



COURAGE GROUP

CLINICIAN MANUAL

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VA | U.S. Department
of Veterans Affairs

COURAGE GROUP

**Helping Veterans Who Have Experienced
Military Sexual Trauma Move Forward Together**

CLINICIAN MANUAL

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INTRODUCTION TO THE COURAGE GROUP



“...MST often disrupts connections to important social systems that soldiers and veterans have come to heavily rely upon. For this reason, reestablishing connections to other MST survivors via support or psychoeducational groups can be an important aspect of reconnection and healing ... these groups offer a means of connection and shared identity based on strength, healing, or a new skill rather than the shared experience of MST alone.”

(Reinhardt et al., 2016)

The Courage Group was developed as a 12-week outpatient therapy group for Veterans who had experienced sexual trauma by Dana Foley, Ph.D., and Michelle Sherman, Ph.D. in 1995. This included Veterans with a history of childhood sexual abuse, sexual assault in adulthood, and military sexual trauma (MST). This educational group draws on cognitive and behavioral principles to promote healing, self-discovery, and self-efficacy. Treatments rooted in cognitive and behavioral principles are effective for many psychological disorders (e.g., anxiety disorders, mood disorders, posttraumatic stress disorder; Cusack et al., 2016; Hofmann et al., 2012; Kazantzis et al., 2018). Each session of the Courage Group provides an opportunity for Veterans to explore how the experience of MST has impacted their lives while also learning strategies that may improve their well-being and quality of life.

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REVISIONS TO THIS MANUAL

The Courage Group has been revised to emphasize treating Veterans (both women and men) who have experienced MST. Revisions of the MST Courage Group are based on the ecological model of sexual assault recovery (Campbell et al., 2009), which expands on the ecological systems theory (Bronfenbrenner, 1979, 1986, 1995). The ecological model of sexual assault recovery describes how interactions between the sociodemographic characteristics of survivors, the circumstances surrounding their experiences of MST, and environmental factors (e.g., informal support, formal support, culture) influence their recovery. **Table 1** details each ecological level and its relation to specific Courage Group sessions.

Other notable changes to this manual include:

- Specific information about the experience of MST and its impact on functioning.
- Addition of four new topic areas - “Surviving Military Sexual Trauma,” “Grief and Loss,” “Self-forgiveness,” and “Moving Forward.”
- A modular design that allows clinicians to vary the length of treatment according to specific group needs or the clinical setting (e.g., specialty mental health, primary care).
- Removal of imaginal exposure from the treatment protocol.
- Availability of a new companion patient workbook that includes all in-session activities and recommended homework assignments. This workbook is intended to supplement treatment. It should NOT be used as a self-help guide.

Table 1. Adapted Ecological Model of Impact for Military Sexual Trauma

Ecological Level	Description	Corresponding Sessions
Individual Factors	Premilitary demographic characteristics (e.g., age, race, ethnicity), genes and biology, personality traits, coping style, and pre-existing mental health symptoms	1-3, 5, 6
Sexual Trauma Characteristics	Includes survivor-offender(s) relationship, presence of serious threat or danger, and use of weapons, substances/alcohol, or violence, and military environment	1, 2, 4, 5
Microsystem Factors	Interactions with and between informal support systems (e.g., family, friends, peers) within and outside military environment	7, 9, 10
Meso/Exosystem Factors	Interactions with and between formalized support systems (e.g., crisis center, hospital, lawyers) during and postmilitary	12
Macrosystem Factors	Influence of military culture, individual cultural background, and societal views on sexual trauma (e.g., victim-blaming, adherence to rape myths)	1, 2, 4
Chronosystem Factors	Changes in person-environment interactions across time, including transitions into and out of military service	1, 2, 12
Self-blame (multilevel meta construct)	The result of interactions across ecological levels over time	4, 8, 11

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BRIEF HISTORY OF MST

MST is a nationally recognized problem. When screened by a Veterans Health Administration (VHA) clinician, about 1 in 3 women Veterans and 1 in 50 men Veterans report that they have experienced MST (Office of Mental Health and Suicide Prevention, 2019). MST is defined by VHA as “physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.” Sexual harassment is further defined as “repeated, unsolicited verbal or physical contact of a sexual nature, which is threatening in character” (Title 38 US Code 1720D).

The Tailhook Incident of 1991 was a major event that increased public awareness of MST as an ongoing issue within the military. Since the incident, several laws have been passed that authorize healthcare services for any servicemembers who have experienced sexual trauma while serving active duty. All VHA facilities and Readjustment Counseling Vet Centers provide free MST-related counseling and treatment (including medical services; Department of Veterans Affairs, 2018). Every Veteran who enrolls in the VHA healthcare system is screened for a history of MST and referred for treatment as needed. Additionally, each VHA facility has a designated MST coordinator who serves as a contact person for MST-related healthcare issues, such as knowledge about local VHA services and programs, community resources, and state and federal benefits. Veterans who report a history of MST do not have to be service-connected to receive free MST-related care (Department of Veterans Affairs, 2010).



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HOW TO USE THIS MANUAL

This manual is intended for mental health clinicians in VHA outpatient clinical settings who wish to treat Veterans who have experienced MST. Trainees in sponsored training programs (e.g., internship, fellowship) may also co-facilitate groups under supervision. Ideally, clinicians will have some experience with or knowledge about working with this Veteran population. A list of supplemental readings and online resources on MST can be found in **Appendix A**.

General Structure of Group

The Courage Group consists of 12 sessions that cover a broad range of life areas that may be impacted following the experience of MST. The group was originally designed as a closed (cohort-based), weekly group with each session lasting about two hours. In our revision of the Courage Group, we have adopted a modular design to increase its use in diverse clinical settings (e.g., specialty mental health, primary care). Clinicians now can vary treatment length, session duration, and frequency of sessions (see “Modifications to Group Structure” section below for additional details). This group can be facilitated by more than one clinician. A sample exit satisfaction survey is included in **Appendix B** to assist with program evaluation data collection.

Modifications to the Group Structure

The new modular design gives clinicians greater flexibility in how they implement the group. We present different format options to guide you in planning your group.

Flexibility in treatment length: The length of treatment can range from 4 to 12 sessions. There are four required sessions that must be covered in each group - “Understanding Military Sexual Trauma” (*session 1*), “Coping with Strong Emotions” (*session 3*), “Not Your Fault” (*session 4*), and “Moving Forward” (*session 12*). These sessions provide basic information on the experience of MST and its impact on functioning, introduce basic cognitive and behavioral skills to promote emotional coping, and discuss posttreatment recovery planning. You may add the other, optional sessions based on specific group needs and/or clinical setting. The first session ends with a treatment planning activity that can help you select whichever topics fit with Veteran needs. Alternatively, you could have Veterans fill in the session selection form in **Appendix B** to indicate topics of interest.

