-regulation, which can interfere in personality development.

Mental health clinicians must understand the first year of a child's development, as it is the foundation of the person's implicit memory, also understood as their unconscious processing. This condition is important to emphasize, as the left hemisphere of the brain is responsible for explicit autobiographical memory, which does not come "online" until 18 months of age or later. On this subject, Schore (2003) has summarized, "[E]arly emotional learning occurring in the right hemisphere unbeknownst to the left; learning and associated emotional responding may later be completely inaccessible to the language centers of the brain" (p. 141). Neurobiologists understand "childhood amnesia" as the result of an undeveloped hippocampus (Siegel, 1999). Once the hippocampus is "online," explicit memory can begin to shape a person's memories of him or herself and the world. The hippocampus, however, does not begin to mature until 18 months and continues to develop into adulthood. This theory attempts to explain why adults have few memories in early childhood and have greater memory recall from later adolescence into adulthood. Only as the hippocampus grows into maturity will autobiographical memory become more salient and recall "the past" as a sequential order of events. If children have a less-than-optimal first year of growth, they can literally "feel" things about themselves and their world but have no explicit autobiographical memory to explain why they "feel" that way. As such, Schore (2008) has stated, "The interpersonal neurobiology of modern attachment theory has thus been a rich source of information

about the essential role of nonconscious nonverbal right communications in the psychotherapy relationship" (p. 13). Siegel has added:

> Salient emotional relationships have a direct effect on the development of the domains of mental functioning that serve as our conceptual anchor points: memory, narrative, emotion, representations, and states of mind. In this way, attachment relationships may serve to create the central foundation from which the mind develops. Insecure attachment may serve as a significant risk factor in the development of psychopathology. Secure attachment, in contrast, appears to confer a form of emotional resilience. (p. 68)

When children experience less-than-optimal early care giving, survival depends on their poorly developed regulatory system to take charge. Neurobiologists now believe that the trauma and insecure attachment relationships associated with poor early care giving is the precursor to psychopathology. Borderline personality development is one possible character diagnosis that can develop from insecure early child attachment relationships. As Schore (2003) stated:

> The most significant consequence of early relational trauma is the loss of the ability to regulate the intensity and duration of affects. Clinical research has revealed that borderline personalities, when stressed, attribute high levels of primitive, negative "all bad" evaluations to others (splitting), exhibit poor empathy and psychological understanding, manifest more intense negative responses to everyday life events, and show an increased sensitivity to even low level emotional stimuli. (p. 141)

Also noteworthy for purposes of this research, symptoms of Post Traumatic Stress Disorder and Borderline Personality Disorder are believed to be the result of dysfunctions in the amygdala and orbitofrontal cortex (Schore, 2003). These regions are the primary areas in which attachment security develops. Therefore, it can be assumed that a client who enters therapy with characteristics of these disorders may have dysregulated amygdala and limbic system functioning and thus may experience the therapeutic relationship as an insecurely attached adult: expecting disappointment and unable to trust.

Adult Attachment

As a person individuates, the parental relationship is replaced by the peer and romantic relationships in adulthood. The affective moments within their social world continue to shape the person's internal working model of attachment. Sable (2008) has defined the internal working model as "early attachment experiences (that) are carried forward as mental representations of attachment figures in relation to the self 'along the pathway toward the adult personality'"(p. 23).

Davila and Cobb (2007) have suggested that even though Bowlby believed that internal working models developed in childhood guide personality, they:

> may be more likely to assimilate new information into their existing attachment models, [because] people are also capable of accommodating new information by updating existing models. Hence, people also should possess the capacity for change in levels and/or patterns of attachment security over time. (p. 133)

Indeed, recent literature on the therapy relationship supports this idea that the internal working model of attachment can be shaped by other experiences within adulthood. Though not every therapeutic relationship can be described as an attachment, many

attachment theorists believe that long-standing therapeutic relationships embody the same attachment potential as interpersonal relationships with family members. Along these lines, Slade (2008) has explained, "[T]he development of both positive and negative transference manifestations indicates that the therapist is becoming an attachment figure i.e. that he or she is activating internal working models originally formed in relation to initial attachment figures" (p. 767). Perhaps most importantly, in her article, Slade stated that "the patient develops a 'secure' attachment to the therapist, meaning, on the one hand, that he or she uses the security inherent in the current relationship with the therapist to rework previously established insecure working models" (p. 767).

With the hope that an insecure model of attachment can be shaped into to a more secure existence in the world, the potential for the reverse dynamic must also exist. Davila and Cobb (2006) have described how some theorists are using the "Life Stress Model," the "Social Cognitive Model," and the "Individual Difference Model" to explain how an adult life event can change the internal working model of attachment security. Evidence for all three models both supports and questions their validity, and they continue to be researched today.

Attachment Theory Applied to Sexual Assault

John Bowlby originally developed his theory of attachment in the wake of the social support—or lack of support—that he witnessed in the medical model of child illness. Following his own interpersonal trauma—the loss of his nanny, whom he described as his primary caregiver—Bowlby began to see that the lack of an attachment security, or a "secure base" to help navigate a child's developing psychology and

biology, could result in pathological disturbance throughout the lifespan. According to Kobak, Cassidy, and Zir (2006):

> From early in his writing, Bowlby conceptualized attachment as a behavioral system that is activated by appraisals of danger and accompanying feelings of fear . . . the importance of perceived threat to the availability of an attachment figure has often been neglected in the clinical literature on trauma. (p. 388)

In most cases of sexual assault, the victim is assaulted within an attachment relationship. Even when the assailant is a stranger, sexual assault often occurs in areas where the victims have constructed a feeling of safety, such as their home, neighborhood, car, or military barrack. Following a stranger attack, the victim often experiences attachment disruptions with her environment and becomes afraid to return to the place with which she previously had had no negative associations. As a result, many victims leave jobs, drop out of school, and move out of neighborhoods associated with their once-securely attached location. Using attachment language, the victim's internal working model has been disrupted and damaged in terms of trust within herself and trust within her environment. As Wallin (2007) has explained:

> Bowlby theorized that from early infancy the individual's working model of attachment enables him or her to recognize patterns of interaction with the caregiver that have already repeatedly occurred and thus "know" what the caregiver will do next. Because the working model influences both expectations and the behavior that flows from them, it can shape interactions as well as being shaped by them. (p. 27)

When incidents of interpersonal violence occur within an attachment relationship, the victim is forced to second-guess her expectation of safety within that relationship—but also within most of her attachment bonds. Military training instills in the soldier that the military is a type of "family" whose functioning is a matter of life and death. When assaulted by a member of his or her military family, the victim experiences the same attachment disruptions as a civilian. The important distinction, however, is that the military soldier cannot retreat from her job or move to family to feel better. Instead, she must remain in her environment and carry on day-to-day responsibilities despite feelings of fear and distrust that did not exist prior to the assault.

Object relations therapists who are uncomfortable with attachment language may refer to this transformation as a change in internalized object relations and the self. Klein and Schermer (2000) have used this language to describe the same idea of attachment disruptions in the following way:

> Changes in the "assumptive world" of trauma victims may deepen into profound alterations of their core sense of self, as well as their mental representations of significant others . . . thus, in addition to schema changes in the person's systems of belief and expectations, trauma may induce deeper levels of harm to the core sense of self. Internalized object relations and the sense of self may undergo radical deformation, as well as a "freezing of development" at the point of the trauma . . . This should encourage group therapists to consider that trauma patients may suffer from genuine "deficits" of cognition and affect that require special supports and empathic attunedness, in addition to intrapsychic and interpersonal conflicts that require uncovering, elucidation, and resolution. (p.10)

Like children who blame themselves for their parents' divorce, survivors of interpersonal violence cannot cognitively comprehend, or rationally interpret, why their attachment object/figure would hurt them. *It must have been her own mistake somehow.* This response leads the survivor to blame herself and her actions for the assault. Thus experiences of shame, self-blame, and guilt emerge as commonly observed responses by interpersonal assault survivors.

Pregnancy Resulting from Rape

As stated at the beginning of this chapter, little research has been conducted on the psychological impact of pregnancy resulting from rape. Some medical literature, primarily journals focused on obstetrics, gynecology, and nursing, has continued to document the tens of thousands of pregnancies every year for the general population.

In a study of 221 women engaging in consensual sexual relations to become pregnant, Gil (2001) found the incidence of pregnancy to be 3.1% "with one completely random act of unprotected intercourse" (Wilcox, Dunson, Weinberg, Trussell, & Baird, 2001, p. 212). Moreover, Lathrop (1997) has stated that "Estimates based on a single random coitus model derived from ovulation, fertility, and probability data suggest a 4%–10% likelihood that a given rape will result in pregnancy" (p. 25). However, that author also acknowledged "a theory of coitus-induced ovulation suggests that fear, anger, and stress may act to trigger ovulation in humans, and that rape may actually be more likely than consensual intercourse to result in pregnancy" (p. 25). Other scientists have also theorized the possibility that rape induces a higher probability of pregnancy. On this subject, Gil stated, "[E]xternal factors can activate neuroendogenous endocrine paths that exist but which are not normally involved in ovulation," a triggering of the endocrine

pathways that can cause premature ovulation and create a higher potential for pregnancy (p. 1). In commentary published in 2000, researchers described pregnancy from rape as a "public health issue," estimating that from 333,000 sexual assaults reported in 1998, 25,000 pregnancies resulted (Stewart & Trussel, 2000, p. 228). All of these studies argued for the exigency of emergency contraception immediately following a sexual assault. The impediment to this medical intervention, however, is that most women do not report their assaults and, if they do, many do so outside of the 72-hour window required for emergency contraception to be effective.

In another journal article, researchers cited the rape-related pregnancy rate as 5% among victims of reproductive ages (12 to 45), and that an estimated 32,101 pregnancies result from rape each year (Holmes, Resnick, Kilpatrick, & Best, 1996, p. 320). In that same study, Holmes et al. reported that 32.2% of rape victims kept the infant, 11.8% had a spontaneous abortion, 50% chose abortion, and 5.9% chose adoption.

The most relevant research for this dissertation was performed by Gil (2001), who conducted her research at a women's clinic in Cali, Colombia. Over a span of 18 months, she studied 121 rape victims whose assaults resulted in pregnancy. Speaking about the nature of the study, Gil stated, "[T]he victim's stories portray not only the tragedy of pregnancy after rape, but also the health, police and legal services' failure to react appropriately and their lack of resources with which to confront this problem" (p. 1). Gil's study found that of 121 rape victims, 62.8% chose abortion, 18.2% chose to keep the child, and 6.6% put the baby up for adoption. She also reported that only 15 victims (12%) had reported their assault in time for emergency contraception to be effective.

The United States Military and Military Sexual Trauma (MST)

In 2008, Representative Jane Harman (D-Calif) wrote in a op-ed article titled "Rapists in the Ranks"—and later that same year testified to Congress—that "women serving in the U.S. military are more likely to be raped by a fellow soldier than killed by enemy fire in Iraq" (p. 1). The statistics are rising. In 2008, the Department of Defense announced having received 2,923 sexual assault "reports," of which 63% represented rape or aggravated assault (http://www.af.mil/news/story.asp?id=123140293). This number represents an 8% increase over the percentage from the prior fiscal year. In 2007, only 181 of the 2,212 reported assaults were referred for criminal prosecution (Harman). In 2012, Dick (2012) disseminated a new documentary titled *The Invisible War,* which documented the incidence of Military Sexual Trauma and how it is ignored, covered up, and improperly investigated throughout all branches of the US military.

Unfortunately, sexual assault in the military has existed throughout the history of warfare. Widespread knowledge exists of how sex and wartime so often coincide. In 2004, Hersh published groundbreaking work about Abu Ghraib and the torture perpetuated by American soldiers. Much of the torture included sexual abuse, such as "pouring cold water on naked detainees, threatening male detainees with rape, and sodomizing a detainee with a chemical light and perhaps a broom stick" (Hersh, 2004). Now-infamous photographs depicted sex scenes ranging from masturbation and oral sex, to naked detainees being hooded and placed in sex positions with one another. The United States government denied encouraging these acts, but military personnel claimed they were ordered to "torture" the detainees in this way.

Elizabeth Wood (2009) has discussed how rape is a harrowing inevitability in war, stating:

> Rape is an effective strategy of war, particularly of ethnic cleansing; rape is one form of atrocity and occurs alongside other atrocities; war provides the opportunity for widespread rape and many if not all male soldiers will take advantage of it. (p. 132)

Rape is not just a tool wielded by soldiers to destroy "the enemy" but is documented in peacetime throughout all military academies around the world. Callahan (2009) has described the training programs in the United States Air Force Academy and how "manifestations of power and control" have negatively impacted the soldiers in training. She has observed high incidents of sexual assaults and eating disorders as a reaction to the military training:

> I suggest that this catalyst is the adversative educational practice of rendering new cadets powerless in a process of stripping individuals' old identities to remold them in the image of an elite USAF officer. This deprivation of power, or control, causes some cadets to seek avenues in which they perceive they can exert control. Thus, male cadets may attempt to gain control over female cadets and female cadets may attempt to gain control over their own bodies. (p. 1151)

Boot camps, developed to train new soldiers, are designed around a socialization process that creates military culture. According to Callahan, they teach:

> A social system by providing legitimate rules for how cadets should act within a culture... Involvement in the culture also reveals more tacit expectations regarding behavior and communication associated with structures of power, control, and

role. This process creates dialectic between the individual sense of self (psyche) and the sense of collective (socius). (p. 1158)

Weatherill, Vogt, Taft, King, King, and Shepherd (2011) studied 658 female US Marine Recruits, and their results "indicated that sexual harassment, performance stress, and unit cohesion mediated the relationship between egalitarianism and mental health symptomology" (p. 348). Their findings are controversial, however, as they found that the more a Marine female cadet felt capable of succeeding in a male-dominated environment, the less likely she was to report an incident of sexual harassment (p. 355). This finding could mean that these women were harassed less because the men saw them as objectified less than other women; or these women could have been downplaying or ignoring the sexual harassment so they could focus on their work, thereby avoiding conflict and potential punishment while moving through the training program.

Sidoli (2005) reported on a poll administered at military academies, noting that 1,906 women were surveyed, and 302 incidents of sexual assault have occurred since they enrolled. "50% of female respondents and 11 percent of male respondents indicated experiencing some type of sexual harassment since entering the schools" (p. 14). Specifically, the poll showed 64 female incidents of rape and 30 incidents of oral or anal sex against the women's will; another 127 incidents occurred in which sex was attempted but not successful. Fifty-five of the men polled said they had experienced incidents of sexual assault since they entered the school. Likewise, Ellison (2011) published a *Newsweek* article that reported a staggering incidence of men being raped in the military; for example, in 2010, over 110 men made confidential reports of sexual assault. It

further discussed that male-on-male assault in the military is not related to homosexuality, but to power, intimidation, and domination.

Much as with civilian sexual assault, few allegations are reported, and thus investigated, in the US military. Many soldiers do not report assaults because they believe that no one will believe them—or that the commanding officer to whom they would report the assault already has knowledge of the abuse and has done nothing. Furthermore, there appears to be no formal training for how commanding officers can go about investigating a rape case. Often, "guilt" is decided by the higher-ranking official, who has the power to disregard the charges and never officially record it. Ellison (2011) has quoted Captain Greg Jacob, who spent 10 years in the Marines, as stating, "Military justice imbued me with the ability to be judge and jury. Honestly, I had no idea what to do" (p 1).

Mulrine (2011) has reported on a lawsuit filed against the Department of Defense, stating the DOD creates a military culture that fails to protect victims. Specifically, the suit identified Robert Gates and Donald Rumsfeld as running institutions in which "perpetrators are promoted and where military personnel openly mocked and flouted the modest congressionally mandated institutional reforms" (p.3).

Though reports exist of the incidence of rapes during military time, no such report presents how many pregnancies result from these assaults. Notably, this author was unable to find reports of pregnancies resulting from rape in the military.

Conclusion

The preceding review of the literature has sought to explore the psychological and medical field's attempt to understand the trauma that can arise out of sexual assault

pregnancy for a military service member. This issue is of direct relevance to social work practice, as rape itself, and the pregnancy that can result, is "a crime of power against a woman's right to self determination" (Lathrop, 1998, p. 27). Though innumerable studies survey the mental health effects of rape, "virtually none...deals with the issue of pregnancy resulting from rape" (Gil, 2001, p. 3). This research project attempted to fill this important gap in the literature about the psychological effects of rape and the resulting pregnancy for women members in the unique, socially conforming world of the US military.

Although Gil (2001) followed 121 women who suffered from rape-related pregnancy, she did not follow the women after they had made decisions about their pregnancies. This research study presented an exceptional opportunity to interview women, and engage them to tell the stories of their lives post trauma and how it had affected them psychologically. Stolorow (2007) has written about the "absolutisms of everyday life" (p. 43) and how trauma compels victims to believe that nothing in their lives can ever be guaranteed. He discussed the possibility that trauma helps a victim achieve "resolution" in the wake of a trauma, stating that "as the smoke begins to clear a bit, traumatized people sometimes feel they have gained 'perspective,' a sense of what 'really matters'" (p. 49). This research will attempt to explore both Gil (2001) and Stolorow's (2007) ideas in the wake of military sexual trauma related pregnancy.

Ferenczi and Bowlby have provided unique perspectives about the psychological implications of a person's social world in the wake of a trauma. The US military, often viewed by its service members as a type of family, claims to uphold a core tradition of trust and honor as well as to imbue a sense of explicit trust into each of its soldiers. This

study sought to use the US military's code of honor and the psychological perspectives of Ferenczi (1933) and Bowlby (1976) to explicate a service member's experience with pregnancy resulting from rape and the psychological implications of the decisions, as well as her sense of the social support she received after the event, and how both shaped the rest of her life.

CHAPTER THREE

METHODOLOGY

This chapter begins with a description of the research design with particular focus on the framework for the qualitative research. Following will be a description of the procedures used for selecting subjects, and the details of the data collection process. The chapter concludes with a description of the data analysis process.

Introduction

The impetus for this research arose out of the investigator's experience treating female survivors of sexual assault and becoming interested in the complexity of emotion evoked when a pregnancy results from the trauma. Because a substantial lacuna exists in the psychological literature around pregnancy from sexual assault, the research herein sought to initiate the inquiry using qualitative research methods, specifically grounded theory, as a way to explore the unknown landscape of this phenomenon.

As discussed in the literature review, deductive logic is the primary method in which sexual assault research has been conducted; thus very few—if any—researchers have used grounded theory in trauma research. The current study addressed this void in the trauma research field. With this in mind, Benight (2012) declared, "The field of trauma psychology needs more theory driven studies" (p. 1). Instead of basing research around a medical model of disease (PTSD), this project focused on data derived from the inductive logic yielded by grounded theory. Urquhart, Lehmann, and Myers (2010) have discussed how "grounded theory is an inductive, theory discovery methodology that allows the researcher to develop a theoretical account of the general features of a topic

while simultaneously grounding the account in empirical observations or data" (p. 357). The use of grounded theory for this research study allowed the investigator to work toward a theory "from data systematically obtained and analyzed in social research" (Glaser & Strauss, 1967, p. 1).