Flexibility in session duration: We recommend planning group sessions to be at least 90 minutes. This will allow sufficient time to review session content and perform in-session activities. It may be possible to complete sessions in 60 minutes, but we discourage scheduling sessions for less than 60 minutes. For suggestions on time management in sessions, see **Table 2**.

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Table 2. Potential Session Breakdown

	60-minute Group	90-minute Group	120-minute Group
Opening exercise or Homework review	Consider omitting	10-15 minutes	10-15 minutes
In-session activities	45-50 minutes	55-65 minutes	85-95 minutes*
Closing exercise	5-10 minutes	10-15 minutes	10-15 minutes
Homework	< 5 minutes	< 5 minutes	< 5 minutes

*With one 10-minute break during in-session activities.

Flexibility in frequency of sessions: We have revised the Courage Group such that clinicians can vary the frequency of sessions. You may now choose to meet with Veterans on a weekly, biweekly, or monthly basis.

Closed (cohort) vs. open (drop-in) groups: The Courage Group can be structured as either a closed, cohort-based group or an open, drop-in group. We discuss benefits and drawbacks to each group design in Table 3. If structuring this group with an open (or drop-in) format, consider conducting a brief introductory phone call or session to orient interested/referred Veterans to the group. This would allow you to review group structure, rules, and expectations as well as answer any questions the Veteran may have.

Single-gender vs. mixed-gender groups: Single-gender groups are preferable to mixed-gender groups. This may enhance Veterans' feelings of comfort, support, and safety. There may be situations in which mixed-gender groups are necessary, for example, in small clinical settings with insufficient numbers of women and men Veterans for separate groups. If you choose the mixed-gender option, you may consider enrolling at least two Veterans from each gender.

Telehealth delivery: The revised Courage Group can be delivered via telehealth platforms. The companion patient workbook has all handouts and worksheets that Veterans will need for in-session activities. Veterans can download a free PDF version of the patient workbook directly from the South Central Mental Illness Research, Education, and Clinical Center (MIRECC) website (<https://www.mirecc.va.gov/visn16/courage-group-manual.asp>). This will save you time, resources, and administrative costs.

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Table 3. Benefits and Drawbacks of Closed vs. Open Group Designs

	Closed, Cohort Group	Open, Drop-in Group
Opening exercise or Homework review	<ul style="list-style-type: none">• Is structured, predictable• Allows Veterans to share a time-limited experience from start to finish• Is easy for Veterans to get familiar with one another• Facilitates intimacy and group cohesion	<ul style="list-style-type: none">• Is less structured, unpredictable• Minimizes wait times to join next group• Maximizes the number of Veterans who are treated• Allows greater variety of skill and experience among Veterans
In-session activities	<ul style="list-style-type: none">• Risks long wait times to join next group• Risk groups' getting smaller if Veterans dropout early• Risk developing "group think"	<ul style="list-style-type: none">• May cause groups to be less cohesive or intimate• May cause group dynamics to shift from session to session• May cause Veterans to be less forthcoming as new Veterans join

Structure of Sessions

Each session includes opening and closing exercises, educational information, in-session activities, and recommended homework assignments (see descriptions below). The **bolded text** in each session chapter denotes information that clinicians are expected to present.

- **Opening exercises (recommended, but optional):** These are ice breakers that were selected to align with session content and facilitate group cohesion. Any additional materials needed for the exercises are listed in the "set up" section (e.g., pencils/pens, markers, blank paper). Be sure to review that section in advance. You may replace these exercises with homework review or omit them altogether. We strongly discourage you from including both opening exercises and homework review in a single session with respect to time management.
- **Homework review (alternate to opening exercises):** Opening exercises may be replaced with homework review during the first 10-15 minutes of session. If you choose this option, you should briefly review the topic and homework before discussing Veterans' experiences with completing the assignments. There may not be enough time to review everyone's assignments. Instead, you may offer that Veterans contact you with questions or for individual feedback as needed.
- **In-session activities:** All in-session activities are required. These activities review cognitive and behavioral skills to promote deeper exploration of topics, cope with strong emotional reactions, and pursue a meaningful life.

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- **Closing exercises:** Leave 10-15 minutes at the end of each session to complete closing exercises. These exercises allow time for Veterans to reflect and debrief about the session topic.
- **Homework assignments (recommended, but optional):** Each session concludes with suggested homework assignments that provide additional opportunities for Veterans to practice skills learned. All handouts and worksheets used for homework can be found in the appendix of the patient workbook. There are no requirements to add a homework review section to a session even if homework is assigned.

Clinical Considerations and Recommendations

Veteran eligibility: The Courage Group is generally appropriate for any Veterans who have experienced MST. Prior psychotherapy experience is **not** a prerequisite to enrollment. Moreover, Veterans do not need to have a mental health diagnosis or be grouped so that everyone has the same mental health diagnosis to participate in this group. Veterans may be taking psychotropic medications or receiving concurrent psychotherapy as long as it does not interfere with their ability to participate or attend sessions. It is important to make sure Veterans are stabilized, safe, and able to participate in this group. Toward this end, the group may not be appropriate for Veterans who are at high risk for suicidal or homicidal behaviors, or who have ongoing, severe, untreated substance use disorders. These conditions should be stabilized first before enrolling these Veterans in group. It is not required, but it may be helpful, to conduct a brief phone screening with interested/referred Veterans to determine appropriateness for group. You may also consider monitoring safety on an ongoing basis.

Group size: We recommend keeping the group size between six to eight Veterans. Groups that are very large may become too complex to manage without multiple group facilitators. Groups that are too small make it easier to notice when someone is absent or has left the group. This can have a major impact on the remaining Veterans in a closed group setting.

Handling disclosures about MST experiences during group: Remind Veterans at the outset of **each** session that they are **not** expected to disclose about their personal MST experiences during group. While sharing one's MST experiences has therapeutic benefits, it is no longer a focus in the Courage Group protocol. Given the introductory, education-focus of this group, disclosures about MST experiences may detract from the session and be emotionally overwhelming to other survivors. Therefore, encourage Veterans to keep specific trauma details to a minimum.

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When responding to disclosures in group, be sensitive, compassionate, and authentic. Start by **expressing appreciation** for the Veteran's willingness to share their experiences. Next, **offer hope and support** by reminding the Veteran that he or she has taken an important step toward healing by attending the group. You may **offer resources** to the Veteran such as those listed on page 81 of the patient workbook. Be mindful that these are national MST-related resources. We recommend you also have information about local resources available to share. If appropriate, you may **help the Veteran get connected** with other healthcare services (e.g., individual therapy, trauma-focused therapy). Remember, you and Veterans can always contact the local MST coordinator with MST-related healthcare questions or for resources. Finally, **gently redirect** the group back to the session topic and/or activity.

If it helps, you may establish group rules that allow you and other group members to signal when someone is disclosing too much detail or when someone is becoming emotionally upset. For example, you could use a physical gesture like the "time-out" hand signal or a short verbal phrase (e.g., "Let's pause," or "Let's take a break"). It will be important to use this signal before too many details are revealed. After the signal is given, be sure to respond following the recommended steps described above.



SESSION 1

UNDERSTANDING MILITARY SEXUAL TRAUMA

Session Goals

In this session, group members will:

- Discuss the definition of MST and the impact on health and daily functioning
- Learn about recovery from the impacts of MST
- Review the general structure and rationale for the Courage Group
- Identify treatment goals

Session Content

Setting the Agenda

A. Welcome Veterans to the group.

B. Review session objectives. The goals of this session are to discuss recovery from the impacts of MST and how this group promotes healing. There are many ways that survivors react to MST and many ways the trauma may express itself in their daily functioning. Research has shown that trauma can influence physical health, mental health, relationships, and ability to work. This group will cover a range of topics and skills that will educate and support MST survivors to make conscious choices about their lives as opposed to allowing the effects of the trauma to guide and direct their choices.

Opening Exercise - Group Orientation

A. **Orient everyone to the group.** It is important to share information about how you have structured the group, including number of sessions, session duration (e.g., 90 minutes), and type of group (e.g., open vs. closed format). Refer to “Modifications to the Group Structure” (**page 13 of this manual**) to review options for organizing your group. For example, you may begin each group with an opening exercise or homework review. Homework is recommended but optional.

B. **Review group rules and expectations. Emphasize the importance of confidentiality and respect.** You may also include other rules and expectations, such as:

- Group members will arrive promptly so that group can begin and end on time.
- Participation is encouraged but not required.

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- No threatening/abusive language or behavior toward others in group will be tolerated.
- No smoking, drinking, or use of intoxicating substances before or during group time is permitted.
- Group members are **not** expected to disclose about their personal experiences of MST during group sessions. *Make it clear that specific trauma details should be kept to a minimum to avoid overwhelming other group members.* Recommendations for addressing disclosures about MST experiences are provided on **page 16 of this manual** (“Handling disclosures about MST experiences during group”).

C. Allow time for questions. Before starting session content, make sure that all Veterans understand the group format, rules, and expectations.

Note: The companion patient workbook does **not** contain a handout with information about group structure, rules and expectations. You may consider creating such a handout. We have included a sample document in Appendix A.

Understanding Military Sexual Trauma

A. Review the information shown on the infographic on page 8 of the patient workbook:

- 1. What is MST?** The legal definition of MST is any unwanted sexual contact or attention, sexual assault, or repeated sexual harassment that occurs during active duty, active duty training, or inactive duty training (Title 38 US Code 1720D). It is not a clinical diagnosis.
 - **Examples.** MST refers to a wide range of experiences. It could be helpful to give examples to demonstrate the breadth of experiences that constitute MST. Examples include: inappropriate and sexualized comments; unwelcomed sexual advances; pressure for dates or sex, such as use of quid pro quo by higher-ranking servicemembers; sexual touching, grabbing, or other sexual activity done without one’s consent; and sexual assault.
 - **Prevalence.** Share that MST is a common experience that **can happen to anyone**. Veterans from all types of background have experienced MST. This includes Veterans of all genders and ages, all ranks, branches and eras of service; all racial and ethnic backgrounds; all sexual orientations; all religious backgrounds; and all physical sizes and strengths. Similar to civilian sexual trauma, MST is often **underreported**. Per 2019 VHA MST screening data (Office of Mental Health and Suicide Prevention, 2019), about one in three women and one in 50 men Veterans who enroll in the VHA report MST. The Department of Defense Sexual Assault Prevention and Response Office (2018) *Annual Report on Sexual Assault* indicates that annual rates among active duty servicemembers are between 6-25% for women and 1-7% for men.

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2. **How MST might affect you?** One point to emphasize from the outset is that MST is an experience, not a diagnosis. The infographic describes outcomes that may follow exposure to MST. **Encourage Veterans to share what changes they have noticed**, including (but not limited to) changes in emotional reactions, physical health, suicidal feelings, sexual functioning, personal relationships, and military and work performance. **Table 1.1.** describes key research findings related to these functional domains. Be familiar with the information presented in **Table 1.1**, but do **not** read the information verbatim.

Table 1.1. Key Findings on the Impact of MST on Areas of Functioning

Functional Domain	Key Research Findings
Emotional Reactions	<ul style="list-style-type: none">• Veterans who have experienced MST often struggle with many of the same problems as survivors of other forms of trauma, such as extreme emotions, re-experiencing and strong emotional reactions to reminders, hypervigilance, sleep disturbance and nightmares, suicidal thoughts or behavior, and drinking and drug use (Turchik & Wilson, 2010).• Among users of VHA healthcare, the mental health diagnoses most commonly associated with MST are PTSD, depression disorders, anxiety disorders, bipolar disorders, substance use and/or alcohol use disorders, eating disorders, dissociative disorders, and somatization disorders (Kimerling et al., 2007; Kimerling et al., 2010).
Physical Health	<ul style="list-style-type: none">• Some physical difficulties that may follow MST include chronic pain (e.g., lower back pain, headaches), gastrointestinal problems (e.g., irritable bowel syndrome), gynecological problems (e.g., menstrual disorders, pelvic pain, urinary incontinence), liver disease, chronic pulmonary disease, and obesity and weight loss. Medical illnesses frequently co-occur with each other and with psychological disorders (Kimerling et al., 2007; Surís & Lind, 2008).• Declines in physical health following MST occur for various reasons, including injuries sustained during the trauma, the impact of living with chronic stress, discomfort with medical care, and less healthy behaviors used in attempts to cope (Hyun et al., 2009)
Suicidal Feelings	<ul style="list-style-type: none">• Sexual assault and MST are associated with increased risk for suicide even after accounting for specific mental health conditions like PTSD or depression (Kimerling et al., 2016).• Note: It can be helpful to differentiate the use of suicidal thoughts as an escape from suffering and taking actions to complete suicide.