Urquhart et al. (2010) discussed four distinctive characteristics of the grounded theory method, which will be followed as part of this research:

> 1. The main purpose of the grounded theory method is *theory building*. 2. As a general rule, the researcher should make sure that their prior—often expert—knowledge of the field does not lead them to preformulated hypotheses that their research then seeks to verify—or otherwise. Such preconceived theoretical ideas could hinder the emergence of ideas that should be firmly rooted in the data in the first instance. 3. Analysis and conceptualization are engendered through the core process of *joint data collection and constant comparison*, where every slice of data is compared with all existing concepts and constructs to see if it enriches an existing category, forms a new one, or points to a new relation. 4. "*Slices of data*" of all kinds are selected by a process of *theoretical sampling*, where the researcher decides on analytical grounds where to sample from next. (p. 359)

Qualitative, grounded theory analysis was the preferred method for this study because of its inductive, logical nature for exploring human experience. Additionally, due to the study's small sample size (n = 7), qualitative, grounded theory was the best way to collect specific data unique to each individual. Because the nature of sexual assault and resulting pregnancy is so distinct from any other trauma, the hope of this investigator was that grounded theory would be the optimal way to collect and synthesize the various

stories into a conceptual framework that could be disseminated throughout the social science field in order to understand this unique interpersonal trauma.

In this research study, the investigator assumed that engagement in the military involves an attachment relationship, as membership is often viewed by soldiers as part of an extended family and workplace. The women participants in this study were part of the US military and experienced interpersonal traumas that have the potential to be more traumatizing than other wartime traumas (e.g., IED threats, gunfire), which do not involve the kind of relationship betrayals that sexual trauma by a colleague implies. When incidents of interpersonal violence happen within an attachment relationship, the victim is forced to second guess her expectation of safety within that relationship—but also within most of her attachment bonds.

Thus, this study is guided by the following research question: What is the emotional and psychological experience and impact of pregnancy from rape on a woman serving in the military?

The present study was designed to explore the emotional and psychological experience and impact of rape and pregnancy on women serving in the military. This study explored both the experience itself and the decision they made about the pregnancy. It also investigated their long-term relationships and how they were affected both at the time of the incident and subsequent to the event. Attachment theory was the theoretical basis upon which these matters were considered.

Research Design

Beginning with personal clinical experience and findings from the literature review, the investigator used a semistructured interview format (interview guide is

included below) to explore the substantive area (using grounded theory terminology) of the women participants. The research question sought to capture the varying degrees of military sexual assault, the choices or results the victims experienced regarding the pregnancy itself (i.e., spontaneous miscarriage, termination, adoption, parenting), as well as the medical, social, and psychological support they received during the pregnancy event and in the aftermath leading up to the research interview. The research questionnaire derived from what qualitative researchers would describe as "hunches" about the data with an avoidance of "any preconceived theoretical ideas before starting the research" (Urquhart et al., 2010, p. 362).

Human Subjects Review Procedure

This research study had to obtain human subjects approval from both The Sanville Institute, the education setting, (see Appendix A) and the VA Long Beach Internal Review Board, the research setting, (see Appendix B). Because it was part of a larger research project titled "Your Story" at the Women's Mental Health Center at the Long Beach VA, the study was added to a pre-existing and approved consent form (Appendix B). With assistance from the research team at the VA, the research questions and the nature of the recorded interview was outlined and sent to the IRB office of the VA Long Beach. In addition to securing the VA consent form, the researcher had each participant sign informed consent (Appendix C) to release information through voice recording as per VA protocol.

Interview Guide

The following prompts were formulated to investigate this topic:

Tell me about the circumstances that led to your becoming pregnant during your military time.

I. *Details surrounding assault*

   a. *Did you know your assailant? For how long? What was his position/rank?*

   b. *Excluding this experience, have you been assaulted prior or after?*

   c. *Did you report your military assault? How was it received by authorities? Family and friends? Fellow soldiers?*

   d. *When did you find out you had become pregnant? What do you remember about the time following your awareness of being pregnant?*

   e. *What considerations did you make around the pregnancy?*

   f. *Whom did you tell about your pregnancy? Were you supported? What were others' reactions?*

   g. *How did you cope? Did you receive any mental health support or crisis intervention?*

   h. *Did you have the baby?*

II. *In the case of miscarriage*

   a. *How did you understand this happening to you? Whom did you tell? Did you feel supported? How did you cope? How do you feel about this experience today?*

III. *In the case of abortion*

   a. *How did you make this decision? Whom did you tell? Did you feel supported? How did you cope?*

b. *How do you feel about this today?*

IV. *In the case of childbirth*

a. *How did you experience pregnancy?*

b. *How was your mental health during pregnancy?*

c. *Risk Factors: Suicidal thoughts? Self-injury? Substance abuse? Partner violence?*

d. *Whom did you tell? Did you feel supported? How did you cope?*

e. *How do you feel about this experience today?*

V. *In the case of adoption*

a. *What led you to the decision to adopt?*

b. *Did you feel supported in this decision?*

c. *Whom did you tell? How did you cope? How do you feel about this decision today?*

VI. *Understanding the event today*

a. *Have you ever been diagnosed with PTSD, depression, anxiety, or other mental health conditions? Do you feel that this diagnosis is related to this experience?*

b. *How do you make sense of this experience today? How did you make sense of it then?*

c. *How do you feel being a soldier impacted this experience?*

d. *What meaning, if any, do you have today around this experience?*

e. *How do you feel this experience shaped the woman, mother, friend, intimate partner, wife, family member, etc. you are today?*

f. *How has this experience impacted your body?*

g. *How has this experience impacted your sexuality?*

h. *Is this experience something you share now? With whom?*

i. *If this experience had never happened, do you feel you would be different in your friendships, intimate relationships, and caretaking roles?*

Procedures for the Selection of Subjects

Potential participants were recruited through the therapists employed at the Women's Mental Health Center or through a flyer (see Appendix D) that was disseminated through the Veterans Administration Hospital. The self-selected participants were screened for the research study by the investigator in telephone contact of 20 minute or less or in a brief face-to-face interview of 20 minutes or less at the VA Long Beach. Inclusion criteria for the study required at least three months of sobriety, currently stable housing (transitional, Section 8, or more traditional) for at least three months, and having no recent history of psychosis. They did not have any trauma (sexual, physical, or medical) in the past year. They had no history of suicidal ideation or suicide attempt for at minimum one year. The clinician's screening interview included a current assessment of post-trauma functioning and depression to screen out any potential participant in an acute phase of clinical distress, such as severe sleeping disturbances, eating disturbances, nightmares, concentration difficulties, experiencing regular flashbacks or dissociative symptoms, and to assess for their amount of social support. Purposefully, the clinician gave each client at least one week between screening interview and research interview so she had some time to think about her participation and ask any questions that may arise.

As deemed appropriate for this study, the investigator arranged for an interview with the participants at the VA Long Beach, for a face-to-face research interview of 90–120 minutes. The interview was guided by the interview guide, however the participants were free to discuss any salient issues that arose. Since this was an exploratory, grounded theory study the participants were able to veer away from the specific questions and narrate her experience from the assault as she experienced it. At the close of the interview, the participant was asked to provide her address if she would like to receive a copy of the research summary. The proceedings were also audio recorded and assigned a research study number, as determined by the Women's Mental Health Center at the VA Long Beach, which included this study in a larger database study for which it was already collecting information. This assigned confidential number was to remain on the audiotapes and all signed papers—which were confidentially transcribed with that same number and identified by number rather than by participant name. Also, any additional potential identifying information was taken out of the transcript or disguised, including platoon name, proper names of military camps, involved service members names, family members, and so forth.

At the time of the study interview, the investigator asked the participants if they were willing to receive a follow-up telephone contact, if needed (from the investigator), for clarification or elaboration, or for checking that the participant had no distress from her participation. That follow-up contact was expected to require no more than 15 minutes. If, at the time of the follow-up interview, the participant was experiencing distress in any way, she was invited to begin psychotherapy services in individual or

group therapy at the Women's Mental Health Center to further process any feelings that may have been evoked.

Data Collection

The data were collected in two ways: audio recording (resulting in transcription) and handwritten notes. Each participant screened and accepted for participation by the investigator was assigned a research number, as outlined in the VA IRB approved study requirements. No mention of the participant's actual name was on the tape, in the interview notes, or in the transcribed material. All materials were kept securely by the investigator. Finally, data were in summary format and not connected to the participant in any identifiable fashion. Identifying demographics only applied to the date of the assault, branch of the military, age at the time of assault, and age at the time of interview, as well as ethnic background. Actual quotations in the research document were not be personally identified but had a letter assigned to each participant, such as "Participant A stated" or "Participants A, B and D agreed around the issue."

Data Analysis

Data analysis was conducted as outlined by Strauss and Corbin (2000) as well as by Urquhart et al. (2010). After the collection of data, the investigator attempted to "slice" the data to see similarities among the participant responses and to "code" them into conceptual categories.

As emphasized by grounded theory, the researcher attempted to derive theory only from the interviewee's experiences expressed during the research interview. The data were first analyzed through a careful reading of the material and by noting the important subjective descriptions of each participant's experience. Next, the researcher

attempted to find commonalities among the narratives and developed categories to describe those similarities. Urquhart et al. (2010) have stated, "Constant comparison with previous data, categories, concepts, and constructs is the key. Additional data are acquired using theoretical sampling until the existing categories are 'saturated' and until no more new conceptual categories or relations emerge" (p. 362). The hope for this study was to derive some deductive analysis of how pregnancy from rape can impact a woman in the military and throughout her life span in social, psychological, and existential realms.

CHAPTER FOUR

FINDINGS

This chapter begins with a brief overview of the methodology used in the study, including the data collection and data analysis, which included NVivo software. Demographic information on the subjects and the presentation of the results with the emerging categories and subthemes follow. An in-depth discussion of the data continues the chapter, which concludes with a summary.

Review of the Methodology

As previously stated in the methodology chapter, this study used an exploratory, grounded theory, qualitative design. Beginning with the combined knowledge of personal clinical experience and the literature review as the basis for the research questions, the researcher conducted semistructured interviews with seven female veterans who reported pregnancy from a military-related sexual assault. The participants were self-selected from flyers and friends in the community. Each participant was given a brief explanation of the study and, when she expressed an interest in participating, the researcher scheduled her at least two weeks in advance to give her time to consider her participation. The researcher contacted the participant by phone before the research interview to answer any questions, and called again after the interview to follow up on any coping issues she had experienced since disclosing information about the trauma. All participants reported they had never talked about their assault and the resulting pregnancy for the length of time the interviews took (approximately 90 minutes), which meant that they were considering most of the research questions for the first time in their lives.

All participants were read the informed consent form, which enumerated the benefits and risks to the study. They were given the opportunity to ask questions. They were informed throughout the study that they could stop the interview at any time. They were monitored continuously for any distress experienced during the interview.

The Participants

This study involved interviews with seven female participants. Ethnic identities ranged from Mayan Indian (1 participant), Cherokee Indian (1 participant), Black (2 participants), White (2 participants), and Hispanic (1 participant). They ranged in age from 31 to 55 years at the time of the interview. One participant self-identified as lesbian. The women served in Air Force, Navy, Army (3), and Marines (2). One participant had been deployed during wartime in both Desert Storm and Operation Iraqi Freedom. One participant was discharged because of medical injury. All other participants had received an honorable discharge. Four women gave birth to their rapist's child, two of those four had raised the children. The three other women had aborted their children between 12 and 14 weeks gestation. All of the women had been raped during their first 18 months in military service, and their age at the times of the assaults ranged between 18 to 22 years-old. They all had known their assailants, who were enlisted and not superiors, though many of the assailants had held higher rank. One was raped at knife point; three were raped under the influence of alcohol; two were raped by a man they were casually dating; three never saw their assailant again after being raped; three of them told their assailants they had become pregnant from the assault. Six of the seven women did not report their assault to authorities. The one who reported her assault was threatened with jail time by her superior officer, because the assault had occurred with a

married man, and she could therefore be jailed for adultery. Five of the seven participants reported that their military service career had ended early because of their sexual assault and resulting pregnancy. None of the women ever told a medical provider about the pregnancy resulting from rape. Six of the seven women were talking about the details of this event for the first time since it had happened. One participant married her assailant due to pressure from her family, and had raised her child in a violent household. Two women had permanent scars on their body from the assaults. Four of the participants had no children other than the rape-related pregnancy outcome. None of the women at the time of interview was married, though two were in romantic relationships. None was employed.

Sexual Trauma History

The seven participants who volunteered to be interviewed for this study ranged in terms of their sexual trauma experiences. Participant A had been sexually assaulted by her band mate during a party in a hotel room that she and her friends had rented for the evening. Participant A went to the bathroom and found the assailant waiting for her. She was the only one in the sample who attempted to report the assault; she was threatened with jail time instead of being offered advocacy. She described this incident as follows:

> We were on tour and when we got back into the office I went into this office and said "I need to talk to you about something" and he said I need to talk to you about something else and he said, "You have the right to remain silent. Anything you say can and will be held against you in a court of law and" I said, "Wait a minute. What are you doing?" I said, "What are you reading me rights for?" and he said "You had sex with a married man" and I said, "No I didn't. I was raped by

a married man." "So you are saying you were raped" and I said, "Yes, there was no doubt about it." And um he said, "Well he came in here the day before and told me that you guys had had sex."

Participant B was stalked and sexually harassed for many months before being raped at knifepoint on Thanksgiving Day in the woods behind her barracks. She initially planned to have an abortion but the evening before the procedure she believed that God told her to keep the child. She kept her daughter for approximately six months and then gave her up for adoption.

Participant C was assaulted by a stranger off-station when she was drinking with friends. Because of her alcohol intoxication, she had little memory of the assault. Because her military base in Europe did not provide abortions, she traveled to Holland by herself to abort her child. She eventually married and had a son.

Participant D was the youngest in the sample, at 31 years old. She had been assaulted by an ex-boyfriend eight years previously. She reported being drugged by her ex-boyfriend and only had flashbulb memories of the assault, which included sodomy and vaginal penetration. She reported telling her assailant she was pregnant but had the desire to keep the baby; he responded threateningly and she, in turn, decided to terminate the pregnancy to escape a tie to him.

Participant E was assaulted by a romantic partner, at which time she lost her virginity. At the time of interview, she presented some evidence of magical thinking, paranoid thoughts, and loose associations, thus making her interview often difficult to follow. Because having a linear dialogue was problematical, the researcher eliminated her interview from the analysis, as historical accuracy was in question. She was also

referred for ongoing psychotherapy at the Women's Mental Health Center to evaluate mental status and any psychiatric needs that she did not report during the screening process.

Participant F was the only career veteran interviewed. She was assaulted by one of her best friends. It was the second sexual encounter she had ever had, and she had lost her virginity a few months earlier in an assault by her drill sergeant. Participant F married her assailant and had a second child with him, whom she also reported was conceived through domestic violence and sexual assault. She stated that she married him out of force from her Hispanic Catholic culture, which is against unwed mothers. She eventually divorced her assailant and was married four more times.

Participant G was being medically discharged from the military and had been assaulted by another dischargee. She reported initially engaging in consensual kissing in a supply room and, when she asked him to stop, he restrained her and had forced sex. She reported that the assailant stalked her throughout the camp for the remainder of his stay there. Three months later as a civilian, she discovered she was pregnant. She had her child and gave her daughter to her parents when the child was five-months old. She had two other children by consent, but they had been removed from her custody.

Results

The interviews were tape recorded and transcribed by the investigator, then entered into a Microsoft Word document that was uploaded into NVivo qualitative analysis software. Leech and Onwuegbuzie (2011) have stated that "with large data sets, conducting qualitative data analysis manually typically is not practical or desirable. Over the past decade or so, the availability of computer software to conduct qualitative data

analysis has increased" (p. 71). NVivo software is one of many software programs used to assist the process in which interviews are analyzed and coded. To aid in a systematic coding process, the software allows researchers to upload interviews, read them systematically and code them as they read, and keep logs of the coded categories as each new interview is read. However, the NVivo software is not capable of doing data analysis without the researcher. Along these lines, Leech and Onwuegbuzie (2011) have explained;

> It is important to keep in mind that when conducting qualitative research, the researcher is the main tool for analysis (Denzin & Lincoln, 2005). Thus, CAQDAS programs, along with all types of analysis software (e.g., SPSS, SAS), do not analyze the data for the researcher. Rather, the researcher utilizes the computer program to assist in the analysis. (p. 72)

The investigator used the NVivo software interactively. Once all of the interviews were transcribed and uploaded, the investigator read each interview and coded emerging themes through the NVivo coding screen. Upon the first review, 24 categories emerged. Notably, the investigator had originally created 23 categories using NVivo narrative analysis, but the NVivo program noticed the multiple word frequency of the word "God." The investigator looked at the quotations with "God" in the text and added it as a separate theme. After analyzing the data through the software program, the researcher used Post-it notes to account for abstraction and to afford a different point of view from the computer-driven coding. After some time analyzing the 24 Post-it notes, the researcher found five major categories, which are as follows:

I. Adjusting to Military Life as a Woman
   a. Naïve and young
   b. It was happening to everybody
   c. Learn to dissociate
II. Looking for Support in the Immediate Aftermath
   a. Nobody was listening
   b. Betrayed in every direction
III. Coping with the New Reality of Being a Rape Victim
   a. Self-blame, denial, and fear responses
   b. Alice in Wonderland (isolation)
IV. The Pregnancy
   a. Not that way
   b. Moral beliefs intersecting the decision
   c. Self-injury
   d. Maternal connection
V. Looking Backwards on the Trauma
   a. They ruined my whole ideal
   b. Making sense of the trauma
   c. God
   d. Hope

Category I: Adjusting to Military Life as a Woman

Three subthemes described the participants' experiences before the sexual assault had occurred. All participants experienced military sexual trauma within the first 18

months of military service—the majority in the first year. As the participants looked back at their younger selves, they painted a picture of a wide-eyed, ambitious new soldier who had left her childhood home for a career and an opportunity for adventure. None of them had anticipated any potential for the victimization and predation they later experienced. The three subthemes are titled "naïve and young", "it was happening to everybody," and "learn to dissociate."

Naïve and young. The first subtheme, "naïve and young," was taken from a quotation by Participant F who reported, "I was naïve and young and stupid. I was raised very protective by my mom and dad." She further stated, "I look at it as overprotective because I wasn't prepared for what came. I trusted people. I was always taught to trust people and give them the benefit of the doubt. I learned the hard way." Participant A more harshly described the younger part of her as "not knowing her ass from a hole in the ground." She further stated, "At 21 I thought I knew everything, and I knew nothing."

Participant A spoke of her naivety in terms of being free from adolescence but taken care of by the military. She stated that the younger version of herself who was experiencing military life believed that she was going to be taken care of and alluded to feeling safe, stating that she didn't have to "worry" about anything. She explained;

> There is something that happens to you when go into the military that all of a sudden you are free. You are free from your parents, you are free from school, what you think, you just feel like "Oh my god, I'm free, and they are gonna give me my clothes, and feed me and, I don't have to worry about it."

Participant B explained that she didn't realize there was anything to worry about regarding her safety. Her naivety related to not knowing that rape existed. Participant B

stated, "I didn't know anything. I didn't really even know anybody that had been raped. You know. You grow up, you get married, and you have sex and all that. That was where my understanding was."

The feeling of being "naïve and young" also emerged when the women spoke about perceptions of their assailants and the men in the military before they had been assaulted. Participant A described herself as "fresh meat" in referencing the predation and sexual harassment she began to experience early in her military training. Some participants described a sense of being watched, or sculpted, into their victim identity. Participant F stated, "I've learned to accept that he was targeting me all along. And I was too naïve to really see it." Participant B, who had experienced sustained harassment and targeting for many months before the rape took place, explained that despite these experiences, she had never anticipated forced copulation. She stated, "I wasn't sexually active so I didn't even think that. That it could even evolve to rape. I thought he was just harassing me to go out. I wasn't even, my mind wasn't even there."

It was happening to everybody. The second subtheme highlights military culture and how the women began to develop awareness of their naivety and "fresh meat" appeal. Participant C began to notice the extent of the abuse of other women, stating:

> There were other things going on there, you know. In the military. They had a gang rape and uh, that happened in those barracks. And uh, there was another incident with a female soldier, she was brutally raped by someone, so there were other things going on in there. In the military, during that time.

Participant B candidly described the internal negotiation involved with coping that assaults were happening to everybody. She stated:

> And there was just a lack of, a break down of trust, in that. You know. You hear it from the other ladies. The other ladies talking. I don't know what happened to them but I know they had their own set of problems. You know, you are in a male dominated field what do you expect? Not to have the jokes being made and all of that? So then you just get sensitized and say to yourself, okay, I am in a male dominated field you know, I'm in nuclear weapons, me and my roommate were the only other females and there were 12 other females at that time on the post around you know, all these men, so then you start to think, okay, maybe I'm supposed to have a little bit of this because I am just a, we are such a small group compared to everybody else and yes, I set out, I didn't set out to be a nurse where I was going to be surrounded by other women, you know, I picked a field—I didn't know it was going to be so small, just me and my roommate, but I picked a field that okay well, maybe its, maybe its partly me.

Participant A reported her assault to her superior officer, but nothing came out of her report. She stated that this nonresponse left her with a sense of helplessness for the remainder of her military service. She remarked, "It was happening to everybody," and no one was reporting it, because "What's the point? Nothing's gonna get done about it." Participant D spoke about having had this sense of futility during her service time and spoke of it during her interview as a fact of her military service and into today's culture:

> I know that MST in the military, for men and women, is highly underreported because the chain of command, the structure that is supposed to protect victims, it does not. Those victims, those, it's not like in the civilian sector where if you are sexually harassed you get moved to a different department, they send you to

> another state. A lot of times you are forced to stay in the same unit and work with your attacker. Um, and it's really the victim that is made to feel like there is something wrong with them. Not the attacker.

When Participant F was asked about the number of times she had sustained sexual harassment during her service time, she was unable to account. She reported:

> I don't think I could count. I don't think I had a label on. I don't know. I think that was among men in the military, I think that was something that they kept within themselves and part of their norm, even though it wasn't reported, so I could even put a number on it. It was very well hidden and swept under the rug. And they didn't want to hear it if you brought it in.

Learn to dissociate. The final subtheme is "learn to dissociate." Participant B's experience with escalated harassment before the assault related to the coping process:

> And then after a while you just start, okay, I just started shutting down. I'm not going to mention it anymore. Nothing's getting done. You close off. Like, you are not as outgoing. You are, when you get off duty you are just going to go to your room. Or you're gonna go to the chow hall and then your room. And you are just going to do activities there. And try to make sure you are off base so that you are not in that environment. Like at home I just closed myself off and it was just better to get away from it. If they are not going to do their thing then all you can do, you still have to work in that environment but after hours you don't have to be in that environment. And that's what I did. I would go to my room and when he would come around I wouldn't answer my door. Act like I wasn't there, I remember one time I even got under my bed, I had my shoes lined up and just sat

> there in the dark, and I didn't want to make a noise that someone was in the room . . . To have to go under your bed it's kind of like, I mean you are doing it and you are doing it but now you can look back and think "Wow that was kind of idiotic" in the moment you are just like that is just what I did.

Participant F spoke to her experience of sexual harassment throughout her military time. Her characterization provided the name of this category: "So you had to learn to dissociate. And that's, I don't know if I became good at doing that. I think I did because I obviously survived." In their descriptions of getting through initial training and the harassment they were subjected to, many of the participants invoked the idea of survival.

During her interview, Participant C reported having had knowledge of other women being sexually assaulted in her platoon but that she felt disconnected from their experience of rape. She reported being sexually assaulted more than once around the time of her pregnancy, but nonetheless explained, "I didn't recognize my situation as being like those other situations."

Category II: Looking for Support in the Immediate Aftermath of the Rape

The first subtheme in this category is "nobody was listening," which characterizes how each participant—in her own way—interpreted her world from the category above, and how each grew to believe such assaults were happening to everybody and that she was powerless to stop it. The participants explained that, as the assaults took place, their expressions of hopelessness often fell on deaf ears.

Nobody was listening. Regarding the subtheme "nobody was listening," the participants detailed the struggles they underwent in the effort to be heard. Of telling her best friend, Participant A stated:

> He was supportive but he also felt like he couldn't say anything because he was, we were, in a stage band and we toured a lot. It was an off-shoot of a main band, and we recruited in high schools and stuff, and so, he felt like he couldn't really say anything because, I don't know why. I don't know why. He couldn't. He was angry. He told me was really angry. But then he couldn't say anything.

She went on to say, "It was like I was telling people but nobody was listening." Participant A had also told a higher enlisted woman who had been at the party where the rape happened. "I was friends with the higher enlisted woman, and, uh. She was, she never took anything very seriously. She kind of laughed when I told her."

Participant B described feeling that no one was listening, because she had made previous attempts to report abuse before the rape even occurred. She stated:

> I tried to, I mean because beforehand, I tried to tell people about the harassment. And that went all the way up my chain of command. And they did nothing about that so after that I didn't want to tell anybody because they didn't want to take anything that I was telling them beforehand so.

Similarly, Participant D described an attempt to report her fear of being assaulted to her superior officer. She explained:

> Even though I did report and all of that, for him to say you are the only black female officer and there is no one to compare you to and there's nothing we can

> do, I just knew this was gonna be a downhill struggle. But there was, there was nothing that was going to be done.

Participant A was the only participant in the sample who tried to report her assault. She explained, "He didn't believe me, he didn't care. He didn't deal with it. Nothing." She remembered: "I was screaming and nobody heard me. Let's get the abortion done so we can all forget about it."

In their descriptions of the pre- and post-assault period, the women often mentioned the "Good ol' boys club" or, as Participant A explained, "Guys sticking up for guys." Participant A went to report her assault the day after it occurred but found that her superior officer already knew that "sex" that occurred. Moments earlier, the assailant had told the superior officer that they had engaged in consensual sex. Participant A tried to tell her superior officer the facts of the assault, but then left. As she explained:

> Like he didn't give a shit how I reacted to it. Because the guy got to him first so there was that male mentality of, you know, a guys sticking up for the guys, kind of thing. So, I don't think that being a woman and walking in there and before I can say anything he is reading me my rights he had already decided I was guilty.

Participant D described her observation of other victims' attempts to be recognized by superiors, stating:

> [T]hey weren't being supported by their command, they were being called trouble makers and told they had no unit cohesion, that they were disruption unit cohesion by filing a complaint on their attacker, they were, um, disgrace to the uniform. So, the chain didn't, they didn't protect the people. You went on what you needed to know basis. Like the medical doctors, the CO of the battalion, your immediate

> supervisor is just supposed to know that something took place, they aren't supposed to know, who, what, where, when, why. And people were being asked questions.

Similarly, Participant B reported:

> My sergeant told me "This is what guys do" and "You put yourself here" so nothing, you know, you can't go and tell some guy to control his mouth because you are a female. That is what the military is.

Participant F's superiors also downplayed her experience;

> I think that was among men in the military, I think that was something that they kept within themselves and part of their norm, even though it wasn't reported, so I could even put a number on it. It was very well hidden and swept under the rug. And they didn't want to hear it if you brought it in. If you said something about it was like, "You're misunderstanding it because you are a female, you're a female, you're a female, you are proving yourself to be a soldier."

Betrayed in every direction. The second and final subtheme in this category is titled "betrayed in every direction," which was how the women characterized their feelings in the aftermath of the assault. This subtheme highlights that feelings of betrayal were not just from the support groups' reactions, but also from society, religion, culture, and the military itself.

Participant F described the difficult reception of her pregnancy by her conservative Hispanic family. Feelings of betrayal came from her family—but she also described the cultural betrayal that underscored her family's position. She stated:

> [T]hat culture is so old school that it's like, you have to save face. Not like the Godfather type thing but you have to save face. So I felt under pressure. And I wanted to tell my mother so I told my mother finally. 1 or 2 months. I can't remember exactly, I remember that I wasn't showing. And she was like "Well you gotta get married. Because what are people going to say?" It's like keeping up with the Jones.' That's dysfunctional! That's dysfunctional in my book. Undue pressure. And I was like what if this guy doesn't wanna marry me? You know what I'm saying. I don't know how it all happened but we wound up getting married. I had to bring it up to him. I had to do something. And just attach to him for the sake of saving the face for the family.

Participant A described the institutional betrayal she experienced by her commanding officer when her attempts to report her assault resulted in either no investigation or retaliation. She explained, "I wish I could find him and tell him how he damaged my life. How did he damage my life, you would say? I just lost faith in the United States Government." She continued to describe how this experience affected her life, "[F]or a long time it shaped me into not trusting people and not believing they could show up for you."

Participant B described the betrayal from her military peers, but also from civilian women. As she recalled:

> I heard a lot of comments, especially when I got transferred um, that I must have been a slut because who gets pregnant without being married, so it was more just being more alone than anything . . . I heard it and I thought I'm not gonna, don't rock the boat, it's very, it's very, women look at you differently, men certainly

look at you differently, your chain of command looks at your differently of you know.

Participant D described the betrayal, and how it surfaced in the larger culture, asserting:

> I know that MST in the military, for men and women, is highly underreported because the chain of command, the structure that is supposed to protect victims, it does not. Those victims, those, it's not like in the civilian sector where if you are sexually harassed you get moved to a different department, they send you to another state. A lot of times you are forced to stay in the same unit and work with your attacker. Um, and it's really the victim that is made to feel like there is something wrong with them. Not the attacker.

Feelings of betrayal also emerged out of the support groups to which the women turned after finding out they were pregnant. Most participants reported that the friends whom they did tell did nothing to support them. Two out of the three participants who had had abortions went alone. Participant C had had to travel from Germany to Holland to gain access to an abortion. She reported, "I don't think anyone, first off I didn't tell very many people and the ones I did tell they didn't, they didn't volunteer to go with me or anything. I just did it." Participant A had also gone alone to her abortion. She reported that her partner had been in San Diego, which was out of her state. Participant A had taken leave to get the abortion, then immediately traveled to San Diego to be supported by her partner. She recalled during the interview:

> She was performing somewhere in LA and wasn't there when I got there and I had this really heavy suitcase with me that I seemed to carry for miles, I don't

know why, and then I finally got in a cab and asked them to take me to this address and I shouldn't have been carrying anything heavy because it was right after the abortion and, uh, as soon as I got in, to her house, I started bleeding profusely. To a point where I was hallucinating and I thought I was dying. Doctor that had done the abortion said I couldn't carry anything heavy because I was gonna start bleeding like that. And they said if you aren't gonna stop bleeding then go to the hospital. And I didn't know where the hospital was so I just laid in bed and bled and I'd sit on the toilet and bleed. And I had all these weird images coming up. And when she got home I told her what happened . . . And she said "Have you been drinking?" And I said, "Yeah." And she got really mad at me and broke up . . . I wasn't expecting that reaction from her. It felt like I was being betrayed in every direction.

Participant C remembered telling very few people about the abortion but that somehow rumors began to circulate. She had to encounter accusations of "Baby killer" throughout her base. She reported in the interview that she still heard those shouts from strangers when she thought about the rape-related pregnancy.

Participant F added:

There's a lot of stuff that happens but doesn't happen. And it doesn't get reported. And a lot of people in high places know this. But it never happened. Funding, keeping the base open. Rank. And then I know that as I went through, even through the air force, encountering because I would become part of the good ol boys club, how rank was held from me and watching them trying to come against me, I mean oh my gosh, this is an ongoing thing in the military.

Category III: Coping with the New Reality of Being a Rape Victim

This category consists of two subthemes: "self-blame, denial, and fear responses," and "Alice in Wonderland." This category, though linked to the pregnancy, centers around the internal world of the victim, who has sustained the unimaginable reality of sexual assault.

Self-Blame, denial, and fear responses. The first subtheme, "self-blame," relates to the control that participants attempted to exert over their new post assault realities. These subthemes emerged out of participant disclosures about the immediate aftermath of being raped, and again when they discussed making their decisions over the pregnancies. On this subject, Participant G summarized the self-blame she experienced immediately after the rape as involving an internal dialogue:

> At first I tried to hide it, like, from myself. I tried to tell myself "Well maybe I consented in some kind of way." Maybe it was both, wanting to have sex. But from what I understand if you are making out and next second you don't want to do it anymore and you say "no" it's considered rape. So when I told him "no" and he kept going then.

Participant C developed a sense of self-directed blame from criticism that already existed in the military culture and from conservative cultural views about alcohol use and premarital sex. She stated, "I remember feeling bad, feeling guilty, for being drunk and I felt like I had put myself in that situation and it was my fault. I was feeling a lot of that." Participant D said that she coped by telling herself she had just made a bad "choice" that she regretted. She stated:

> I knew something at the time I just knew something had happened and for me it was just easier to, I was in shock for a couple of days, um, well eventually I just told myself "It was bad sex, it didn't happen." I just kept pushing it down and whenever it would come up I would just say, "It was bad sex, it was bad sex."

The "shock and fear" element of this category illustrates how the women experienced their reality internally. Participant A described this feeling in the following way:

> I was afraid of the whole thing. I was afraid of being pregnant, I was afraid of the abortion, of not knowing what to do. It was just a lot of fear going on. And shock. I was just in shock that that had happened.

Participant G remembered leaving the supply room where she had just been raped and seeing CO officers outside. She could have taken that moment to report the incident, but felt too scared and in shock to do so. Similarly, Participant B described fear of the assailant and the retaliation, stemming from the lack of protection that she had already experienced. She articulated this anxiety in the following way:

> It was part of the whole harassment thing. So if he could do that and then escalate to hurting you then you are going to take it serious that okay, the next time it could be very serious, and I could be hurt even more, why would you want to tell anybody when they didn't believe you the first time? He would make comments like, "See I've already been talked to you and they're not doing anything," so why would you want to do anything more?

She further stated:

> I was just stunned. I wasn't, I never even thought of, that it could even happen. But yeah, that was my first thought of "What am I going to do?' "How is this

> going to affect my career?" "What am I going to tell people?" "Who am I going to say is the father?" "What is going to happen?" All those questions went through my mind.

Along similar lines, Participant B spoke about being in such shock about the rape that the pregnancy came as a surprise:

> I didn't even, I didn't even know, I didn't even think about being pregnant. Then one day, when I found out I was pregnant, I got violently ill and I was trying to figure out why I was ill at the time, you know like after I ate or like cause I came out of the library once and I got violently ill on the side of the building and I didn't even think and I went to the doctors you know, cause I wasn't even, I didn't even put it in my mind that I could be pregnant.

Likewise, Participant D stated, "I went into a daze and I just walked out of the nurse's office, really, really, really, numb like, you know like, everything is ruined." Participant F also described feelings of denial, stating:

> What I remember is that in my head I kept going like "What the hell, I'm saying 'no,' what is going on, this can't be happening again?" Something happened to me emotionally and um, I felt like somebody had just taken my soul and totally destroy my future. How was I going to reconstruct myself again?

Alice in Wonderland (isolation). The final subtheme of this category, "Alice in Wonderland," came from Participant F, who described the internal conflict and confusion of being raped and pregnant while coping with external factors such as the military and filial cultures and norms. She explained:

> I was lost, it was one fucked up whirlwind or something. It was like an Alice in Wonderland experience. I felt like I was in this labyrinth and everywhere I looked the walls were higher, the bushels were higher, and it was darker and here I am and now this guy, and I have to save face for the family.

Such feelings of isolation come from the prior disbelief and harassing culture in which they lived and from coping with the belief that no one could help them. This experience, in turn, left them feeling isolated and forced to cope alone.

Participant B's Alice in Wonderland experience came from her decision to keep the child and to move to a new duty station to escape the assailant's harassment and to avoid anyone discovering that she was pregnant. She reported a sense of feeling lost in the "lies" she told her family, friends, and military colleagues as a way of avoiding any questions about the rape. As Participant B explained:

> First of all you can't talk about it because I already went down that road, especially after you go to a new duty station who is gonna believe you, you know that, that the pregnancy is because of that. You would think you'd feel safe to go to somebody then because you're like in a whole new group of people, this person's not there, and yet, it's not. Then you become the person that's a liar. That, well then you should have spoke up at a certain point in time.

Participant A described parallel feelings of isolation on her journey, stating simply, "I remember just walking around lost. I was just lost. I didn't know where to go, what to do, who to talk to." When Participant C spoke about the first instance in which a stranger on her base yelled "Baby killer" after she returned from having the abortion. She reported feeling isolated and alone, remembering immediately afterwards, "I think I kept it just to

myself and I went to my room. I didn't know what else to do. I just cried." Participant D spoke about the anticipated disbelief she experienced in facing that the man who had raped her was a boyfriend with whom she had had consensual sex with in the past. When she became pregnant, she told no one. She stated, "[A]t the time I was like, who do you tell? You know because people have seen you with this person before."

Category IV: The Pregnancy

This category begins to detail the journey of how each individual woman came to a decision about her pregnancy. The subthemes are "not that way" (broken dreams), "moral beliefs intersecting with the decision," "self-injury," and "maternal connection."

Not that way. The subtheme "not that way" derived from Participant A's statement: "Well I was really young and I, I had wanted kids, you know. But I didn't want it that way." This subtheme highlights the intersection of what they wanted for their lives and what they were encountered with through the rape. Another way to conceptualize the experience they described in this subtheme is a sort of "life flashing by their eyes," which is a life they had wanted, an experience they had wanted, but were thwarted by the pregnancy. Participant B described her thoughts in the following terms:

> I was just stunned. I wasn't, I never even thought of, that it could even happen. But yeah, that was my first thought of "What am I going to do? "How is this going to affect my career?" "What am I going to tell people?" "Who am I going to say is the father?" "What is going to happen?" All those questions went through my mind.

Participant G didn't want anyone to know her life had taken a turn, stating, "I just didn't want anybody else to know that I was going to have a child from the result of a

rape. So I didn't tell anybody." Participant F mourned her desire to conceive a child through love, explaining:

> [T]o me it's supposed to be a beautiful experience where two human beings become as one, biblically, and I never knew that. I've only known the distorted part of it. And in my head that was a normal thing. And at the age that I'm in, from what I've learned, no its not. That was distorted. That was dysfunctional. That was not the way God intended it to be. Between a man and a woman . . . that's what set my future and spiraled me out of everything and the path that God intended for my life.

Moral beliefs intersecting with the decision. The next category of subtheme is "moral beliefs intersecting with the decision," which describes how most of the participants struggled with their own beliefs about motherhood and pregnancy along with society's view of the same. The participants all agreed that the decision to terminate or give birth to the child was a difficult one that weighed heavily on them. Participant A stated:

> And I struggled with it because I was very Southern Baptist. And I thought, "Am I going to be killing something because I can't handle it?" or, so I had trouble with the whole abortion thing. I wasn't sure what my beliefs were about it but the idea of keeping it was [silence] it was just distressful. It was disgusting. But I'm also, even now, in a conflict about it because babies aren't disgusting.

Participant C explained that her decision to end the pregnancy was not entirely her choice, but that pressure had come from within the military community as a result of rumors that had begun to circulate:

> I chose to abort. There were some other things surrounding that. I was babysitting for my, uh, commander and his wife. And ah, you know being over there is like being in a, like they say, a small country town. Everybody knows everybody's business and people found out that I was, ah, babysitting for the commander and his wife, and, just the pressure of, the pressure, now I can say being raped. There was a lot of pressure on me, and now people finding out that I was babysitting for the commander, and accusations started rising up that maybe he was the father and he was not the father. Never had any sexual contact with him. So, there was just a lot of, a lot of pressures and that was my decision.