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Table 1.1. (continued) Key Findings on the Impact of MST on Areas of Functioning

Functional Domain	Key Research Findings
<p>Sexual Functioning</p>	<ul style="list-style-type: none"> • Changes in sexual activity and/or sex drive may occur, which may range from decreases in sexual activity due to avoidance of intimacy or fear of revictimization to increases in sexual activity as a way to reassert control or reclaim a sense of sexual power or periods of both (Maltz & Katz, 2016). • Other possible changes may include low sexual desire, decreased sexual satisfaction and arousal, and increased pain, anxiety, or re-experiencing symptoms during sexual activity (Pulverman et al., 2019). • Erectile dysfunction may occur in men, while genital and pelvic pain issues may occur in women (Cichowski et al., 2017; Turchik et al., 2012).
<p>Personal Relationships</p>	<ul style="list-style-type: none"> • Survivors often struggle with trust of others after experiencing MST (Lofgreen et al., 2017). Distrust of others may lead to social withdrawal and isolation. • Another potential roadblock to relationships is whether the other person(s) knows about the MST. Survivors who choose to keep their experience of MST a secret may yearn for others to know and understand. On the other hand, those who share their experience may regret it (Katz, 2015). • Negative reactions to disclosures about MST may exacerbate the impact on emotional and physical functioning (Campbell & Raja, 2005; Dardis et al., 2018). Many people (including loved ones) do not know how to respond and their attempts at comforting the survivor may come across as insensitive, dismissive, or inaccurate.
<p>Military and Work Performance</p>	<ul style="list-style-type: none"> • Decreases in work performance are not uncommon. Military recruits are less likely to complete basic training. Active-duty servicemembers are more likely to separate from the military earlier than anticipated (Millegan et al., 2016). • Occupational stress can persist during and after military service (Rosellini et al., 2017). Chronic illness, emotional distress, and relationship problems can impact occupational functioning (Sienkiewicz et al., 2020).

3. **Normalize that survivors are not alone in their experiences and that what happened was not their fault.** You will cover these topics in more detail in later sessions but present these ideas at the first session.
4. **Mention the VA National MST Website resource.** A link is provided (<https://www.mentalhealth.va.gov/mentalhealth/msthome/index.asp>). This website includes additional education materials about MST and other resources that are available to Veterans.

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Healing from the Impacts of MST

- A. Review the components of the recovery from the Campbell et al. (2009) model. The patient workbook presents simplified information regarding this model. Refer to **Table 1** on page 11 of this manual for a full description of the model. The main points to discuss are:
1. **Healing from the emotional, physical, and social impacts of MST varies and is unique for every survivor.**
 2. **Healing is impacted by multiple factors, such as:** (1) premilitary personal characteristics, beliefs, biology/genetics, mental health functioning, and coping skills; (2) the sexual trauma experience including military context, (3) interactions with informal social support systems (e.g., family, friends, peers) within and outside the military; (4) access to post-MST medical, mental health, and legal services within and outside the military; (5) cultural views of sexual trauma, including military values; (6) changes at any of these levels across time; and (7) self-blame.
- B. Have someone read the quote on page 10 of the patient workbook (*“People say that time heals all wound, and, to a certain extent, that’s true. Time will dull some of the pain, but deep healing doesn’t happen unless you consciously choose it.”*).
- C. Ask for initial reactions and interpretations. The purpose of this quote is twofold:
1. **First, to normalize that avoidance is a common response to trauma exposure and a symptom of posttraumatic distress that prolongs distress.** It can be painful to address the impact of MST. Engaging in avoidant behaviors such as distraction, pushing away uncomfortable memories or thoughts, or staying away from trauma reminders may provide temporary relief. However, avoidance delays the recovery process.
 2. Second, to highlight the **importance of being an active participant in the healing process.** You may present the following metaphor or something similar: “It’s like when you’re hungry. You could wait for your hunger to go away on its own, or you could get food and eat. Which one best meets your needs in this moment?”

Finding the Courage to Heal

- A. Present the rationale for MST Courage Group. Main points to highlight are:
1. **MST Courage Group is based on cognitive-behavioral therapy (CBT) principles.** Although this educational group has not been tested in research, it is based on the well-supported theory and principles of CBT. The skills included in this treatment have been shown to improve mental health and overall quality of life.

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- 2. Group therapy is powerful.** This treatment mode offers many benefits that individual therapy cannot provide. For example, group therapy provides a sense of belonging where members feel like they are not alone. Members also don't feel "crazy" because others share their feelings and thoughts. Even if they don't discuss their own issues, members can benefit and learn by listening to others' alternative ways to cope and to address situations.

Closing Exercise - "Planning Your First Steps"

- A. Discuss treatment planning as a group.** The first session ends with treatment planning to help you and patients determine the best course of treatment.
- B. Give group members a few minutes to answer the questions.**
- C. Discuss group members' responses to the questions.** The questions ask about how the experience of MST has affected group members and how they believe attending this group might help them with healing.

Note: If you would like, you could also have group members complete printed copies of the "Session Selection" form in **Appendix B**.

Homework (Optional)

- Review the "Military Sexual Trauma" infographic once.
- Read once through the "Planning Your First Steps" worksheet and revise as needed.

SESSION 2

SURVIVING MILITARY SEXUAL TRAUMA

Session Goals

In this session, group members will:

- Recognize and honor what it took for them to survive MST
- Identify personal strengths that have or will help with healing from the impact of MST

Session Content

Setting the Agenda

- Ask a group member to read the quote on page 13 of the patient workbook** (*“With limited resources for taking care of yourself, you survived using whatever means were available”*).
- Ask for initial reactions.** Many survivors may minimize or neglect the fact that they survived MST. It may not feel like something that should be honored, and they may be focused on things they did to survive that they aren’t proud of. Moreover, they may be ashamed that they had the experience and blame themselves that it happened.
- Review session objectives. The goal of this session is to acknowledge the strength it took to continue moving forward after the experience of MST.**

Opening Exercise (optional) - “Fill in the (Blank)”

- Set up.** Write the following stems on a white board as follows:

Rest _____

Space _____

Heart _____

Under _____

Make _____

- Review instructions.** The objective of this exercise is for group members to write down (or say) the first word that comes to mind after you call out a word stem. Present each word stem one at a time, giving group members a minute or two to write down their answer. Next, ask for volunteers to share their responses. There are several possible answers to each stem. For example, “Rest _____” could be “restroom” or “restaurant”. **The**

SESSION 2

SURVIVING MILITARY SEXUAL TRAUMA

purpose of this exercise is to highlight the automaticity of our behavioral responses to environmental cues. The fight-flight-freeze response (described below) is a representation of an automatic, involuntary behavioral response to environmental cues of danger or threat. In the next session, you will discuss the role of this response in reactions to certain forms of MST.