Participant D stated that she never felt fully resolved about any of the events that had happened to her even as she underwent the abortion. She remembered:

> When I got on the table I remember crying, and I think they thought I was crying because I was aborting the baby, but I wasn't crying because I was aborting the baby I was crying in how I got the baby. And there was this lady in the recovery room and she was like "You know, it's gonna be alright" and I just looked at her like "You have no idea" I mean this wasn't like a just an unplanned pregnancy, this was a violation. And you know I cried for the baby cause I knew I couldn't carry the baby because I didn't think I would take proper care. And even if I did carry to term and give him up for adoption, I would get, because of the things that I had done, I would get somebody else a child that wasn't fully developed.

Participant D's assertion that "because of the things that I had done" the child wouldn't be fully developed was a common theme shared during many of the interviews. This remark is detailed in the next category.

Self-injury. This subtheme title of "self-injury" refers to the women's beliefs that they had harmed their children because of self-destructive behavior they undertook during their initial trimester—upon finding out that they had become pregnant. Five out of seven of them described this phenomenon. Participant D's statement about what "things I had done" referred to the following behaviors:

> Working out a lot, hitting myself in the stomach, you know you aren't really supposed to be taking strong painkillers but I was because I was having really bad physical pain with this pregnancy. Um, so, I was taking stuff like 800 mg ibuprofen, stuff like that.

Participant F also undertook heavy physical activity out of a desire to miscarry. Similarly, Participant B stated:

> I tried not eating, you know, um, really there would be days I would go without eating and I would pray "Please let me lose this child," so different things, I mean, I remember taking like aspirin where maybe I thought if I took enough that, you know, maybe I would just, you know something would happen where I would just have a miscarriage. So yeah, there's things. That I have to answer to now, but there are things that I tried, I tried to not eat and just "Please please please, you know."

Participants A and G used drugs (methamphetamine, IV cocaine, and LSD) in an effort to spontaneously abort the pregnancy. Both reported that this response marked the first time they had ever used hard drugs. Participant A recalled never consciously saying to herself that she wanted to miscarry; but, looking back at the moral dilemma she had about

abortion, explained, "Um, it made it easier for me to get an abortion. Because I knew that this baby would not survive all that."

Participant C said she was "unsure" if she drank alcohol during her pregnancy; however, the evening after her abortion, she was alone and in Holland recovering from the procedure, and remembered going into town to get drunk. She stated, "I think I just started drinking more. That's all I knew. My drinking started right around, shortly after I got outta there. Shortly things started happening and that's all I knew." Participant B also remembered coping through alcohol immediately after giving birth, explaining:

> I never had a drinking problem before I was pregnant or anything. I drank but never like I was doing. I look at I don't know how I didn't die of alcohol poisoning and you heard of people that die from alcohol poisoning all the time. And I don't know if I was consciously trying to have that happen. Because I don't think it was a conscious decision but I don't know why I would drink so much to begin with because I wasn't, you know alcohol in high school I never felt pressure and being raised Greek orthodox I always was raised around holidays where I had a little bit of alcohol so when I got into high school trying alcohol and beer wasn't something I had to do because it was open in my house and I never went through that. Same for in the military it was like, you know, some of it tastes nasty, why would you do it? But afterwards in that six months was I trying to kill myself or not? I still can't answer that.

Though not always described exactly as suicide, the desire to end it all was shared by many of the women as a result of becoming pregnant from rape. As they contemplated the fate of their unborn child, they also thought about their own future fate

and whether they could handle the extreme pressure they were under to make a life-changing decision. Participant F recalled, "Secretly I was thinking this would be so easier if I just ended it all. Cause where am I in this?" Participant G remembered fighting with her boyfriend, who was pressuring her to have an abortion, and contemplating a suicide pact. She recalled:

> At that time I was three or four months pregnant. And the whole thing just got to him. So we were arguing and we went on a drive. And it was basically let me go find a tree to hit. One of those drives. We both wanted to commit suicide, we both wanted to end it all. His parents were on his back and he was on my back. About "Why are you gonna have this other man's baby?"

Maternal connection. The fourth subtheme in this category is the "maternal connection" factor of the pregnancy. Six out of the seven of the women spoke about initially being conflicted, disconnected, and feeling disdain toward their unborn child. Participant D described her experience of being pregnant has having a "tape worm" or a "parasite" inside of her.

However, many of them also spoke of a connection they had felt to their child during the pregnancy after the decision—abortion or birth—had been made. Women who had had the abortion reported fantasies about what their child "was," feeling that they knew the sex of the child. Two of the three women who had abortions described feeling that they had met the child in visions. Participant C stated, "I remember rubbing my belly, I think I apologized. Over what I was gonna do." Participant A remembered, "I felt connected. I felt connected. Because that night I was staring at my stomach in my

barracks I just remember crying because a big part of me wanted to get rid of it and a big part of me didn't want to."

For the women who had had their child, the maternal connection was difficult upon birth. For example, Participant F remembered the difficulty of feeling connected to her child. However, when she went into preterm labor and gave birth to a two-pound child, she felt a shift in which she then wanted the child to live. She described that experience:

> Deep inside no. Deep inside, no. I remember trying to knit, and I don't know how to knit or crochet, to see if I found some connection. Or trying to fix a crib to get some connection. But I was never connected. It's terrible [crying] yeah. Not to have a connection with a child when so many people want to have children and can't have them. I should have been enjoying my pregnancy and I didn't. Horrible. And then at the end when I almost lost the baby I was fighting for the baby.

Participant B also described the challenge of connecting to her child during her pregnancy:

> You know I had friends who are pregnant, and like, they go through the whole pregnancy, they're happy. That wasn't me. I just wanted it to end. Um, I would pretend like I wasn't pregnant. You would do things, like you are there, and you just try to be outside of it.

When the four children were born to the participants in the study who had carried their children to full term, the women experienced varying degrees of connectedness. Because Participant F married her assailant and continued to experience abuse at his

hands, she remembered experiencing a "mama lion" connection when her son was born, which arose out of her desire to protect him from the violence in the home. She stated, "I had to. I had to love him enough to protect him. I had the crib in the bedroom. I really didn't sleep. I just wanted any noises or whatever, just keep an eye on the baby."

The three other women in the study found that forging a bond to their children was very difficult; two gave up their child for adoption a few months after birth. Participant G remembered giving birth and immediately experiencing anger and disgust with her child. She explained, "The second she came out, they wrap her up and they give her to me and I said, 'No, I don't want her.'" She became tearful as she described the difficulty of bonding with her child and her refusal to feed the child, hold the child, or help with any activities after birth. She left the childcare to her husband. She described hearing the baby cry one day when her husband had left for a period of time. It sounded like "nails on a chalkboard." She stated, "I let her cry. I tried to suffocate her one time. Because, I didn't want to deal with it."

Participant B did not express homicidal tendencies, but similarly described the disconnected feeling she had about her baby and the bonding that never came easy for the few months she had her daughter:

> I tried very hard to be a mom. Like, okay, this is what the military expects you know in New York I had a commander and they made all these things about getting me housing this is what you are supposed to do once you decide to be a mom, even though I don't know that I truly wanted to be a mom, but, you know I told my mom I would do that, "Okay, gotta be a mom now," um, so it was, I tried very hard to make sure I had a connection with her because I wouldn't just like

> leave her, but I know I probably didn't do everything I could. You know my mom was there and stuff, she did a lot of things, and took care of her and played with her more than I think I tried to do that bond and then tried to make sure she was healthy but I don't know if I gave her everything that a mother should give her. You know, all the time and the attention.

Both Participant G and Participant B described thinking that their child looked like the assailant, which made it harder for them to bond. Participant B stated that the day she decided to put her daughter up for adoption was the day that her mother said to her "The baby doesn't look like you."

Category IV: Looking Back

The final category of this research outlines the idea of looking back to a time period in which the women felt they were "young and naïve" and without worldly experience. They saw that time as having shaped the rest of their lives and developed perspectives of themselves retrospectively as well as about the future and what remained to be overcome. Though sadness prevailed throughout the interviews, this category reflects some of hope for their future and for happiness in life. Such thoughts were new to them, and had not been part of their experience during the crisis of the rape and the pregnancy. The subthemes within this category are: "they ruined my whole ideal," "making sense of the trauma," "God," and "hope."

They ruined my whole ideal. The first subtheme, "they ruined my whole ideal," reveals the perspective the women had gained about their lives, attitudes, and beliefs, and how they had changed as a result of the pregnancy and rape. Participant F explained that she never got to experience normal sex, conception, childbirth, marriage, or any of the

fairytale aspects she had wanted for her life. She stated longingly, "I have never really experienced real Christmas. Only when I was young, with my parents. The Christmas tree, and the family dinners, and everything else. I never did that." She continued:

> Yes, I never experienced the traditional family period. What I experienced was a dysfunctional life a dysfunctional family. Always on survival mode. And masqueraded with a Christmas tree or lights to make it look normal. It was always a façade always a masquerade. Nothing was what is seemed to be.

Participant D also felt that she had lost her youth and her plans for the future:

> I've hit 30 and 31 and I have to rediscover who I was. And I feel like I am behind the curve because of all the stuff that happened. And I think, if I had never gone into the military, where would I be right now? Well, I'd be a wife a mother, would I be an entrepreneur or a world traveler, what could I have been if all of that hadn't taken place?

Participant B echoed that sentiment:

> I was starting to find out who I was at 21, to stand up and go down that avenue of whatever that is, to be a soldier, to be a female soldier, to have a dating world open up to you, to just enjoy your life as a young person. To make my decisions of what I wanted to study. What courses I was doing. I was taking college courses while I was in Germany; I was taking correspondence courses to be a better soldier. So that stopped. It stopped my growth as a person. It stopped my growth as a female.

Five of the seven participants felt that the pregnancy resulting from rape had led to their early discharge from services. They mourned the career they had dreamt of as teenagers

and the hope they had had to be a retired, proud military veteran at this point in their lives. Participant C asserted:

> I kinda feel that this getting pregnant and all this happening and the thing that, uh, then suspecting the commander and having to go before the company commander about this pregnancy and all that, yeah, I feel like my life could have been a little bit different. I wanted to be a career soldier. It was something I wanted since I was very very young.

As well, Participant B explained

> I'm 43 now, so you think I would have just been now retiring if I had stayed in. So you think, if this wouldn't have happened. Not that I'm saying anything else wouldn't have happened, but you think what if I would have made it a career, I would have been retiring now, or another year, or whatever. So you get mad.

Making sense of the trauma. The second subtheme of this section, "making sense of the trauma," relates to a specific question asked during the interview—one that many women had difficulty answering. Participant F stated, "It's a wound that goes to your soul that affects the rest of your life."

Participant C wasn't at peace with her decision to have an abortion. She reported dreaming and longing for the child she had terminated:

> I think today I feel less guilt. And now that I recognize and have admitted that the pregnancy was because of a rape I am just feeling less, less guilty and more accepting that it was because of a rape . . . I do regret it. And now, you know with help, I have been able to recognize that I did the best I could at the time. I think that I was, you know, I think if I could go back I probably wouldn't have. But I

> can't change the past. I have to accept what I did now. Because I know now that I can't move forward if I don't just accept it. There is still, I mean a desire to have that child.

Participant D was still in her early 30s and thus still had the biological potential to have children; however, she appeared ambivalent about her future in a relationship. She remarked;

> I have no children. I feel that whole experience just kinda, it really tainted my vision on motherhood, in being a wife and being in a relationship. Cause it was like how could someone who said they loved me, do this to me? Um, so, you know, you develop trust issues. Why would I be in a relationship if I don't trust you? . . . I had never been in love, I had loved people, but I had never been in love. It was always kind of messed up that whole happy feeling for me, when you become in love with the idea of being in love but because of all the trauma it's like um, "Oh that's a nice dream for everybody else" or "They're in love, that so, you know". . . The whole being violated like that makes you feel unlovable.

Participant A identified as gay and had recently turned 51. She reported experiencing a longing for a child throughout her life and admitted to some conflicted feelings around the abortion. She said:

> It makes me very sad that I had it. But at the same time it makes me, I can't imagine not having it. You know. I mean I, I certainly know why I had to have it. Because I couldn't keep a baby that I had conceived through a rape.

Participant F had raised her child and felt a loving connection since the child had grown into an adult and she had divorced her assailant. However, looking back she

reported she would have strongly considered abortion, "If I wasn't manipulated, I would have been one of those women who had an abortion. Even though my moral beliefs were fighting me. Being a true Roman Catholic, God forgives."

Participant G still saw her child, though she was not the primary parent. She kept the rape a secret from her family, and at the time of the interview was questioning whether that was the right thing to do for herself and for her relationship with her child. She stated, "So I didn't tell anybody. And, I think in the long run. I wish it was the other way around. Because even today I still cannot bond with my daughter, as a mother should."

Participant G broke down at the end of the interview, admitting to feelings of shame and regret around the decisions she had made as a parent, and around the choice that had been forced on her by the rape:

> It hurts. That I tried to end her life. That she could have been better than she is now if I hadn't done that or I hadn't done drugs [during the pregnancy] . . . What a fucked up mom I am. Excuse my language, but. That's why I lost my boys, that's why I don't even have patience for hearing babies cry. I can't stand, it's like nails on a chalkboard.

She continued:

> It is hard because it's molded me into the person that I am today. My mother always compared me childhood friend. She's got a yacht, she has a house, she's got this she's got that. I don't have anything. But yet we grew up together. Sometimes I wish I knew exactly what it was that happened to me. Why I'm bi-

> polar, why PTSD, why? I don't like it. I wish there was some surgery so they could just remove it from my mind. Cause it hurts.

Participant B, much like Participant F, questioned whether if she had had more support she would have had an abortion. She speculated:

> If they would have taken it seriously or afterwards if they would have found out maybe I wouldn't have, maybe I would have had her, maybe I wouldn't maybe I would have had an abortion, but if there was more support, you know. What could have happened? You know, if it was handled differently.

When asked during the interview about any sense she may have made of the trauma, she stated:

> There is no sense in that is it? When you feel like you could have been so much more and yet what did you do with that twenty years? Where did it go? You wasted them. You can't go back and get your future back, you can do other things, but you can't go back and get that time back. That's an awful lot of time. Try not to dwell on it, but at least for me you can't help but dwell on it, you can't just think okay so you have to go on. You have a hard time doing that.

She spoke about her diagnosis of PTSD and the difficulty she had had trusting other people. She explained that since the assault she had hidden away from most social situations out of fear of being hurt again:

> This is all I know is to shut down and be quiet and make sure I don't get hurt again and that's my normal. Cause I don't know any better, or didn't know any better, I am learning it now, but like I said I can't get those 21 years [since the assault and pregnancy] back and that's a shame.

Participant C described a fantasy about the child, one that could have been real if she hadn't aborted it:

> You know I see girls, young ladies, that are around that age. I think about my child. Because I felt really strong that it was a girl. Sometimes I think I could have had a daughter around the age of some of the girls that I know.

Participant C added that, nonetheless, she believed that the trauma itself helped her to be a better person in the world. She stated, "It's helped me to have more compassion. More love towards people. For the most part."

God. God was mentioned 33 times during the seven interviews; indeed, the word appeared in every interview except for that of Participant D, who described herself as not very religious. The women invoked God in various ways, such as a presence throughout the pregnancy-related decision and as response to a question they hadn't considered before, such as "Oh my God." God was also used as a way to understand the experience, "The God of my understanding." As one participant put it:

> At 21 I thought I knew everything and knew nothing. I had experienced a lot of traumatized things and was caught up in the victim role. Which is why I say the God of my understanding is the only reason why I think I was propelled forward. Because you can't figure that out . . . I think that God working through me. I had to do the work.

Participant F had a unique point of view around God and her rape. She felt that God had not decided her fate to be raped but was with her throughout the ordeal. She explained her belief that the rape and resulting pregnancy was not intended by God, but in fact had interfered with God's plan for her. She stated, "That's what set my future and spiraled

me out of everything and the path that God intended for my life." She looked back on her rape and the child born from the assault, and had a sense of longing for herself. She explained:

> To me it's supposed to be a beautiful experience where two human beings become as one, biblically, and I never knew that. I've only known the distorted part of it. And in my head that was a normal thing. And at the age that I'm in, from what I've learned, no its not. That was distorted. That was dysfunctional. That was not the way God intended it to me.

Participant F looked back at her reaction to the pregnancy and explained, "I was in denial. I didn't want to believe it. And I kept praying that God would take it away." However, once her child had been born and grew into a healthy adult, she was able to say, "My God, he's a gift."

Participant F ultimately made meaning of her entire experience—good and bad—through her belief in God. She stated, "The bottom line in life, everything is just material stuff. In the end the only thing you have is your relationship with God, first and foremost, and your relationship with people. Your family. The love of your family." Participant B also used knowledge of God's presence throughout her interview, and in looking retrospectively at her decisions. She described having scheduled an appointment to have an abortion and laying in bed the night before it was to happen: "I just had a message from God to go through with the pregnancy so in the morning I told my mother I had to cancel the appt that I couldn't go through with it." However, immediately after giving birth, she began to binge drink and have blackouts. She asked God for help during this time. She remembered:

> [F]or a short time after she was born, I used alcohol, but like I said, once again with God, I knew because I had blacked out a few times I told God that I am going to kill myself with alcohol and you have to make me stop or I'm gonna die this way.

Three times Participant B described the oath to "God, Country, Military" that she had taken as a service member as a code of honor she trusted. Participant C expressed guilt about her decision to abort and about how God felt about her decision. She stated that shortly before the abortion began "I prayed and asked God to forgive me." She also described making a promise to God about having a child through a consensual union: "I had a lot of regrets aborting that child. Cause I just made a promise to myself and to God that if I ever got pregnant I would never do that again. And so today I pride myself as a mother."

When Participant A was asked how she made sense of the trauma and her journey in life after she had made her decision about the pregnancy, she referenced God as an intermediary:

> I can only imagine its only a god of my understanding. You're talking about something that's intangible here. I can't understand how I kept going either. About a lot of things in my life. How do you keep going when you've had a lot of crappy things happen? What propels you forward?

Participant A intersected God and hope, which will be discussed as the final subthemes. She described her drug addiction and how she had had to overcome not only her rape and pregnancy, but also the aftermath of the habitual drug use she engaged to cope with the

rape and abortion. She had been in AA for over 20 years and reported often trying to make sense of her difficult and often "unfair" journey in her life:

> Hope is, and I've had moments where I've had no hope whatsoever, but hope is something that I believe in because I believe we are basically good people and things that happen to us aren't decisions that are made by human beings, not by God. We have free will and choice. And if I have free will then I choose to have hope. Because if I have hope I feel better about myself, I feel better about the world I'm in, what could happen, you know.

Hope. The final subtheme is about hope. At the end of her interview, each woman made some expression of hope. Some articulated hope for the research and that they could help other victimized women. Participant F summarized this thought well:

> I still haven't made sense of it. But I am trying to take what has occurred and I would hope, like part of this interview, from something horrific in my life, and traumatizing, as I'm still working through it that it can be used for a greater good. That something good can come out of it. Whether it's the knowledge, diagnosis, teaching others, enlightening others, discernment, education, it has to serve for something. It has to. Has to. I want to believe that. And that's why I'm here. It has to.

Some women expressed hope for themselves as they looked back and saw how the trauma had disrupted their lives and that they could begin to rebuild themselves and their world and find happiness again. Participant B described her symptoms of PTSD and how they negatively affected her life and her pursuit of a career or a stable income. At the time of the interview, she was in transitional housing and had returned to school to develop job

skills. She explained that the biggest obstacle that had arisen out of the pregnancy and rape was her withdrawal from social connections. She had hope for changing this reaction:

> You get to a certain age and that's what you do is you find out who you are. And I was just beginning that and I was cut short. Because of something and then I just perpetuated it by what I did. By closing off and all that. I'm not saying that's a bad thing but that's all I knew then was to close off. It doesn't make it right or wrong again, it just is.

Participant F also concluded her interview by describing hope for her future:

> I don't believe it's too late, though. That's why I'm trying to do everything I can to go through the process. It's not too late to reclaim your future. That's why I'm fighting that's why I'm allowing myself to stretch even if a part of me doesn't want to. If I don't deal with it, I'll stay stuck in the past.

Summary

In this chapter, the investigator presented an overview of the procedures used in data collection and analysis, demographic information, and the results of the data analysis. The five major categories that emerged in the data analysis appeared in sequential experiential order. They include: (1) Adjusting to Military Life as a Woman, (2) Looking for Support in the Immediate Aftermath, (3) Coping with the New Reality of Being a Rape Victim, (4) The Pregnancy, and (5) Looking Backward on the Trauma. The categories in each theme were defined and examples from the data illustrated the findings. Chapter Five will discuss the findings, including their relationship to the

existing literature, limitations of the study, and recommendations as well as implications for future research and social policy.

CHAPTER FIVE

CONCLUSION

> You are very lucky to have JUST been raped. You truly were. And I know that's mean because I never want to put that on somebody else that you are lucky to be raped but what I meant is you are lucky that you didn't get pregnant, that puts a whole different set of things on you. – Participant B

The researcher found only one published study on women who have become pregnant from sexual assault. This study presents the first exploratory research conducted on women who have become pregnant from a sexual assault during military service time. The results from this study are original in the field of pregnancy-related sexual trauma, and the researcher's hope is that it will mark the beginning of much more exploration of how pregnancy resulting from sexual trauma affects women in the immediate aftermath and during their lifetime.

Discussion

This chapter includes a discussion of the findings presented in Chapter Four with respect to the themes identified in the data analysis. Additional theoretical ideas will be suggested to help explicate the data. The chapter will also discuss limitations of the study, as well as implications for clinical practice, social policy, and further research.

Review of the Purpose of the Study

The purpose of this study was to find out what, if any, effects pregnancy from rape have on a US service member. Despite numerous studies on the effects of rape on a woman's psychological health, only one study has explored how pregnancy from rape might affect a woman. As discussed in the literature review, the present study was

designed to explore attachment relationships and internal working models of the service women regarding themselves, their unborn children, their relationship to the military, and their sense of the support they received—or did not receive—during this traumatic time. This project was an exploratory study by design.

This discussion will be organized around the five major themes that emerged from the data. The first theme, "Adjusting to Military Life as a Woman," describes how the women looked back on their 20 year-old selves entering military service and how it played into the eventual assault. The second theme, "Looking for Support in the Immediate Aftermath," talks about the attachment behavior exhibited following the trauma and the unfortunate experience of the women, who felt they had no one to turn to who could—or would—help them cope with having been raped. In the third theme, "Coping with the New Reality of Being a Rape Victim," the women exhibited many themes documented in the literature about Acute Stress Disorder from sexual assault (at this point in time they were not aware that they were pregnant). The fourth theme that emerged was "The Pregnancy," which pertains to how the women coped with carrying a rapist's child. The fifth and final theme was how the women were "Looking Back" at themselves then, comparing their lives then to now, seeing the trajectories of their lives playing out, and the coping mechanisms they employed then and into the present.

Theme 1: Adjusting to Military Life as a Woman

The first theme, "Adjusting to Military Life as a Woman," emerged as the women reflected on their younger selves as "naïve and young." Sexual harassment was perceived as "happening to everybody," and they coped by dissociating from internal alarms of feeling threatened by their peers and superiors. Every participant contributed to

this category except for Participant G, whose assault happened as she was being discharged from the military after a few months of boot camp for a physical injury she had sustained. One might speculate that she had not experienced the same degree of sexual harassment the other women described, or that her service time was too short to immerse herself in the culture of the military.

All participants had been sexually assaulted within the first 18 months of military service time; three of the participants, A, B, and F, described being "naïve and young" as a precursor to the sexual assault. Though self-blame is a theme that emerged later on, the researcher observed that this notion of being "naïve and young" served as a form of setting the stage for the assault; that is, that the participants appeared to take some responsibility for what happened. Self-blame is a highly documented symptom of post-traumatic stress disorder for sexual assault in nonmilitary settings. Indeed, Najdowski and Ullman (2009) have described various findings in the literature regarding self-blame and its adaptive quality to processing adult sexual assault. Surprisingly, they reported that "perceived control" in a sexual assault victim leads to better coping in the aftermath of the trauma. However, self-blame, specifically characterological self-blame, can mitigate those effects. Further, they have defined perceived control as the victim's belief that he or she can control the impact of the trauma on his or her life (Najdowski & Ullman, p. 43). In describing themselves as "young and naïve," the participants appear to have taken on the characterological attribution of their assault. That is, if they had been older and wiser, they would have had more control and would not have been assaulted.

Sexual harassment and the perception that sexual harassment is ingrained in military culture are not new ideas. Indeed, as discussed in Chapter Two, they have been

documented in the literature. Weatherill et al. (2011) studied 658 female U.S. Marine Recruits; their results "indicated that sexual harassment, performance stress, and unit cohesion mediated the relationship between egalitarianism and mental health symptomology" (p. 348).

Also as discussed in Chapter Two, a 2005 poll of military academies reported that 1,906 surveyed women reported 302 incidents of sexual assault since they had enrolled: "50% of female respondents and 11% of male respondents indicated experiencing some type of sexual harassment since entering the schools" (Sidoli, 2005, p. 14). Additionally, the poll indicated 64 female incidents of rape and 30 incidents of oral or anal sex against their will, and another 127 incidents in which sex was attempted but not successful (Sidoli, 2005, p. 14).

Dunivin (1994) has described military culture and the conflict between institutional acceptance and experiential change, characterizing the nature of training as part of its "masculine-warrior mentality":

> In summary, the traditional model of military culture is characterized by an underlying combat, masculine-warrior paradigm, with complementary ethics/customs, laws/policies, force structures, enculturation, attitudes, and interactions. Traditionally, the military has recruited, trained, and rewarded soldiers that embody its CMW ideology—a homogeneous force comprised primarily of white, single, young men who view themselves as masculine warriors. (p. 532)

Dunivin has further argued that effective cultural change within the military and to its "masculine-warrior mentality" means that the military will have to shift its focus on war

and embrace peace keeping and disaster relief as pillars of soldierhood. Specifically, with regard to gender discrimination and harassment, she has suggested:

> [T]he military must alter its prevailing view of warrior as a male-only vocation. In the emerging pluralistic, egalitarian military, combat includes soldiers (e.g., gays and women) who do not fit the traditional mold of "masculine warrior." Their very existence and success challenge the military's traditional notion of warrior. Therefore, the military must begin to view the warrior as a soldier whose job extends beyond combat and whose ability transcends gender or sexual orientation. (p. 538)

Although her article was written 18 years before this research was undertaken, issues around gender equality continue to make headlines in the United States press. As these interviews were taking place, a presidential campaign was featuring political discourse about the definition of "legitimate rape" and why the United States national policy should not allow abortions in the case of rape. Rep. Todd Akin of Missouri, on the House Armed Services Committee, was asked about his views on pregnancy from rape; he responded: "It seems to be, first of all, from what I understand from doctors, it's really rare. If it's a legitimate rape, the female body has ways to try to shut the whole thing down" (Moore, 2012, p.1). The discussion incited by his remarks highlighted biological inaccuracies; however, the political discourse that followed these comments painted a picture. Even though this research study focused on the military culture and the ongoing sexual harassment and victim blaming that women in the military experience, these phenomena must not be ignored in a larger US culture that too often tolerates such discourse. In short, the issue is far greater than this research study.

The final finding in this category related to dissociation, which is common in Acute Stress Disorder as found in the literature (Elklit, Due, & Christiansen, 2009). Based on disclosures from their interviews, this finding and other findings in Category Two suggest that the women in this study were feeling bodily based fear much earlier than they reported. From an attachment lens, the women revealed having had an idealized perception of the military and of what they could expect from the culture. The loss of attachment security from the harassment and victimization—and absent a safe object to help them feel secure again—is reminiscent of Bowlby's original research with children who lose an attachment figure and thus enter into despair and detachment (Bowlby, 1976). Because of political discourse and the military environment, the women were frozen with fright and suffered from even more severe symptoms of PTSD—such as dissociation—because the environment prevented them from finding a "safe place" or attachment object.

Theme 2: Looking for Support in the Immediate Aftermath of the Rape

Two subcategories emerged from this data: "no one was listening" and "betrayed in every direction." This theme emerged as the women talked about feeling that they could not find any support from the leaders or peers in the service. This finding is not unique and is, in fact, documented heavily in the United States press about the incidence of military sexual trauma as well as in various feminist law journal articles examining military culture, the institutionalization of abuse, and power dynamics.

Even when a victim has the courage to report an assault, military culture often fails to take the assault seriously, to follow up with a proper investigation, and/or to hold assailants responsible for their acts of violence. A recent 2012 article in the *Huffington*

Post titled, "U.S. Military Failing Female Survivors of Sexual Assault" (O'Toole, 2012) discussed the conundrum between military leadership's two-decade-old commitment to "zero tolerance" of military trauma and the reality that incidence numbers continue to rise without the military really doing much to alter the culture of sexual victimization:

> Despite over 20 years of such "zero tolerance" directives and policies, some 10 years of record keeping and seven years in operation for SAPRO, there has been no marked decrease in sexual assault or uptick in the rate of convictions. Yet the line from Defense is that more reported cases means more reporting, not more assaults. Nevertheless, the escalation in numbers is troubling: 901 reports of MSA in 2002 more than tripled to 2,947 in 2006. That number rose further still by 2011, when some 3,200 reports flooded in. (O'Toole, 2012, p. 1).

In the discourse of law journals, some authors have maintained that military law has undertaken "ambitious legal reform" to change the way it investigates and prosecutes accused assailants. However, very few rapists go to military jail or suffer any severe penalties. As Hillman (2009) has stated:

> Much, then, has already been done to attempt to reduce the prevalence of military-on-military rape. The military criminal code governing sexual assault has been overhauled, the policies that set the tone for the investigation and prosecution of rape have been rewritten, and the cultural norms that encouraged sexual exploitation and the degradation of women have been undermined with training and education . . . *Yet this generation of change has seemed to make little progress toward reducing the harms of military-on-military sexual violence.* Both the root problem (sexual violence) and its military corollaries (bad publicity,

> compromised operations, poor physical and mental health among veterans and service members) seem invulnerable to even the most ambitious legal reform. (Hillman, 2009)

The O'Toole (2012) article also cited recent statistics regarding the investigation and prosecution of the accused:

> By the end of FY2011, only 240 of the original 3,192 reported crimes had made it to trial. Just fewer than 6 percent of the total reports resulted in a conviction by courts martial. According to SAPRO's [Sexual Assault Prevention and Response Office] latest report, "most" of the people convicted in FY2011 were reduced in rank or placed into confinement, but fines were more common than discharges. But the punitive measures the military is handing down may not mitigate the risks: Repeat offenders, according to the report, commit 90 percent of all assaults. (O'Toole, 2012, p. 1)

Reflecting these latest statistics, the emergence of the themes of "nobody was listening" and "betrayed in every direction" illuminate how a woman who has been raped must feel when futilely looking to her comrades for guidance. As described, many participants knew of past victims whose official reports had fallen on deaf ears and who had been ridiculed for making their reports. The participants described a time when they were trying to create a career and begin their lives as military soldiers. Even to report their assault—or to find someone to support them—seemed to go against the image they wanted to create of being strong and able to make it in the "man's world" of the military.

This isolation, partly self-imposed and partly a construction of military culture, prevented the participants from finding the appropriate coping skills they needed to

recover and feel better. These women described being alone, without someone to support and encourage them in their recovery; instead others told them to "suck it up and drive on," as their military career had taught them. Najdowski and Ullman (2009) studied the effects of perceived control and PTSD in adult victims of sexual assault, explaining:

> More traumatic life events and more self-blame were each related to more PTSD symptoms and less self-rated recovery, whereas greater perceived control over recovery was related to fewer PTSD symptoms and more self-rated recovery. These relations were partially mediated by the strategies in which survivors engaged to cope with the ASA experience, consistent with Frazier et al.'s (2005) research suggesting that maladaptive coping mediates the effect of self-blame on postassault distress. In our study, the effects of traumatic life events, self-blame, and perceived control over recovery on PTSD symptoms and self-rated recovery were all partially explained by maladaptive coping. Thus, women who engage in maladaptive coping may be aware that the strategies they are using are not effective in alleviating their psychological distress. (Najdowski & Ullman, p. 49)

From an attachment lens, the world in which the women found themselves was far from providing the idealized attachment security they had imagined. Adjusting to the new world of danger, and lacking someone to shield them from the victimizing culture, will be discussed in the next theme. Recognizing this moment in an 18 or 22 year-old's life means seeing how she begins to question prior beliefs, or an internal working model, of feeling safe and protected.

In talking about her perception of being "naïve and young," Participant F described coming from an overprotective family. She stated during the research interview

that she trusted others and believed that others were safe. Most can only imagine the feelings of betrayal that arose out of assuming that the safety and security she had experienced in childhood was being transferred to her comrades in the training program. The first betrayal, of rape by a trusted comrade, was enough to destabilize her sense of safety. Looking around to her trusted base of friendships and feeling that "no one was listening" provoked a second, more devastating, betrayal. This kind of betrayal trauma is reminiscent of that discussed by Ferenczi (1933) and Symonds (2000). As discussed in the literature review, Symonds has described the devastation that peer group betrayal can have on a victimized person. This betrayal shatters one's sense of safety in one's social group, but also one's sense of safety in who one is as a person. He emphasized;

> The "second injury" is essentially a perceived rejection and lack of expected support from the community, agencies, treating personnel, society in general, as well as, family or friends to an individual who has been injured or victimized . . . all his past feelings of security, safety and feelings of invulnerability are shattered. In addition, his personal idealized image of himself as a self-sufficient, autonomous individual are damaged. (Symonds, 2010, p.33)

Feeney (2007) likewise described the social group of an individual and how peer group reliability is crucial to securely attached adults. She described Bowlby's (1969) assertion that healthy dependence on a reliable social support is crucial to psychological well-being:

> Attachment figures promote healthy functioning by providing a safe haven to which a relationship partner can retreat for comfort, support, reassurance, assistance, and protection, and by providing a secure base from which a

> relationship partner can explore the world and strive to meet his or her full potential. (Feeney, p. 268)

Feeney studied how the positive impact of dependence on others in times of need can reinforce a securely attached, autonomous adult. She quoted Bowlby:

> [T]his concept of the secure personal base, from which a child, an adolescent, or an adult goes out to explore and to which he returns from time to time, is one that is crucial for an understanding of how an emotionally stable person develops and functions all through his life. (Feeney, p. 268).

How *do* securely attached individuals cope with being raped, and then ignored by the very peer group and superiors who have sworn to protect them in times of war? Because of their commitment to the military, soldiers who experience a trauma must continue their assignments. They have little opportunity to quit their jobs and return home—like civilian workers would if they were assaulted by coworkers. Because they must remain on base and keep operating in their daily command, one must ask what a victim can do and where a victim can go to receive support in coping?

We do not know what kind of attachment security the women had when they entered the service and no measure was conducted at the time of interview to assess where they were at that point. That being said, clearly their expectations of living and working with people who would keep them safe was not met. Most of all, they had not expected that what they assumed to be a safe military base would become the very opposite. Because the expectations or fantasies went unmet, the women formulated new, negative, expectations of insecurity and betrayal.

This shift in perception may be where some women began to develop an ambivalent or disorganized attachment relationship to their military comrades. Pittman, Keiley, Kerpelman, and Vaughn (2011) have described how identity formation, according to Bowlby and Erikson, is created not only by early childhood personality development but also by the surrounding culture in which a person lives. They have suggested that attachment representations related to the larger culture will shape their future identity formation:

> A building's foundation does not determine what rooms will be defined in the stories built on it, but foundational walls do shape external parameters and load-bearing structures for the building that rests on them. Attachment yields representations of the self and other that can be likened to these attributes of a foundation that later shape the organization of identity. Identity, then, functions as a future-focused process connecting one's individual development and history, including attachment representations, to one's social and personal goals in the context of a larger culture. (Pittman et al., 2011, p. 33)

Themes 1 and 2 appear to set the stage for the "identity formation" that took place in each participant's future. The "naïve and young" new soldier separated from her secure base (parents, childhood home, school-aged peers) and, by the time we look at Theme 3, attachment insecurity had taken hold of them and no secure base existed to provide sanctuary. The participants withdrew and became internally focused on the future of their careers, their sense of motherhood and femininity, and the fate of their unborn children while trying to negotiate a new place in the surrounding culture of military and civilian life.

Messina-Dysert (2012) has theorized a spiritual death that can occur in rape victims, particularly in relation to the "second injury" (Symonds, 2010) that she describes as a "second rape," in which rape victims are not believed or helped in the way they need to be:

> In a rape culture victim blaming is commonplace and those who have been raped suffer some sort of community rejection and punishment. Women are seen as inferior and deserving of the violence perpetrated against them causing an additional victimization or "second rape." The response to rape and treatment of victims triggered by rape culture is widespread. Rape culture must be understood as a key component of the suffering endured by the rape victim; thus the destruction to a rape victim's spiritual health occurs across cultural boundaries. (Messina-Dysert, 2012, p. 121)

As theme 3 begins, the women coped with the news of pregnancy— alone and without the support they had always expected. No matter where they may have started in their attachment security, the women—as this theme illustrated—began to learn that the world was, in reality, an insecure place. Thus, the possibility of a new experience arose: *experience dependent adult onset insecure attachment.*

Theme 3: Coping with the New Reality of Being a Rape Victim

The first two themes of this study supported findings within the trauma literature, but theme 3 began to reveal a new perspective on sexual assault trauma. What emerged in theme 3 was a more detailed look into the psychological life of a soldier entering the military and how she copes with institutionalized abuse. This theme offered a more subjective narrative of the inner world of women who found themselves pregnant from

rape. It began to illustrate the isolation, fear, and post-trauma symptoms taking hold in the world in which she had been assaulted—as well as the recognition that she could not find anyone to protect her (i.e., the loss of a secure base). This realization initiated the victimized soldier's journey from a securely attached "naïve and young" person to an insecurely attached adult soldier.

The themes in this category began with the participant's distorted perception of the sexual assault. The participants stated that they had tried to convince themselves it was "bad sex" and not a rape—even denying that the events had taken place. Some participants recalled telling themselves they were to blame because of drinking too much alcohol or "putting" themselves in compromising situation. Though this theme is congruent with the literature on Acute Stress Disorder and Post Traumatic Stress Disorder, blaming themselves also set the stage for what emerged in Category 4 with "not this way."

Fear is also an important element of this theme. Although it has been widely documented in PTSD symptomology as a hyperarousal symptom, fear is a biological response—not solely a psychological one. In fact, fear is an activation of the attachment system.