Following Your Instincts

- A. **Explain the fight-flight-freeze stress response.** The fight-flight-freeze stress response is a survival mechanism that is out of our conscious control. We all have it. It allows us to react quickly to danger without much thought, which is very helpful. Imagine if we had to fully process that a bear was charging in our direction before we acted. The fight-flight-freeze stress response triggers a cascade of bodily changes that prepare us to run away, stay and fight, or freeze when we feel threatened.
- B. **Highlight that certain experiences of MST may automatically activate this system,** such as sexual assault, unwanted sexual touching, or threats of sexual contact against one's will. Group members will likely have a broad range of MST experiences. Therefore, it is important to acknowledge that not all experiences may lead to the fight-flight-freeze response. Another important point is that freezing may seem like a non-action; but it is a common automatic, involuntary reaction to inescapable situations.
- C. **Allow a few minutes for group members to ask questions or make comments. Remind them that no one is expected to share details about their personal MST experiences.**

Coping After MST

- A. **Acknowledge that there are different ways to cope with MST in the immediate aftermath.** This is represented by the number of methods listed on page 15 of the patient workbook.
- B. **Provide a brief explanation of each method** (descriptions below). When reviewing these methods, be careful not to label them as "good" or "bad." Instead, frame these methods as things we may do to function during times when we might, otherwise, fall apart.
 - **Denial:** Acting as if something didn't happen.
 - **Minimization:** Saying that the experience or impact of MST wasn't a big deal or that it doesn't bother you.
 - **Humor:** Using laughter or jokes to hide how you really feel about MST and its consequences.

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- **Forgetting:** Trying not to remember what happened; avoiding memories of MST.
- **Spacing out:** Not being present in the moment; being lost in your thoughts or feelings without any awareness of what is happening in your external environment.
- **Dissociation:** Disconnecting from your body to lessen pain. Dissociation can involve spacing out but is usually more intense. People have described it as feeling detached (or “not in”) one’s body or feeling like they are in a dream-like state. There is also a tendency to lose track of time and location, which may not occur when someone is spacing out.
- **Rationalization:** Coming up with reasons for the offender(s)’ behavior or why MST happened (e.g., “It happened because I was drinking,” or “I was ordered to”).
- **Suicidal thoughts:** Having thoughts of hurting yourself or wishing you could “disappear” to escape emotional pain. Be mindful of any group member expressing current suicidal ideation or intent that needs to be addressed immediately.
- **Other possible unlisted responses include (but are not limited to):** sleeping too much or too little; emotional eating, drinking or drug use; and isolating from others.

C. **Read instructions.** They are as follows: *“Think about strategies that you may have used at the time to cope with the impact of MST. Circle all that apply. Feel free to add anything else that isn’t listed in the box below.”* The point of this exercise is to have group members recognize and honor what it took for them to get through a difficult time in their lives.

D. **Allow time to complete the activity before discussing their responses.**

Protecting Yourself After MST

- A. **Discuss strategies that group members might have used at the time or immediately following MST to protect themselves.** Experiencing MST may make survivors feel vulnerable, which is scary. When we feel vulnerable, we will do whatever it takes to protect ourselves. Survivors may work hard to prevent MST from happening again.
- **Avoidance.** Staying away from people, places, and things that are directly associated with or reminiscent of MST (e.g., isolating, avoiding intimacy with significant others). Servicemembers who remain in the military after experiencing MST may avoid memories of the trauma for self-preservation. This is an adaptive response when survivors need to maintain a relationship with the offender or continue to perform their duties.
 - **Control.** Taking great efforts to regain a sense of control. Hypervigilance is a symptom of posttraumatic distress that may become a control strategy used to anticipate future danger. Survivors who use control might also play it safe to achieve greater control.

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- **Escape/numbing.** Using distraction, substances/alcohol, or other behaviors (e.g., excessive busyness, workaholism, overeating) to get rid of or “numb” strong feelings of pain, discomfort, shame, anger, etc.
- **Self-destruction.** Engaging in behaviors that put you or others’ health and safety at risk (e.g., self-injurious behaviors like cutting, high-risk driving or sexual behaviors, addiction).

B. Discuss the ways in which these strategies may and may not be helpful anymore. While these strategies may have worked well at the time, are they still helpful? Many coping behaviors have the potential to be both helpful and hurtful. Developing the awareness to recognize when a coping behavior is no longer working is a valuable skill.

Closing Exercise - Honoring Your Inner Strength

- A. Set up.** You will use page 17 of the patient workbook.
- B. Review instructions.** Give group members a few minutes to write down at least three personal strengths (“*I am ...*”) that have helped them cope with the impacts of MST. You may want to provide a few examples, such as “I am a survivor”; “I am a fighter”; or “I am successful, despite what I went through.”
- C. Allow everyone to share their responses.**
- D. Ask how these inner strengths can support efforts to heal from MST.**

Homework (Optional)

- Read the personal strengths statements from the “Honoring Your Inner Strength After MST” worksheet aloud once a day.

SESSION 3

COPING WITH STRONG EMOTIONS

Session Goals

In this session, group members will:

- Define the range and function of emotions commonly associated with MST
- Learn about the connection between thoughts, feelings, and behaviors
- Identify more adaptive coping strategies for managing difficult emotions

Session Content

Setting the Agenda

- A. Explain that experiencing MST can be highly emotional at the time that it is happening and thereafter.** Survivors may experience a mix of emotions that feel overwhelming – fear, anxiety, sadness, regret, guilt, and shame. They may have received messages growing up or while in the military that they should “control” how they feel or that they should “suck it up.” It is not helpful that “bad” or “negative” emotions don’t feel comfortable, making us want to get rid of them. On the other hand, we assume that “good” or “positive” emotions are ideal. However, we can’t be happy or joyous all the time; and sometimes negative emotions “fit” the reality of what has been experienced.
- B. Review session objectives. The goals of this session are to increase awareness of one’s emotions and ways to cope when one feels overwhelmed or triggered.**

Opening Exercise (optional) – “Find the Hidden Objects”

- A. Set up.** You will need printed copies of the “Hidden Objects” handout in Appendix A.
- B. Review instructions.** This game is played in two rounds. **Round 1:** Give group members 10-15 seconds to find all seven objects. **Round 2:** Now give everyone one to two minutes to find the hidden objects. Although an answer key is provided in Appendix A, completing this activity is not important.
- C. Process reactions to the exercise.** You may ask the group, “Which round was easier and why?” or “What did you learn from this game that you might be able to apply to your life?” **The exercise demonstrates how easily we can become overwhelmed when we focus on too many things at once.** But if we slow ourselves down, we can concentrate on the current emotion or an emerging one and react appropriately.