> As Van der Kolk (2007) now famously states, "the body keeps the score". This recognition of the salient role of somato-sensory-motor, right-brain mediated processes in chronic, early relational trauma provides us with a neurobiological context for making sense of PTSD symptoms, that is, flashbacks, body sensations, startle responses, behavioral impulses, and shame; and, *a fortiori*, of the symptoms of complex PTSD, that is, somatic and emotional dysregulation, hyper-

and/or hypoarousal, profound mistrust, shame, dissociation, and so forth. (Lipton & Fosha, 2001, p. 259)

As a nervous system response to danger, attachment activation in the face of fearful stimuli, such as a sexual assault, includes fear and proximity-seeking behaviors. For the victims, the culture of the military and the lack of protection and attachment figures to help them reregulate their nervous system agitation offered an important aspect of this finding. As discussed above in theme 2, regardless of their prior attachment classification, the women *had believed* that the military was going to be a safe and protective environment in which they could build careers and new lives. However, none of these expectations was fulfilled. Instead, they began relationships with their comrades and felt trust; that trust was met with violation and betrayal. Some of the participants made many attempts to reach out to superior officers, family members, and peer group members within the service to help them down-regulate their nervous system arousal—but nothing seemed safe.

This phenomenon is reminiscent of Erikson's (1968) viewpoint on development, primarily his belief that the emerging adult's "crisis" is "intimacy vs. isolation." In this stage, young adult are expected to find safety and security in relationships to others or to retreat and isolate themselves from social supports. The women in the present study narrated their desire for emotional intimacy and physical safety with their military comrades; but after the trauma, they found themselves isolated and alone. The pregnancy, one can imagine, further complicated this issue. Participant B described wanting to be alone rather than having to lie to her social group about a one-night stand

and a fabricated man who didn't want to be a father. Being alone was easier than spinning a web of lies to protect herself from telling the real truth of the rape.

Blos (1967) explicated his ideas about a "second individuation" at the same time that Erikson shared his psychosocial stages. The second individuation is a time when an adolescent begins to engage in rapprochement with his attachment objects to find security in forming a more permanent identity for adulthood. Applegate (1984) described this phenomenon:

> Disengagement from parents requires the adolescent to repudiate earlier dependency on them as ego extensions and try to find his or her own ego resources to cope with the renewed separation-individuation struggle. As Blos states, "Ego regression connotes the re-experiencing of abandoned or partly abandoned ego states which had been either citadels of safety and security, or which once had constituted special ways of coping with stress." (p. 173)

The participants in this study were unable to find their own ego resources to cope and, because of the nature of the military commitment and contract, were unable to quit their jobs and retreat to childhood homes in order to make better sense of the trauma that just happened to them. The nature of their military assault and military service prevented them from acting on the innate desire to return to a safer place; or, for those who didn't feel that their families provided a safe place, to at least run away and escape the imprisonment and betrayal that they felt.

As discussed earlier, this category initiated the apparent discovery of a could-be securely attached young person transitioning into an insecure attachment network. Feeling betrayed by an internal working model of safety that had been transferred to her

military peers—and not being able to find safe harbor anywhere—impacts these internal structures. The fear, and subsequent heightened nervous system response, creates the stress hormone cortisol, which is influential in attachment security (Schore, 2003). Svanberg (1988) has described Bowlby's original conceptualization of secure attachment and the obstacles to secure attachment:

> In this conceptual framework attachment behaviour is defined as proximity-seeking, comfort-seeking, security-seeking in situations of real and/or perceived threat/danger. Attachment--in Bowlby's framework--is the bio-behavioral process which leads from distress to solace, from real or perceived danger to "felt safety." (p. 544)

The proximity-seeking behavior arose from the need for comfort and security that the raped female soldiers in this sample were unable to fill. Instead, they described becoming fearful, without anyone to help them feel safe, and isolated, which prevented them from reaching out, leaving them to cope with the news of a pregnancy alone and without guidance. From an attachment classification system, this feeling is reminiscent of that of an infant in the Strange Situation (George, Kaplan, & Main, 1985) who has been labeled insecurely attached, often avoidant or disorganized classifications, because of a lack of safety within an abusive parenting environmental that left them only able to self-soothe and disconnect from other forms of intimacy and closeness to others. This idea is further discussed in the attachment discussion of the next section in this chapter.

Theme 4: The Pregnancy

Theme 4 focused on how the women participants described their emotional reactions and ability to cope with being pregnant. It is important to notice the similarities

among their responses, even though three of the seven women terminated their pregnancies, and the rest gave birth to their rapist's child. The participants described a similar idea of "not this way," indicating that they all (before the rape) desired to be a mom and to have a child but not by way of a rape. Thus, they all faced a moral dilemma, describing a torturous time of spiritual, religious, ethical, personal, and egocentric ideals intersecting—and each participant came through the decision-making process at a different place. None of the women who had had abortions felt 100% resolved with their decision; neither did the women who had had live births. Instead, they talked about deciding on the ultimate fate of the unborn fetus as difficult and unresolved. Interesting, they also described a period of wanting to "naturally" terminate their pregnancy through various methods.

The existence of a maternal connection was another similarity among the participants—despite the ultimate decision regarding the unborn fetus. Most participants described a period of disconnection, but upon making the ultimate decision, they began connecting with the fetus and having fantasies about what the child could or would be.

The women who kept the pregnancy to full term reported their connection and love "turning on" more during the last trimester of pregnancy. This response corresponds to Winnicott's theory of primary maternal preoccupation, which takes place from the third trimester on into the first few months of infancy:

> Winnicott observes that primary maternal preoccupation gradually develops during pregnancy, especially towards the end, and lasts a few weeks after the birth: in this heightened form, it does not last very long. Winnicott's basic observation here, that women's former balance of mind is temporarily disturbed if

> they enter this state, is consistent with my general conclusions about ordinary internal conflict and psychological upheaval in becoming a mother. (Hollway, 2010, p. 25)

Most of the research on this psychoanalytic concept supports the idea of maternal connection and fantasy about life with the unborn child; however, for the participants in this research study, the feeling of an idealized infant in the third trimester of pregnancy did not endure, and two of the participants described the difficulty of being a "good enough mother" to their newborns. The maternal connection to the infant is an important component for women keeping pregnancies to full term. Leerkes, Parade, and Gudmundson (2011) performed a study investigating how pregnant women responded to infants crying prenatally. After 16 months postpartum, the Strange Situation experiment was performed to determine if the mother's prenatal response to crying was linked to the infant child's attachment classification. They found, "the results indicate that negative, self-focused emotional reactions to crying undermine the developing attachment relationship, although the mechanisms vary for maternal anger and anxiety" (p. 641).

This finding is reminiscent of Participant G's report of being unable to hold her child in the delivery room—or anytime following. Her anger became so powerful that she reported trying to suffocate her child to stop the crying. Difficulties in performing simple tasks of parenting, such as holding the child in the delivery room or tolerating cries, were discussed by Participant G as impossible to fulfill. Participant B admitted that her mom did all the important newborn work because she felt too disconnected to do it herself. Participants B and G, and perhaps the other women who had carried their children to full

term, had difficulty regulating their own hyperarousal from the assault and subsequent pregnancy, and thus weren't equipped for motherhood.

A study published by Moskowitz (2011) looked at the effects on primary maternal preoccupation for new mothers who had lost their husbands in the 9/11 attacks. The author noted:

> Although the mothers in our Project were heroic in their attempts to simultaneously experience and process these highly contradictory states, we found the work of mourning largely incompatible with the work of primary maternal preoccupation. It did not seem possible for the psyche to be consumed with the lost object in mourning and at the same time to be consumed with the infant in primary maternal preoccupation. (p. 229)

The idea of mourning, as the above citation notes, appeared to fit the description of the participants in this category. The news of pregnancy was certainly not what was anticipated in their idealized fantasy of motherhood. Instead of excitement, pregnancy was met with fear. Instead of anticipation, it was met with dread. The women in this study were mourning their idealized motherhood, soldierhood, and traditional family roles—but also their identities and whom they had always envisioned themselves to be in their lives. They were bereft from having lost a past life of who they were and a future of what they wanted to be. As stated by Participant F, they found themselves *alone* in a type of wonderland, a world they did not know existed, with a baby whom some said looked like the assailant. The women experienced deep ambivalence about taking part in this new life and mourned the life they believed they deserved. This idea of mourning carries us into our final category in this study.

Theme 5: Looking Back

This final category described the women's perceptions of themselves at the time of the assault, and how they felt it had shaped the trajectory of their lives. One of the participants was still in her early 30s and had the potential to become a mother consensually; however, she felt that the assault had tainted her perception of motherhood, and she described experiencing fear that she would not love the child, just as she had not loved her rapist's baby. She didn't deny having love for others, but could not imagine finding a person to trust and take care of her in her lifetime. Another participant—also in her 30s—had two other children, both removed from her parental custody. During the interview, she stated that she believed the rape and resulting child had impacted her ability to be a good mother to her other children. She expressed mourning her youth, her idealized perception of motherhood, and being saddened that her drug use and abuse after the rape had thrown her life off course.

The older participants, no longer in their child-bearing years, appeared to mourn the idea of a traditional family and what they could have had. Participant F, divorced four times, mourned the loss of Christmas and the loving family moments she always thought she would have as a mother. Participants A and B never had children after the assault, both admitting that had they had wanted to be mothers before the rape, but that their sense of identity shifted after becoming pregnant from the assault.

Most participants also described a loss of youth. They yearned for innocence and the option to have a future without the baggage they carry. Despite the age differences of 30 to 50 years old, they all agreed that they were not satisfied or settled in their lives. Like the younger versions of themselves who were "young and naïve," they still feel like

they had not found meaning in life and were trying to figure out "what to do when they grow up"—though many admitted they had "grown up" but did not have anything to show for their years. In mourning their loss of time, the participants questioned whether they had been full participants in their own lives. As stated in the introduction, though all of the participants had wanted to be married and have loving partners, at the time of interview five of the seven were not dating or in romantic relationships. Of the two who reported being in a relationship of some duration, only one felt she was in a stable, romantic, committed relationship, whereas the other reported having ongoing difficulty with her partner dynamics. Participant A was the only participant who had engaged in psychotherapy earlier in her life and had a specialized certificate in substance abuse counseling. This researcher wondered if her earlier experience with mental health treatment for resolving the trauma affected her ability to be in stable, intimate relationships, as she is one of the two participants who sustains a romantic relationship at this time.

When talking about the effects of the sexual assault and resulting pregnancy, Participant F stated simply, "It's a wound that goes to your soul, and affects the rest of your life." However, despite grimly "looking back" on the past, most of the women still had hope for their future—in therapy and in life—that they would be happier in their future than they had been in their past. Many referenced their participation in the research as a way of wanting to help themselves, and each other.

As described in Chapter Four, the theme of God was not directly captured by the raw readings of the interviews but rather through the NVivo analysis software. Participants B and F weaved the concept of God into their interviews. One commonality

around their views of God and the assault was that their God did not inflict the pain, but was someone who could help them through the predicament and lend an ear to their prayers when they had chosen to tell no one else of their suffering. God appeared to be—for all but one participant—a secure attachment figure. Because this theme did not arise out of a direct interview question and was only noticed in the analysis afterwards, understanding why Participant D did not believe in God and how that has affected her cannot be fully understood. Nonetheless, this information could significantly serve our understanding of coping because, in some ways, the other women saw God as a being who was with them throughout the traumatic journey and who was a witness to their suffering. Their perception of God and their faith meant that despite their mourning and radically changing lives, they could still have hope for their future. In some ways, the belief and presence of God in their trauma meant that these women had a purpose, and that God was guiding them, and holding them, when no earthly creature would. In other words, the majority of these women described what one could hypothesize as a secure attachment to God—some being who was there for them, despite the betrayals. This idea will be further discussed in the implications for further research section.

Limitations to the Study

The participants were self-selected through flyers and peers at the Women's Mental Health Center at the Long Beach Veterans Administration. All of the women in this sample were unemployed and unmarried. Though it appeared that being pregnant from a sexual assault may permanently affect a woman's sense of self and her future goals, this sample of women did not represent women who had gone through similar experiences and still maintain full-time employment and supportive family units. A

greater sample would need to be recruited and explored to determine if there are soldiers who sustain MST and pregnancy and leave the military with a secure or autonomous attachment style. Further, the women were not evaluated for attachment style before joining the military, nor were they evaluated during the interview, so all assertions made about changes in attachment security remain suppositions.

This sample was small. Though the raw data included information on seven women, only six were analyzed. To generalize the data and develop further conclusions about how a woman experiences pregnancy from rape and to draw a valid hypothesis from these interviews, a much greater number of participants would need to be interviewed. Further, the women in this sample were recruited from a mental health center where they were seeking psychotherapy for a life event (not necessarily sexual assault). The nature of their motivation to seek psychotherapy may affect the results of these findings.

Finally, because the women who participated in this study had not talked about this trauma before, they often lacked words to describe their affective responses. In conversations the researcher had with the participants in less formal anecdotal ways after the interview had taken place, they appeared to have more to say, more affect to access. Thus subsequent research on this topic would benefit from having an initial and follow-up interview to allow for any material that wasn't easily accessible when participants initially talked about these experiences—for some—for the first time in 30 years.

Also notable was that the 90-minute interview was limiting. If there had been more time, or if the study had allowed a second and third interview question, more social network questions could have been explored, which could have illustrated prior-

attachment relationships. As will be discussed below, some women did follow up with the researcher and stated that they had further thoughts they wanted to share. If the interview had permitted them to process and re-interview, some of the attachment assumptions could have been much richer. This implication could also inform further research, which will be discussed next.

Implications for Future Research

As noted above, a number of ideas that arose out of this study had not been fully explored in the trauma literature to date. The idea that a personal relationship with God could serve as a secure base for trauma recovery is new and something the researcher would like to explore further in future studies. Additionally, knowledge of the women's social support network and how they could have fared over time if they had had civilian supports versus none at all could be informative. It is unknown if the transition from adolescence to soldier inhibits ongoing civilian friendships; however, one can imagine that some soldiers maintain strong attachment ties to relatives and best friends who can be a protective barrier between trauma and the isolation and identity confusion that ensues from assault. A longer interview and greater sample size could enhance this research.

The Shift to Experience Dependent Post Trauma Adult Onset Insecure Attachment Hypothesis

As discussed in the literature review of this dissertation, attachment in adulthood occurs when the parental relationship is replaced by peer and romantic relationships in adulthood. The person's internal working model of attachment continues to be shaped by the affective moments within his/her social world. Sable (2008) defined the internal

working model as "early attachment experiences [that] are carried forward as mental representations of attachment figures in relation to the self 'along the pathway toward the adult personality'" (p. 23).

Davila and Cobb (2007) have suggested that even though Bowlby believed that internal working models developed in childhood guide personality, adults may assimilate new information into their existing attachment models. People are also capable of accommodating new information by updating existing models. Hence, people also should possess the capacity for change in levels and/or patterns of attachment security over time (p. 133).

This idea that the internal working model of attachment can be shaped by other experiences within adulthood is supported in recent literature on the therapy relationship. Though not every therapeutic relationship can be described as an attachment, long-standing therapeutic relationships are believed by many attachment theorists to embody the same attachment potential that interpersonal relationships with family members can. Slade (2008) stated that "the development of both positive and negative transference manifestations indicates that the therapist is becoming an attachment figure i.e. that he or she is activating internal working models originally formed in relation to initial attachment figures" (p. 767). Perhaps most importantly in her article, Slade (2008) explained, that "the patient develops a 'secure' attachment to the therapist, meaning, on the one hand, that he or she uses the security inherent in the current relationship with the therapist to rework previously established insecure working models" (p. 767).

This evidence is promising for attachment researchers, suggesting as it does that an insecure attachment style has "hope" in a supportive and nurturing culture that can

help patients attain an earned security despite prior beliefs that they wouldn't always be safe. In agreement with this argument, the findings in this study support the idea that hope is possible after such a traumatic event. As discussed in theme 5, despite years of maladjustment and feeling that they were all alone in the world, the women expressed resilience in the face of the insecure distrust they had developed in the trauma's aftermath. During the interviews, they discussed having hope for themselves and for each other in their recovery. Perhaps the passage of time had served their progress from the once-hopeless place in which they had found themselves; or, perhaps society's recent attention to sexual trauma helped them realize it was not their fault. But that they were seeking out psychotherapy after so many years in silence indicated that they were harboring some hope again. Was this evidence that they were attempting an internal working model reorganization in which they could feel trust again, and eventually, could return to a more secure attachment style? On this subject, Roisman, Padron, Sroufe, and Egeland (2002) have stated: "Of particular interest in the study of change in attachment security are developmental processes by which individuals rise above malevolent parenting histories to rise above the intergenerational parenting history, typically referred to as 'earned-security'" (p. 1204).

With the hope that an insecure model of attachment can be shaped into a more secure existence in the world, the investigator questioned in Chapter Two that potential must also exist for the reverse. With this research completed, the writer now hypothesizes with greater interest that when a woman in late adolescence experiences a traumatic rape and pregnancy, and does not feel safe and supported following the trauma,

she can shift her prior internal working models, unfortunately, into a new realm of insecurity.

Bernier, Larose, Boivin, and Soucy (2004) have described this idea in terms of an "attachment state of mind," which was used in the Adult Attachment Inventory. Researchers Main and Goldwyn (1998) identified three types of adult attachment "states of mind": autonomous, dismissing, and preoccupied. In another study, Bernier et al. (2004) investigated the attachment state of mind and college adjustment. Their sample included the same age group and developmental stage as those in present research. They found:

> The findings show that tendencies toward preoccupation with attachment are related to poor adjustment at the end of the freshman year and to a general decrease in adjustment and in grades during the freshman year. Preoccupation with attachment also accentuates the negative relation between parental psychological control and social adjustment . . . The results suggest that the pattern of relation between preoccupation with attachment and poor adjustment in adolescence extends to the school context. Preoccupied tendencies were found to be negatively related to academic and personal adjustment, as well as to institutional attachment, after 1 year in college. (p. 799)

Most of the participants in this study had been assaulted during their "freshman year" in the military—within their first 18 months of military service. If generalizable to military service, this study could help explain how the women found it difficult to make social adjustments following the trauma and faced challenges assimilating successfully into military culture. This study may also support the experience dependent post trauma

adult onset insecure attachment style hypothesis that the dissertation study findings suggested.

Studies such as this one need to be extended to other military service women, to determine if the same effects have been replicated. Though this study's exploration was limited in size—and thus is unable to be generalized—it does suggest profound implications about how women in the process of developing secure attachments with military service were left to cope in the wake of trauma without any secure attachment object. More research needs to be conducted to fill the current gap in the literature on pregnancy resulting from sexual trauma—both in the military and civilian worlds.

Another aspect of this study concerns the social welfare of children born from women who were raped. This area also presents a gap in the literature and is certainly important to consider within an attachment domain. There should be greater acknowledgement of this epidemic by obstetricians and midwives to assist in the probable maladjustment of caring for children who are products of rape. Leerkes, Parade, and Gudmundson (2011) found that mothers who experienced heightened distress prenatally to infant cries had a greater likelihood of having children who were insecurely attached in the Strange Situation at 16 months:

> From an applied perspective, our results suggest mothers who find infants' crying particularly aversive and struggle to respond sensitively can be identified prenatally, which would allow for early identification and intervention with at-risk mothers. Further, efforts to alter mothers' emotional reactions to crying by changing their perceptions or attributions about what infant crying signals or by enhancing their strategies to regulate their arousal in response to crying might be

> fruitful modes of intervention to enhance sensitivity and subsequent attachment security. (p. 641)

Screening for postpartum depression may prevent some children from experiencing attachment disruptions with their maternal caregiver, as some of the participants in this study were too traumatized and depressed to care for themselves, let alone another dependent human being. In general, it would be hard to imagine how a woman who has become pregnant from rape could raise a securely attached child without greater assistance from physicians, nurses, peer groups, and military culture. This phenomenon has implications for the greater medical and psychological community, particularly in terms of endorsing greater trauma assessment prenatally to help increase attachment security for the greater society's future. Funding prenatal trauma assessment and assistance with parenting postnatally would be a good starting point for this kind of intervention.