SESSION 3

COPING WITH STRONG EMOTIONS

Purpose of Emotions

- A. State that emotions, like pain receptors, serve an important function.** When our skin receptors are activated, we experience pain. You may ask the group, “Would we want to get rid of our pain receptors? If we did, what would happen if we put our hand on a hot stove?” The answer: We would severely burn our hand. Pain receptors let us know when something is hurting us like an alarm or alert. Emotions are similar. They tell us when something isn’t right, when we like something, or when we need to act.
- B. Discuss the function of listed emotions. Refrain from labeling emotions as “good” or “bad,” “positive,” or “negative.”** This gives the impression that some emotions are more useful than others. Instead, you want to emphasize that all emotions have a purpose, including the emotions that feel unpleasant (e.g., sadness, shame, guilt). You want to cultivate a willingness in group members to embrace and listen to any emotions that show up. This will help them make informed decisions about the best ways to cope with their emotions in the moment.

Identifying How You Feel

- A. Explain the relationship between thoughts, behaviors, and feelings.** Emotions can be broken into three components – thoughts, behaviors, and bodily reactions. These components interact with one another such that changes in one area influence changes in another. This is shown in Figure 3.1.

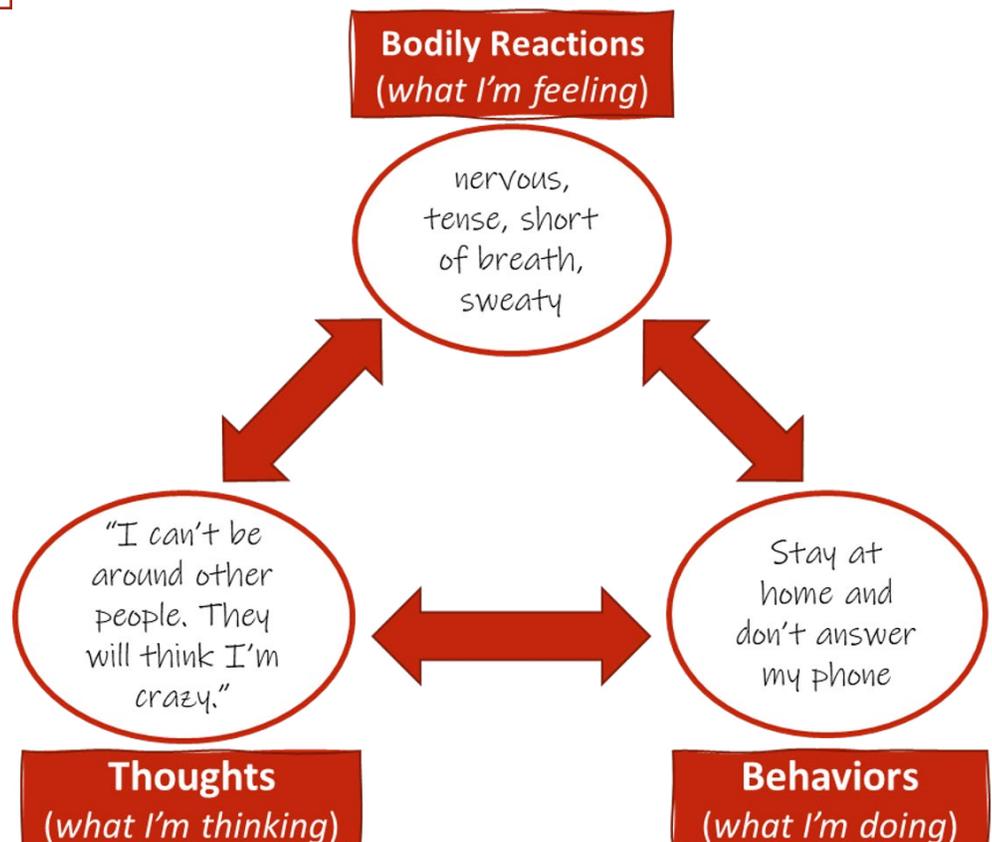


Figure 3.1. Three components of emotions

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- B. To illustrate this, use the example on page 20 of the patient workbook to describe the bidirectional relationships between thoughts, feelings, and behaviors.** Make sure group members understand the interrelationship between these three components. To begin, have group members imagine that they are getting ready for a party.
- 1. Elicit examples of thoughts:** Maybe they start thinking, “I can’t be around other people” or “These people already think I’m crazy.” As you discuss different thoughts, you may ask what emotions that specific thought brings up. For example, the thoughts listed above may make individuals feel nervous.
 - 2. Elicit examples of physical signs of anxiety (or other emotions named during group discussion):** Signs of anxiety include a racing heart, sweaty palms, shortness of breath, “butterflies” in stomach.
 - 3. Elicit examples of behaviors to deal with anxiety:** Ask group members what behavioral urges they have when they start to feel different bodily sensations. For example, when they feel nervous, they may choose to stay at home or not answer a friend’s phone call.
- C. Give a trauma-related example that elaborates on the model described in Figure 3.1.** For instance, someone might smell something that reminds him or her of the offender(s). The person may first recognize changes in his or her physiological response (e.g., increased heart rate, shallow breathing, sweaty palms). He or she then feels an urge to escape and has thoughts suggesting that something bad is about to happen or that he or she is not safe. These thoughts can intensify physical reactions or lead to further avoidant behaviors that ultimately reinforce beliefs that he or she is in danger.
- D. Note that there are many ways to cope with strong emotions.** Effective coping may include learning skills to manage physical reactions, challenge unhelpful thoughts, or reduce avoidant behaviors. Specific skills will be discussed in the next activity “Staying Ahead of Stress.”
- E. Note that emotions are not behaviors.** Many people confuse feelings with actions. But feeling angry is not the same as attacking someone. There are countless times when we think or feel something and don’t act on it. For example, some survivors of MST may think about hurting themselves or wanting to die. But these thoughts and feelings are not actions. It’s okay to talk about these thoughts and feelings; talking about them can actually help prevent taking actions.

Note: You may provide contact information for the **Veterans Crisis Line** (call 1-800-273-8255 press 1, text 838255, or chat online at [veteranscrisisline.net](https://www.veteranscrisisline.net)) or local emergency services.

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COPING WITH STRONG EMOTIONS

Staying Ahead of Stress

- A. **Discuss potential triggers of trauma-related distress.** There are times when strong emotions seem to come out of nowhere. There are other times, however, when survivors can anticipate when they will become upset or anxious.
- B. **Elicit examples of internal and external trauma reminders (or triggers) that elicit strong emotional responses.** External triggers can be any person, place, thing, or activity that reminds survivors of their trauma experience. Possible external triggers include trauma anniversaries; news stories about sexual trauma; being around other Veterans; and certain smells, sounds, or sights. Internal triggers include trauma memories, thoughts, and bodily sensations (e.g., pain).
- C. **Brainstorm ways to cope with anticipated triggers.** The more survivors can anticipate triggering situations (e.g., anniversaries, thoughts like “I’m not good enough”), the more time they have to prepare/cope in advance. Strategies may include healthy distraction (but not avoidance), exercise, self-expression, mindful awareness. Avoidance is not a long-term solution or always possible.
- D. **Remind group members to do what works and get support.** It is okay to feel upset when we are triggered, but remember how to productively manage this and stay safe.

Closing Exercise - “Changing Your Emotional Experience”

- A. **Explain how to complete the thought record.** Ask group members if anyone would be willing to share a recent situation in which they had a strong emotional reaction. It would be preferable to start with a situation that is not trauma- or MST-related. A traffic example is provided on the handout.
- B. **Practice completing recording using one to two examples.**
 - **Situation/Trigger.** Describe a situation in which you had a strong emotional reaction, felt triggered, or wish you had reacted differently. The description should be based on facts (e.g., “A car cut me off in traffic”) not interpretations (e.g., “The driver tried to run me off the road”).
 - **How I felt.** Write in how the situation made you feel. Emotions are usually described in 1-2 words.
 - **What I thought.** List thoughts or memories that came to mind during the situation. This may include interpretations (e.g., “He/she was trying to run me off the road”).
 - **What I did.** Describe how you behaved either during or after the situation occurred.

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- ***Did it work?*** Write down whether the behavior/outcome improved the situation. For example, yelling might make you feel more frustrated, leading to more aggressive behavior that could make the situation worse. On the other hand, if you slowed down and let the person in front of you, then the situation may have improved because you felt less distressed.
- ***What else can I do?*** If you didn't get the desired outcome (i.e., situation worsened or you felt worse), then consider other ways to handle similar situations in the future. Select behaviors that you think will improve the situation or lead to the desired outcome.

Homework (Optional)

- Complete one to two “Changing Your Emotional Experience” handouts (found in Additional Resources section of patient workbook and Appendix B in manual).

SESSION 4

NOT YOUR FAULT

Session Goals

In this session, group members will:

- Learn about the relationship between self-blame and MST
- Work to develop an appropriate sense of blame as it relates to their MST experiences

Session Content

Setting the Agenda

- A. **Normalize that many survivors of sexual trauma believe that what happened was their fault when it wasn't.** They believe that their behavior either initiated the incident or that they deserved what happened. This is simply not true. It may be hard to believe at first, but sexual trauma is the responsibility of the offender(s) - not the responsibility of the survivor. It is never justifiable for anyone to abuse power or use violence to take advantage of someone else.
- B. **Review session objectives. The goal of this session is to explore why sexual trauma is not the survivor's fault.**

Opening Exercise (optional) - "Count the F's"

- A. **Set up.** Write on the board (or print) the following sentence exactly as is and in all caps.
- FINISHED FILES ARE THE RE-
SULT OF YEARS OF SCIENTIF-
IC STUDY COMBINED WITH THE
EXPERIENCE OF MANY YEARS
OF EXPERTS.
- B. **Review instructions.** Ask each group member to count all the *F*s in 30 seconds. Let each group give a response. The correct answer is seven. Most people miss the *F* in *of*. **The purpose of this exercise is to illustrate the importance of context.** Without another's perspective, someone might think there are only three *F*s. It is easy to miscount the number of *F*s in the given phrase because the *F*s in *of* are subtle. In life, there are times when we may get "stuck" in our thinking and have difficulty seeing a situation from a different perspective. This session is about looking at the details of what happened closely enough to determine whether self-blame is appropriate.

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The (Self-)Blame Game

- A. **Elicit reasons why survivors might blame themselves for MST.** Common reasons to highlight during the discussion are:
- **Assimilated thinking.** Assimilated thinking is altering incoming information so that it matches existing beliefs. For example, most people believe that the world is fair and just. This belief assumes that if something bad happens (such as MST), then the victim must've done something to deserve it. The fallacy with this belief is that bad things happen to good people all the time. When survivors hold onto assimilated beliefs, they are likely to blame themselves for what happened.
 - **Hindsight bias.** Hindsight bias is the tendency for people to overestimate their ability to have predicted an outcome that couldn't have been predicted. It is the "I knew it all along" phenomenon. Survivors who believe that they could've prevented MST from happening will struggle with self-blame.
 - **Conditioning.** Our personal history plays a role in how we react to stressful situations. Survivors may be more prone to blame themselves for the occurrence of MST if they experienced prior trauma or came from home environments where they were punished for speaking out when something went wrong.
 - **Internalized messages.** Offenders may make accusations that their victims "deserved" what happened to exert control. Other people may also hold the opinion that survivors of sexual trauma are to blame. They may assume that victims must've done something to provoke the offender(s). This is known as victim-blaming. Survivors may, over time, come to believe these messages are true, especially if they come from reputable sources (e.g., family, friends, authoritative persons).
 - **Repeated victimization.** It can become harder to believe that sexual trauma is not one's fault when it happens more than once. Revictimization still doesn't justify blaming the survivor. Remember the fault lies with the offenders and, in some cases, the environment that allows this to occur.

Finding a Place for Blame

- A. **Introduce activity. Note that self-blame neglects many things that survivors of sexual trauma have done to survive.** This exercise will help group members consider the evidence for and against any beliefs of self-blame. When completing the activity, the evidence should reflect facts. No judgments, beliefs, or feelings should be included in group members' responses.

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- B. Review each section individually.** For this section, (1) introduce the topic with the information provided, (2) allow time for a brief discussion and/or questions, and (3) give group members time to respond to all questions in that section. Let group members know beforehand that you will process this activity in the next exercise, entitled “A New Understanding of Blame.”
- **Blame vs. Responsibility.** The difference between blame and responsibility is one’s intention. Intention determines blame. If you plan to do someone harm and harm results, then you’re at fault. However, if you don’t mean to do harm and harm results, then blame is not appropriate. In the latter case, our actions contributed to the outcome but may not be the sole cause of the event. You may provide an example: “Let’s say you spill a glass of milk. You can knock the glass over because you didn’t see it (*responsible, but not blameworthy*), or you can knock the glass over to get revenge (*blameworthy*.” You may acknowledge that there might be ambiguous scenarios (such as the offender(s) were intoxicated or under the influence) in which survivors may question the offender(s)’ intentionality.
 - **Role of the offender.** Survivors often wonder “Why me? Why was I chosen?” It can be very dissatisfying to think that these answers may never be known. Offenders may target victims for several reasons.
 - » **Opportunity.** Sexual trauma is not a random event. Some offenders seek victims who they think are vulnerable or who can be manipulated. They then create or look for opportunities to commit a violent act.
 - » **Abuse of power.** Sexual trauma is more about power than sex. Offenders use their power to hurt others.
 - » **Manipulation.** Manipulation, coercion, force, and alcohol/drugs are more common weapons used in MST than guns or knives. Offenders may develop a trusting relationship with the victim first to exploit them later.
 - » **Lack of Consequences.** In the military environment, survivors may experience more adverse consequences than offenders, such as reprisal, being treated differently by their supervisors or peers, or being blamed for the incident.
 - **Natural responses during sexual trauma. Review two common responses to sexual trauma.** Be mindful that these two responses may not be relevant to all group members or their experiences.
 - » **Freezing.** When danger occurs, our natural instincts are to fight back, run away, or freeze. Fighting back may seem like the right response to servicemembers due to the nature of their training and jobs. However, in many cases, fighting back can make offender(s) more violent or make the situation worse. Survivors may also freeze if they do not say “no” to the offender’s advances or sexual behaviors. Running away may not be an option. Sometimes freezing is the best way to ensure survival, especially when a victim is caught off guard and doesn’t know what