In summary, this research study ponders the reverse phenomenon of earned security in the literature. What if a person who previously believed the military was a safe and protective culture that embodied all the good things about "God and Country" is raped and then not supported? When they look to be protected from the trauma and find nothing to help them feel safe, do they then experience a "second injury" (Symonds, 2010), whereby they have (a) the trauma of rape, (b) the trauma of attachment security not being obtained, (c) becoming pregnant, thus experiencing another trauma on their body, and then (d) dealing with the pregnancy in isolation? Does this compounding traumatic effect create the potential for attachment security to become attachment insecurity for the older adolescent transitioning into adulthood? We know from

interpersonal neurobiology that the adult brain continues to be rewired throughout early adulthood (Schore, 2003) in an experience-dependent environment. Tsopelas (2009) has explained, "Traumatic events put our secluded way of living in danger and have as a consequence the development of different neurobiological responses on various brain circuits" (p. S29). This investigator questions whether this trauma affects the neural rewiring (because of the heightened cortisol and sympathetic hyperarousal in the nervous system) thus causing an "autonomous state of mind" (Main & Goldwyn, 1998) to be changed into a more pre-occupied or ambivalent insecure attachment?

This investigator would also like to briefly discuss the practice implications for the mental health community treating these victimized new-mothers. For a mental health provider to understand the deep shift in attachment security that these women have experienced, the better equipped a therapist can be to help them find security again. Because of the effects of the betrayal they experienced, the women did not seek out psychotherapy earlier in their life (with the exception of Participant B). If the military and the obstetric medical community could have identified the problems earlier in these women's lives they may have had an opportunity to engage in psychotherapy earlier on. To experience this kind of interpersonal trauma in late adolescence/early adulthood and becoming pregnant may be worse than having these experiences at any other time in adult psychological development. This phase of life is characterized by individuation, identity formation, and rapprochement strategies to internal working models of safety and trust, all of which appear to have been shattered. But the betrayal of the rape did not appear to be as significant as the institutional, filial, and peer betrayals, which were responsible for the destruction of their core sense of self and impeded mastery over their subjective

worlds. If a trusted psychotherapist could have entered the picture and understood this crisis of identity and trust, the women could have experienced a shift from their traumatized states.

Right Brain to Right Brain Synchrony

The investigator would like to comment briefly on the personal experiences the women reported after the study interview had been completed. Because the investigator worked at the Veterans Hospital—where many of the women received medical services—some participants would drop into the Women's Mental Health Center to see how the research was coming along. As a result, ongoing conversation took place about the impact of this interview following the recorded research. Most of the women reported feeling greater emotional distress, that is, more pre-occupation with the traumatic memory of the pregnancy and the course of events that led to the abortion or birth. However, many of the women said that despite this reaction, they also felt "lighter" for having talked about it. Many commented on how they appreciated openly dialoguing about issues they had not previously discussed. As stated earlier in this chapter, most women had not talked about the details of the assault and pregnancy before. They explained being unable to obtain distance from the events; many women spoke about talking to others in their lives about the interviews, which thus decreased the sense of isolation they had sustained since the trauma.

Notably, the women wanted to know what the others interviewees had said. Even though a support group was offered to the women—which most were enthusiastic about participating in—when the investigator attempted to get the participants to schedule a group time, they showed some ambivalence. As a result, the women never met one

another. The researcher regarded this response as evidence of the approach/retreat tactics of disorganized attachment. They desire, yet they fear. They want to understand, but they don't want to listen. In some ways, I wondered if they were still scared to be seen, even if it was from someone who had experienced the same traumas.

They did, however, stop in my office and ask about what the other participants had said. They all expressed interest in attending conferences in which this research would be presented, and all wanted to be notified and sent a copy of the completed research and any subsequent published articles.

I had the opportunity to read excerpts of Chapter Four to a few women as my writing progressed. They would cry and tell me that even though the quotations were not their own, they described their experiences exactly. The women who had the opportunity to hear me read excerpts from Chapter Four had one common response when leaving my office: They didn't feel alone anymore, and were comforted to know that others shared their experience.

Even though our research interview lasted approximately 90 minutes, I need to acknowledge the impact these meetings—both formerly and informally—had on my own right brain system over the months of collecting and analyzing data. I began this study with a sense of empathy, but now feel deeply saddened. I am a part of the data. In some way, I identify with these women, in that I, too, am alone. I carry the legacy, and the burden, of communicating the profound suffering from these events and the psychic changes these women underwent to the wider academic community. I was witness to the devastating effects of the institutionalized harassment, neglect, and denial that is the

reality for military service women who continue to be victims, some of whom become pregnant from these atrocious acts.

I am a witness. I am a participant observer. In some ways, this qualitative grounded theory analysis has become intersubjective, as it is an entity between me and my participants and has impacted all of our subjectivities. It is bigger than all of us. And it must be talked about. These women, and the silent others, need a voice. And I am burdened, perhaps honorably, in helping to tell their stories.

APPENDIX A: PROTECTION OF RESEARCH PARTICIPANTS APPROVAL

THE SANVILLE INSTITUTE
PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project :
Understanding the impact of rape and pregnancy on on an enlisted US servicewoman

Principal Investigator: Judith Schore, PhD, LCSW

Investigator: Kristen Zaleski, LCSW

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the Student and Faculty Handbook), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

_____XX_____ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Judith R Schore PhD
(signature of principal investigator/date)

Kristen Zaleski LCSW
(signature of investigator/date)

Action by the Committee on the Protection of Research Participants:

Approved _____ Approved with Modifications ✓ Rejected _____

Cynthia A. O'Connell PhD Date 06/18/12
Signature of representative of the Committee on the Protection of Research Participants/date

Whitney Moore, PhD 6/20/12
(signature of dean & date)

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ Date: ___/___/20___

Title of Study: **Observational Study for the Women's Mental Health Center**

Principal Investigator: **Katz, Lori S., Ph. D.** **VA Long Beach Healthcare System, CA**

Bill of Rights for Human Subjects in Medical Research

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment or who is requested to consent on behalf of another has the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or the procedure involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of any signed and dated written consent form used in relation to the experiment.

10. Be given an opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

Projects Office Use Only

INSTITUTIONAL REVIEW BOARD

Approved 11/8/12

LBVAMC

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF
THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ **Date:** ___/___/20___

Title of Study: **Observational Study for the Women's Mental Health Center**
Principal Investigator: **Katz, Lori S., Ph. D.** **VA Long Beach Healthcare System, CA**

Purpose of the Study

You are being asked to participate along with approximately 1000 other participants in an observational research study for the Women's Mental Health Center. The purpose of this study is to learn about the needs, characteristics, and use of mental health services among Veterans who visit the Women's Mental Health Center. We also aim to gather information about how Veterans are functioning in their day-to-day lives after they receive services in order to improve upon the psychotherapy treatment and other services we offer.

Your participation in this study is completely voluntary. In order to decide whether or not you wish to participate, you should know enough about the risks and benefits of the study to make an informed judgment. This consent form will give you detailed information about the observational research study, and a member of the research team is available to discuss this with you. Please read this information and ask questions about anything you do not understand before deciding whether or not to participate.

Procedures

If you decide to participate in the study, we will ask you to complete a packet of questionnaires. The questionnaires will ask about general background information such as your living arrangements, and employment status, as well as personal questions about how you perceive your mental and physical health, social support resources, and how you cope with stress. These questionnaires will take between 30 and 90 minutes to complete (based on the specific test package used). There is neither right nor wrong answer to these questions.

After completing the questionnaires, you will receive individual and/or group psychotherapy or other health services according to the treatment plan agreed upon by you and the therapist conducting your intake interview. There may be a 3-month as well as a 6-month follow-up when you will be asked to complete a similar packet of questionnaires, which may also take between 30 and 90 minutes. These questionnaires will include questions about how satisfied you are with the services you receive.

Projects Office Use Only
INSTITUTIONAL REVIEW BOARD
Approved 11/8/12
LBVAMC

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ **Date:** / /20

Title of Study: Observational Study for the Women's Mental Health Center
Principal Investigator: Katz, Lori S., Ph. D. VA Long Beach Healthcare System, CA

You may be asked to re-consent prior to completing additional questionnaires during the course of your treatment, depending on your individual treatment plan and goals. This may include participating in an interview regarding Military Sexual Trauma (MST) which we might voice-record on audiotape. You will need to sign a separate voice and/or picture consent form. In addition, your therapist may write a log or summary of individual therapy sessions to help us to identify common issues among Veterans receiving mental health services that are shared during therapy. All the psychotherapy sessions and questionnaires will be completed in a private office in the VA Medical Center.

The questionnaires will be maintained confidentially for 15 years. At the end of that period the research staff will destroy them for confidentiality purposes. Please be aware that the answers you give will not affect your VA medical treatment or any other VA benefits you receive. In addition, none of your answers will be shared with any person outside of this study, including other clinicians – with one important exception. If you indicate intent to harm yourself or someone else, the interviewer may contact your other clinicians to assist you. Your participation in this study will end upon the completion of the questionnaires provided to you at the end of your treatment.

Standard Care and Experimental Procedures

Individual and/or group psychotherapy procedures and measurements of responses to treatment, as well as other general procedures will be offered to you through the Women's Mental Health Center as part of your standard care, even if you do not participate in this research observational study. In addition to the standard treatment and measurement procedures, you will complete several questionnaires, which will be conducted for the purpose of this research only. You should discuss with your study doctor any procedures done only for research. The study doctor will monitor tests that are done for the purpose of standard of care as well as those that are done for research and will alert you if there are any problems.

Projects Office Use Only

INSTITUTIONAL REVIEW BOARD
Approved 11/8/12
LBVAMC

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ **Date:** __/__/20__

Title of Study: Observational Study for the Women's Mental Health Center
Principal Investigator: Katz, Lori S., Ph. D. VA Long Beach Healthcare System, CA

Risks

You may change your mind about participating in this study because you may become uncomfortable while completing the questionnaires. If you chose to withdraw from the study for any reason, at any time, your VA medical treatment or disability payments will not be affected in any way. Participants may experience some discomfort when responding to questions or when thinking about their experiences or mental health. However, you will not be required to answer any questions or disclose any information that makes you feel more uncomfortable than you feel you can handle. You may indicate that you prefer not to answer certain types of questions. In addition, referral information and services will be available for any participant who requests it or if a trained research staff makes a recommendation.

There are questions on the interview, and assessments during individual psychotherapy, that pertain to the risk of suicide. If you indicate a serious intent to harm yourself, we are obliged to report this information to a person or persons who can get you help. This person will be your primary clinician, if they are available. If that person is not available, we will seek the assistance of the emergency room staff. You should know that this might result in your hospitalization, even against your will.

Risks of Pregnancy or Reproductive Harm

There are no risks of pregnancy or reproductive harm in this study.

Anticipated Benefits to Subjects

Taking part in this study may not personally help you, but your participation may lead to knowledge that will help others. In particular, your experiences may help us to continue to improve VA services for Veterans to make them more effective and to better meet their needs.

Projects Office Use Only
INSTITUTIONAL REVIEW BOARD
Approved 11/8/12
LBVAMC

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF
THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ **Date:** ___/___/20___

Title of Study: Observational Study for the Women's Mental Health Center
Principal Investigator: Katz, Lori S., Ph. D. VA Long Beach Healthcare System, CA

Alternatives to Participation

The alternative to participating in this study is not to participate. If you choose not to participate or to withdraw from the study, individual psychotherapy is available for all Veterans through the Women's Mental Health Center or the Women's Clinic, and also may be requested through one's primary care or outpatient psychiatry provider as well.

Compensation for Participation

There is no compensation for participation in this observational research study.

Costs

You will not be required to pay for research-related treatment you receive as a subject in a VA research program.

Withdrawal and Termination from the Study

Your participation in the study may also be discontinued at any time without your consent by the investigator, Institutional Review Board, or other regulatory governmental agencies. This could happen if you experience a study-related injury, to protect your health or safety, if you do not follow study procedures, do not meet study requirements, or if the study is cancelled.

Privacy and Confidentiality

Your medical records may be examined by the Department of Health and Human Services (DHHS), the VA, other international governmental regulatory agencies (including the Office of Research Oversight and the Government Accountability Office) and the Institutional Review Board (IRB) for verification of study related data.

The results of this study may be published in the medical literature or presented at scientific medical or educational meetings, but your name or identity will not be revealed and your records will

Projects Office Use Only

INSTITUTIONAL REVIEW BOARD
Approved 11/8/12
LBVAMC

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ **Date:** ___/___/20___

Title of Study: Observational Study for the Women's Mental Health Center
Principal Investigator: Katz, Lori S., Ph. D. VA Long Beach Healthcare System, CA

remain confidential unless disclosure of your identity is required by law. Because of the need to release information to the parties listed above, absolute confidentiality cannot be guaranteed.

New Findings

All new findings that develop during the research which may reasonably influence your desire to continue participation in this study will be provided to you as such information becomes available. If your participation is cancelled the reasons will be explained to you.

Emergency Care and Compensation for Injury

In the event you are injured as a result of your participation in this research study, you should return to the Long Beach VA Medical Center immediately for evaluation. The VA will provide emergency care and appropriate medical treatment to you at no cost and in accordance with federal law and Department of Veterans Affairs policy. The Medical Center Director will provide reasonable reimbursement for emergency treatment in a non-VA facility. Compensation is not routinely available if injury should occur. You do not give up your option for legal recourse by signing this informed consent.

Whom to Contact

In case there are medical problems, you are injured by the research, or you have questions or complaints about this research, you can call Dr. Lori Katz at (562) 826- 8000 x 4380 during the day or during the evening and call (562) 826-8000 and ask the operator to page her after hours.

If you have questions regarding your rights as a research subject or any questions, complaints, or security concerns about this study that are not answered by the investigator (including the verification of the validity of a study and authorized contacts) you may contact the Associate Chief of Staff for Research and Development for the VA Long Beach Healthcare System at (562) 826-5801.

Projects Office Use Only
INSTITUTIONAL REVIEW BOARD
Approved 11/8/12
LBVAMC

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF
THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ **Date:** ___/___/20___

Title of Study: **Observational Study for the Women's Mental Health Center**
Principal Investigator: **Katz, Lori S., Ph. D.** **VA Long Beach Healthcare System, CA**

Voluntary Participation Statement

I have read or have had read to me all of the above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I understand what the study is about and how it is being done. I have been told of the risks or discomforts and possible benefits of the study. I have been told of other choices of treatment available to me.

I understand my rights as a research subject and I voluntarily consent to participate in this study. **I understand that I do not have to take part in this study, and my refusal to participate will involve no penalty or loss of VA or other benefits to which I am entitled. I understand that I may withdraw my consent at any time and discontinue participation without penalty or loss of VA or other benefits to which I am entitled.** I will receive a signed copy of this consent form along with a copy of the Bill of Rights for Human Subjects in Medical Research. By signing this form, I willingly agree to participate in the research it describes.

_____	_____	___/___/20___
Subject's Signature	**Name (print)**	**Date**
_____	_____	___/___/20___
Signature of Person Conducting the Consent Discussion	**Name (print)**	**Date**

Projects Office Use Only
INSTITUTIONAL REVIEW BOARD
Approved 11/8/12
LBVAMC

VA FORM 10-1086 dtd –03/07/2012
Replaces: 05/10/2011

Department of Veterans Affairs

VA RESEARCH CONSENT FORM

FILE IN CONSENT FORM SECTION OF THE MEDICAL RECORD IN DATE ORDER

Subject Name: _____ Date: / /201

Title of Study: Observational Study for the Women's Mental Health Center

Principal Investigator: Katz, Lori S., Ph. D. VA Long Beach Healthcare System, CA

Bill of Rights for Human Subjects in Medical Research

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment or who is requested to consent on behalf of another has the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or the procedure involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of any signed and dated written consent form used in relation to the experiment.

10. Be given an opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

Protocol Office Use Only
INSTITUTIONAL REVIEW BOARD
Approved 7/14/2011
LBVAMC

Department of Veterans Affairs

CONSENT FOR USE OF PICTURE AND/OR VOICE

CONSENT OF *(Name)*

NOTE: The information requested on this form is solicited under the authority of title 38, United States Code. The execution of this form does not authorize disclosure of the materials specified below except for the purpose(s) stated. The specified material may be used within the VA for authorized purposes, such as for education of VA personnel or for VA research activities. It may also be disclosed outside the VA as permitted by law. If the material is part of a VA system of records, it may be disclosed outside the VA as stated in the 'Routine Uses' in the "VA Privacy Act Systems of Records" published in the Federal Register. A copy of the 'Routine Uses' is available upon request to the administrative office of the VA facility involved. You do not have to consent to have your picture or voice taken, recorded, or used. Your refusal to grant your consent will have no effect on any VA benefits to which you may be entitled.

I hereby voluntarily and without compensation authorize pictures and/or voice recording(s) to be made of me ***(or of the above-name individual if the individual is legally unable to give consent)*** **by** *(specify the name of the VA facility, newspaper, magazine, television station, etc.)*

Katz, Lori S., Ph. D. and her staff working on this research project.
VA Long Beach Healthcare System
5901 E Seventh Street, Long Beach, CA 90822; (562) 826-8000 x 4380

While I am *(describe the activity, if any to be photographed or recorded)*

recalling traumatic memories

I authorize disclosure of the picture and/or voice recording to *(specify name and address of the organization, agency, or individual(s) to whom the release is to be made)*

Dr. Lori Katz and her team.

I understand that the said picture, video and/or voice recording is intended for the following purpose(s):

to facilitate collecting and analyzing data on a project about recalling traumatic memories.

I have read and understand the foregoing and I consent to the use of my picture and/or voice as specified for the above-described purpose(s). I further understand that no royalty, fee or other compensation of any character shall become payable to me by the United States for such use. I understand that consent to use my picture, video and/or voice recording is voluntary and my refusal to grant consent will have no effect on any VA benefits to which I may be entitled. I further understand that I may at any time exercise the right to cease being filmed, photographed or recorded, and may rescind my consent for up to a reasonable time before the picture, video or voice recording is used.

SIGNATURE OF INDIVIDUAL OR OTHER LEGALLY AUTHORIZED PERSON	DATE

PERMISSION OBTAINED BY *(NAME - TITLE - ADDRESS)*

Katz, Lori S., Ph. D., Director of the Women's Mental Health Center

SIGNATURE OF INTERVIEWER OR INDIVIDUAL OBTAINING CONSENT	DATE

PRODUCTION TITLE	PRODUCTION NUMBER
Observational Study for the Women's Mental Health Center	MIRB 711

INDIVIDUAL' S NAME AND ADDRESS

IMPORTANT: This form must always be completed prior to the making or using pictures, video or voice recording(s) of any VA patient. If any patient health or demographic information is to be provided or released with the picture, video or voice recording, VA Form 10-5345, Request for and Authorization to Release Medical Records or Health Information is required prior to the release of such data to any source.

VA FORM
MAY 2005 **10-3203**

Study Title: Observational Study for the Women's Mental Health Center

DEPARTMENT OF VETERANS AFFAIRS
VA LONG BEACH HEALTHCARE SYSTEM

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

You have been asked to be a part of a research study under the direction of ***Dr. Katz*** and ***her*** research team. The purpose of this study is to learn more about the ways people remember traumatic events, and how this influences their feelings and beliefs about the event.

You may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with the terms of the authorization. If you revoke this authorization, you will no longer be able to participate in this study. Written revocation is effective upon receipt by the Research Service at the facility housing the records. Redisclosure of your medical records by those receiving the above authorized information may be accomplished with your further written authorization and may no longer be protected. Without your express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) expires upon completion of the research; (3) under the following conditions:

If the authorization is for the Agency to use or disclose individually identifiable information for creation or maintenance of a research database or research repository, the authorization has no end date. Check here if the information will be used in a research database: ____

By signing this document, you will authorize the Veterans Health Administration (VHA), VALB to provide ***Dr. Lori Katz*** and ***her*** research team to access the following information about you:

The information that will be released includes information regarding the following conditions: N/A.

_____Drug Abuse
_____Alcoholism or Alcohol
_____Testing for or Infection with Human Immunodeficiency Virus (HIV)
_____Sickle cell anemia

INSTITUTIONAL REVIEW BOARD
Approved 7/19/2011
LBVAMC

Study Title: Observational Study for the Women's Mental Health Center

The research team may also need to disclose the information to others as part of the study process. The others may include the Institutional Review Board and other entities that will monitor this study.

If you do not sign this authorization, you will not be part of the study. Participation in a research study may be contingent on you signing the authorization (45 CFR 164.508 (b)(4)(i). Completing this authorization will not affect your rights as a VHA patient to treatment, payment, enrollment, or eligibility benefits.

If you revoke this authorization, Dr. Katz and his or her research team can continue to use information about you that has been collected before receipt of the revocation. Individually identifiable information disclosed pursuant to the authorization may no longer be protected by Federal laws or regulations and may be subject to re-disclosure by the recipient. The research team will not collect information about you after you revoke the authorization.

The VHA complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its privacy regulations and all other applicable laws that protect your privacy. We will protect your information according to these laws. Despite these protections, there is a possibility that your information could be used or disclosed in a way that it will no longer be protected. Our Notice of Privacy Practices (a separate document) provides more information on how we protect your information. If you do not have a copy of the Notice, the research team will provide one to you.

I have read this authorization form and have been given the opportunity to ask questions. If I have questions later, I understand I can contact ***Dr. Katz.*** I will be given a signed copy of this authorization form for my records. I authorize the use of my identifiable information as described in this form.

_____	___-___-____	___/___/201__
Signature of Participant or Person Authorized To Sign for Participant (Attach Authority to sign, e.g. Power of Attorney)	SSN	Date

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Act. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We expect that the time expended by all individuals completing this form will average 2 minutes. This includes the time to read the instructions, gather the necessary facts and fill out the form. The purpose of this form is to specifically outline the circumstances under which we may disclose data.

The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information that you may specify in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, ad 38 U.S.C. 5701 and 7332. Your disclosure of information requested on this form is voluntary. However if the information, including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request.

APPENDIX C: AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR RESEARCH

Study Title: Observational Study for the Women's M[redacted]al Health Center

DEPARTMENT OF VETERANS AFFAIRS
VA LONG BEACH HEALTHCARE SYSTEM

REVOCATION OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

TO: Dr. Katz

I revoke my previous authorization for you to use or disclose my protected health information as part of your study.

I understand that the research team will continue to use and disclose health information about me that has already been collected. However, they will only use and disclose the information for the reasons discussed in the Consent Form I signed when I joined the study.

I understand the revoking of this authorization may mean that my participation in the study will also end. It will not affect my rights as a VHA patient, including health care I may need when I am no longer in the study.

_____ ____/____/201____

Research Participant's Signature Date

INSTITUTIONAL REVIEW BOARD
Approved 7/19/2011
LBVAMC

Version 8/25/2006

VA LONG BEACH
HEALTHCARE SYSTEM

A Division of VA Desert Pacific Healthcare Network

Women's Mental Health Center

Your Story

Are you a survivor of military sexual trauma?

Did you become pregnant after the assault?

Do you want to tell your story?

We are listening.

Please call us to participate in this interview study.

Your participation will take approximately 90 minutes.

Dr. Lori Katz (562) 826 8000 ext. 4380

Kristen Zaleski (562) 826 8000 ext. 4367

Cristi Huffman (562) 826 8000 ext. 4919

APPENDIX E: THE SANVILLE INSTITUTE CONSENT FORM

THE SANVILLE INSTITUTE

INFORMED CONSENT FORM

I, hereby willingly consent to participate

in the study, **Understanding the impact of rape and pregnancy on enlisted US servicewomen.**

This doctoral research project will be conducted by Kristen Zaleski, LCSW Investigator, under the direction of Judith Schore, PhD Principle Investigator and faculty member, and under the auspices of **The Sanville Institute** which has approved this research.

- I understand the procedures to be as follows:

1. Voluntary, self-selected participation in a research project screening of approximately 30-45minutes or less in person with the investigator.

2. Receiving a follow-up telephone call of approximately 10-15 minutes to answer any additional questions that the participant may have from the screening interview and to assess their level of distress, if any, in their decision to participate in the interview.

3. Voluntary, self-selected participation in an audio tape-recorded interview of 60-90 minutes at the Womens Mental Health Center with the investigator or a research assistant.

4. Receiving a follow-up telephone call of approximately 10-15 minutes within two weeks after completing the interview with the investigator.

5. A voluntary decision on my part about receiving the research results following completion of the study.

6. Potential publication of the study or parts of it in which the anonymity and confidentiality of the research participant will be preserved. Such publication would exclude any reference to my name or personal identity. Moreover, any clients I discuss in the context of the research interview will have their confidentiality protected also; no identifying information including agency or service will be disclosed.

APPENDIX E: THE SANVILLE INSTITUTE CONSENT FORM

- I am aware of the following potential risks involved in the study:

1. I might feel vulnerable talking with the investigator on tape despite the agreed-upon procedures for ensuring anonymity and confidentiality.

2. A self-examination and reflection on the trauma history could trigger some discomfort in the form of tears, anxiety, vulnerability, negative self-thoughts, labeling, intrusive thoughts, flashbacks, sleeping disturbances, and any other symptom you might have experienced in the immediate aftermath of the trauma itself.

3. Sometime after the interview with the investigator has been completed, I may still have some uncomfortable recollections and symptom reemergence that could feel uncomfortable and distressing.

4. If I have elected to receive the results of the research study and find those results both interesting and relieving, I might still be discomforted in recalling other situations related to the research that I wished I had discussed or other forgotten situations that now may emerge.

- Provisions to be made in case of emotional discomfort:

1. The investigator will remind me that participation is by choice; voluntary. I may drop out of the research process at any time without explanation or recrimination.

2. The investigator and I will be monitoring my comfort levels in all contacts and I may take a break at any time or discontinue my participation in the process altogether.

3. The investigator has left her contact information and I have been encouraged to contact the investigator should stress related to the research project arise for me.

4. I know that the investigator will be contacting me in two weeks and I may discuss any emotional discomfort I may be feeling with her at that time.

5. The procedures for this research project include the option for ongoing psychotherapy in the form of individual or group therapy to work through any lingering emotional discomfort in relation to my participation in this research study, should that occur. These psychotherapy services can be provided at the VA Long Beach Women's Mental Health Center or the referral can also be made to a community agency within my local area.

I understand that I may withdraw from the study at any time. I understand that this study may be published and that my anonymity and will be protected—that is, any information I provide that is used in the study will not be associated with my name or identity.

Signature: _____

APPENDIX E: THE SANVILLE INSTITUTE CONSENT FORM

Date: _____

If you would like a copy of the results of this study, please provide your name and address:
Name: _____
Address: _____

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Applegate, J. (1984). Transitional phenomena in adolescence: Tool for negotiating the second individuation. *Clinical Social Work Journal, 12*(3), 233–243.

Benight, C. (2012). Understanding human adaptation to traumatic stress exposure: Beyond the medical model. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1), 1–8.

Bernie, A., Laros, S., Boivin, M., & Soucy, N. (2004). Attachment state of mind: Implications for adjustment. *College Journal of Adolescent Research, 19*, 783-806.

Blos, Peter (1967), The second individuation process of adolescence. *The Psychoanalytic Study of the Child, 22*, 162-186

Bowlby, J. (1976). Separation: Anxiety and anger. New York, NY: Basic Books.

Callahan, J. (2009). *Manifestations of power and control: Training as the catalyst for scandal at the United States Air Force.* San Francisco, CA: Sage.

Conrad-Wragg, E. (1978). *Conducting and analysing interviews.* London, UK: University of Nottingham School of Education.

Corbett, S. (2007, March 18). The women's war. *The New York Times Magazine.* Retrieved from http://www.nytimes.com.

Davidovitz, R., Miklincer, M., Shaver, P., Izsak, R., & Popper, M. (2007). Leaders as attachment figures: Leaders' attachment orientations predict leadership-related mental representations and followers' performance and mental health. Journal of Personality and Social Psychology, 93,632-650.

Davila, J., & Cobb, R. J. (2006). *Adult attachment: Theory, research, and clinical implications.* Steven Rholes and Jeffry Simpson (Eds.). New York, NY: Guilford Press.

Dick, K. (producer & director) (2012). *The invisible war.* Documentary. United States of America: Cinedign.

Dunivan, K. (1994). Military culture: Change and continuity. *Armed Forces and Society, 20*(4), 531-547.

Ellison, J. (2011, April 11). The military's secret shame- when men in the military rape other men in the ranks, no one wants to talk about it. Why the sexual assault of males is finally being confronted. *Newsweek.* Retrieved from http://infoweb.newsbank.com.

Erikson, E. H. (1968). *Identity: Youth and crisis.* New York, NY: Norton.

Feeney, B. C. (2007a). Adult romantic attachment: Developments in the study of couples relationships. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment.* New York, NY: Guilford Press.

Feeney, B. C. (2007b). The dependency paradox in close relationships: Accepting dependence promotes independence. *Journal of Personality and Social Psychology, 92*(2), 268–285.

Feeney, B. C., & Collins, N. L. (2001). Predictors of caregiving in adult intimate relationships: An attachment theoretical perspective. *Journal of Personality and Social Psychology, 80*, 972–994.

Firenczi, S. (1933). Confusion of tongues between the adult and children: The language of tenderness and of passion. *International Journal of Psycho-Analysis, 30*(4), 1949.

Frankel, J. (1998). Ferenczi's trauma theory. *The American Journal of Psychoanalysis, 58*(1), 41–61.

Friedman, M. J., Keane, T. M., & Resick, P. A. (2007). *Handbook of PTSD: Science and practice.* New York, NY: Guildford Press.

Freyd, J. (1994). Betrayal Trauma: Traumatic amnesia as a response to childhood abuse. *Ethics and Behavior, 4,* 307–329.

George, C., Kaplan, N., & Main, M. (1985). *Adult attachment interview protocol* (2nd ed.). Unpublished manuscript, University of California at Berkeley

Gil, A. (2001). *Pregnancy resulting from rape: Breaking the silence of multiple crises (consequences of gender violence).* Women's Health Collection.

Gilligan, J. (1982). In a different voice: Psychological theory and women's development. Cambridge, MA: Harvard University Press.

Glaser, B & Strauss, A (1967). *The Discovery of Grounded Theory: Strategies for qualitative research.* Chicago: Aldine.

Grindley, K., Yanow, S., Jelinska, K., Gomperts, R., & Grossman, D. (2011). Abortion restrictions in the US Military: Voices from women deployed overseas. *Women's Health Issues, 21*(4), 259–264.

Harman, J. (2008, March 31). Rapists in the ranks: Sexual assaults are frequent, and frequently ignored, in the armed services. *Los Angeles Times.* Retrieved from http://www.latimes.com/news/la-oe-harman31mar31,0,5094340.story

Herman, J. (1992). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror.* New York, NY: Basic Books.

Hersch, S. (2004). Torture at Abu Ghraib: American soldiers brutalized Iraqis. How far does the responsibility go? *The New Yorker.* Retreived from http://www.newyorker.com/archive/2004/05/10/040510fa_fact#ixzz2Gp5Y9LMA

Hollway, W. (2011). Rereading Winnicott's "Primary Maternal Preoccupation." *Feminism & Psychology,* 22, 20.

Holmes, M., Resnick, H., Kilpatrick, D., & Best, C. (1996) Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women. *American Journal of Obstetrics and Gynecology, 175*(2), 320–325.

Jaffe, G. (2012, May 6). Psychiatrists seek new name, and less stigma, for PTSD. *Washington Post.* Retrieved from http://www.thewashingtonpost.com.

Janet, P. (1924). *Principles of psychotherapy.* New York: The Macmillan Company.

Kaniasty, K. (2012). Predicting social psychological well-being following trauma: The role of postdisaster social support. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*(1), 22–33.

Klein, R., & Schermer, V. (2000). *Group psychotherapy for psychological trauma.* New York, NY: The Guilford Press.

Kobak, R., Cassidy, J., & Zir, Y. (2006). *Adult attachment: Theory, research, and clinical implications. In* S. Rholes & J. Simpson (Eds.). New York, NY: Guilford Press.

Kupferschmid,J. (1993). Freud's rationale for abandoning the seduction theory. Psychoanalytic Psychology, Vol 10(2), 1993, 275-290.

Lathrop, A. (1998). Pregnancy resulting from rape. *JOGNN Principles and Practice, 27,* 25–31.

Leerkes, E. M., Parade, S. H., & Burney, R. V. (2010). Origins of mothers' and fathers' beliefs about infant crying. Journal of Applied Developmental Psychology, 31, 467-474.

Lipton, B., & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. Journal of Psychotherapy Integration, 21(3), 253-279.

Messina-Dysert, G. (2012, January). Rape and spiritual death. *Feminist Theology, 20*(2), 120–132.

Moskowitz, S. (2011). Primary maternal preoccupation disrupted by trauma and loss: The early years of the project. *Journal of Infant, Child, and Adolescent Psychotherapy, 10,* 229–237.

Mulrine, A. (2011, March 17). Exclusive: 1 in 5 air force women victim of sexual assault, survey finds. *The Christian Science Monitor.* Retrieved from http://web.ebscohost.com

Najdowski, C., & Ullman, S. (2009). PTSD symptoms and self-rated recovery among adult sexual assault survivors: The effects of traumatic life events and psychosocial variables. *Psychology of Women Quarterly, 33,* 43–53.

NCIHD Early Child Care Research Network. (2001). A new guide for evaluating child care quality. *Zero to Three, 21*(5), 40–47.

Pittman, J, Keiley, M, Kerpelman, J, & Vaughn, B. Journal of Family Theory & Review. 3 (1) pp. 32 – 46.

Roisman, G., Padrom, E., Sroufe, A., & Egeland, B. (2002). Earned-secure attachment status in retrospect and prospect. *Child Development, 73*(4), 1204–1219.

Sable, P. (2008). What is adult attachment? *Clinical Social Work Journal, 36*(1), 21–30.

Scaer, R. (2005). The Trauma Spectrum: Hidden wounds and human resiliency. New York, NY: W.W. Norton and Company.

Schore, A. (2002). *Affect regulation and the repair of the self.* New York, NY: W.W. Norton

Schore, A. (2003). *Affect regulation and disorder of the self.* New York, NY: WW Norton & Company.

Schore, A. (2012). *The science and art of psychotherapy.*: New York, NY: W.W. Norton & Company.

Seigel, D. (1999). *The developing mind.* New York, NY: W.W. Norton & Company.

Slade, A. (2008). The Implications of Attachment Theory and Research for Adult Psychotherapy: Research and Clinical Perspectives. In Cassidy, J & Shaver, P (Eds), *Handbook of Attachment.* New York, NY: W.W. Norton & Company.

Sidoli, L. (2005, March 19). *Assaults concern military academies- more than 300 women victimized, survey reports.* Retrieved from http://infoweb.newsbank.com

Solomon, Z., Mikulincer, M., & Hobfall, S. E. (1986). Effects of social support and battle intensity on loneliness and breakdown during combat. Journal of Personality and Social Psychology, 51, 1269-1276.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* New York, NY: Sage Publications.

Stewart, F., & J. Trussell. (2000). Prevention of Pregnancy Resulting from Rape: A neglected preventive health measure. *American Journal of Preventive Medicine, 19,* 228–229.

Stolorow, R. (2011). *World, affectivity, trauma: Heidegger and post-Cartesian psychoanalysis.* New York, NY: Routledge.

Solomon, M., &Siegel, D. (2003). *Healing trauma: Attachment, mind, body, and brain.* New York, NY: W.W. Norton.

Svanberg, P. (1988). *Attachment, Resilience, and Prevention.* Journal of Mental Health. 7(6) 543-578.

Symonds, M. (2010). The "second injury" to victims of violent acts. *The American Journal of Psychoanalysis, 70,* 34–41. (Originally printed 1982).

Tabin, J. (1993). Freud's shift from the seduction theory: Some overlooked reality factors. *Psychoanalytic Psychology, 10*(2), 291.

Tsopelas, C. (2010). Pertinent changes in adult brain neurobiology due to trauma. *Annals of General Psychiatry, 9* (Suppl 1), S29.

Urquhart, C., Lehmann, H., & Myers, M. (2010). Putting the 'theory' back into grounded theory: Guidelines for grounded theory studies in information systems. *Info Systems Journal, 20,* 357–381.

Van Der Kolk, B. A. (1989). The compulsion to repeat the trauma: Re-enactment, revictimization, and masochism. *Psychiatric Clinics of North America, 12*(2), 389–411.

Van Der Kolk, B. A. (2007). *Handbook of PTSD: Science and practice.* New York, NY: Guildford Press.

Van Der Kolk, B. A., McFarlane, A., & Weisaeth. (2006). *Traumatic stress: The effects of overwhelming experience of mind, body, and society.* New York, NY: The Guilford Press.

Vogt, D., King, L. A., & King, D.W. (2002). *Handbook of PTSD: Science and practice.* New York, NY: Guildford Press

Wallin, D. (2007). *Attachment in psychotherapy.* New York, NY: The Guilford Press.

Weatherill, R., Vogt, D., Taft, C., King, L., King, D., & Shepherd, J. (2011). Training experiences as mediators of the association between gender-role egalitarianism and women's adjustment to marine recruit training. *Sex Roles, 64,* 348–359.

Weissert, W. (2012, July 21). *Luis Walker, air force staff sgt., sentenced to 20 years for rape, assault.* Retrieved from http://www.huffingtonpost.com/2012/07/21/luis-walker-air-force-sta_n_1691690.html

Westerlund, E. (1986). Freud on Sexual Trauma: An historical review of seduction and betrayal. *Psychology of Women Quarterly, 10,* 297–309.

Wilcox, A., Dunson, D., Weinberg, C., Trussell, J., & Baird, D. (2001). Likelihood of conception with a single act of intercourse: Providing benchmark rates for assessment of post-coital contraceptives. Journ*al of Contraception, 63,* 211–215.

Wood, E. (2009). Armed Groups and Sexual Violence: When is wartime rape rare? *Politics & Society, 37,* 131–161.

Zeig, J. (1994). *Ericksonian Methods: The essence of the story.* New York, NY: Brunner/Mazel Publishers.

KRISTEN ZALESKI Ph.D. 2013