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the offender(s) is going to do. Remind group members that this response is an automatic survival response outside our conscious awareness or control.

- » **Feeling arousal or pleasure.** In cases of sexual assault, some survivors may mistake their bodily responses as signs that they enjoyed what happened or weren't strong enough to stop it. It is important to understand that our body is less sophisticated than our mind at differentiating between experiences like sexual assault from consensual sexual activities. survivors may feel as though their bodies have betrayed them. Offenders might even say these bodily responses were signs that the survivor liked what was happening at the time. The body is hard-wired to respond to sexual stimulation with feelings of pleasure and arousal. This doesn't mean that survivors enjoyed what happened. Be aware that, although men who experience arousal, ejaculation, or an erection in response to male-on-male sexual trauma may question their sexuality, this doesn't suggest anything about their sexual orientation.
- **Importance of military context.** There are many reasons why people join the military. Maybe it is to honor a family legacy, to express patriotism, or to pursue opportunities for education or a better life. Sometimes it is an escape from a troubled home or past. No one joins because they want to be sexually victimized. When MST happens, there are aspects of the military environment that can make it hard to deal with the trauma and get help. Examples include:
 - » **Hostile work environment.** Survivors may continue to live and work with the offender(s) and friends of the offender(s). Consequently, there may be an increased risk and fear of future harm, retaliation, or victim-blaming by peers or chain of command. This creates a hostile work environment that compromises survivors' sense of safety, trust, and work performance.
 - » **Pressure to conform.** The military promotes deindividuation, which emphasizes the group over individualism. As a result, individuals may feel pressure not to do things that would make them deviate from the group (e.g., disclosing or reporting MST). MST may be kept secret to preserve unit cohesion and not stand out. There may also be pressure to preserve the military hierarchy or another servicemember's "career" if the offender(s) are of higher rank.
 - » **Military culture.** The military values physical strength and mental toughness. Servicemembers may assume sexual trauma is their fault because they couldn't stop the offender(s). This is especially true for individuals who adhere to masculine traditions (e.g., non-emotional, brave, physically strong, seeing oneself as a defender). Survivors may, thus, minimize or deny MST to avoid embarrassment, shame, or appearing "weak" to their peers.
 - » **Trained in lethal means.** Given the integral role the Armed Services play in maintaining national security, training servicemembers in use of lethal force is

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critical. While these skills are valuable in combat situations, they may enable offenders to be more violent when perpetrating MST and increase fears about violent retaliation.

A New Understanding of Blame

A. Ask group members to reflect and complete the sentence stems in reference to the previous activity “Finding a Place for Blame”:

- *“What I learned in today’s group is ...” (seeking answers that reflect something group members have learned about the appropriateness of assuming blame for experiencing MST or who should be held responsible for what happened)*
- *“I did not have responsibility for ...” (seeking answers that reflect an understanding that group members are not 100% to blame for experiencing MST, even if it happened more than once)*
- *“Next time I start to blame myself, I will ...” (seeking answers that reflect actions that group members may take to reduce self-blame, such as “remembering that I am not responsible for what happened” or “read this handout.” Be creative!)*

B. Invite group members to share what they have taken away from these exercises. Keep in mind that, although group members may intellectually understand that it wasn’t their fault, they may not accept it on an emotional level. This will likely take more time.

Closing Exercise – “Compassion for A Younger You” Exercise

A. Set up. None.

B. Read the following script at a slow, steady pace.

“Find a comfortable position. You may close your eyes or look at a neutral point on the floor. Next, take a few slow, deep breaths to begin (pause for 15 seconds).

Imagine you could go back in time and visit a younger you. Now, I want you to travel back to a time when you were feeling vulnerable or were in a lot of pain and needed to be comforted (pause). It doesn’t matter how far back you go. Just take a few moments to fully call up that image of you at this younger age (pause).

Now take a good look at this younger you (pause). Imagine what life is like for her (or him) right now, what is she (or he) going through (pause for 10-15 seconds)? Get a sense of the pain she (or he) must be feeling right now (pause for 10-15 seconds). Think about what you could give to your younger self that would provide her (or him)

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with comfort, love, and safety? What does she (or he) need to hear right now (pause)? Or maybe no words need to be said because you completely understand what this younger you is going through (pause). She (or he) can see that you are here, in this moment, and that you care (pause). Stay for awhile with this younger you, ready to do anything your younger self asks. Offer a hug. Say a word of kindness. Sit together in silence (pause for 10-15 seconds).

Take a few last moments with this younger you. Let her (or him) know you can return anytime you are needed (pause). Begin to bring your awareness back to your breathing, returning to the present moment (pause). Notice any sounds you can hear right now (pause). Notice anything you can feel (pause). As you return to the room, slowly open your eyes.”

Homework (Optional)

- Re-read the “A New Understanding of Blame” worksheet two to three more times
- Practice the “Compassion for a Younger You” meditation once a day (found in Additional Resources section of patient workbook and Appendix B in manual)

SESSION 5

GRIEF AND LOSS

Session Goals

In this session, group members will:

- Develop a deeper understanding of the grieving process
- Discuss barriers to grieving after the experience of MST
- Recognize and honor any losses incurred because of the experience of MST

Session Content

Setting the Agenda

- A. Introduce grief and loss.** Grief is the acute pain that follows a loss. Most people associate grief with the loss of a loved one, but we can experience grief after losing anything. This includes losing physical objects such as relationships, work, and health, or intangible objects such as time, pride, and honor. Grief can be a painful, confusing experience overwhelmed by many feelings (e.g., fear, loneliness, betrayal, depression, helplessness, hopelessness, yearning).
- B. Review session objectives.** The goals of this session are to gain a deeper perspective on grief and how to honor what was lost.

Opening Exercise (optional) - “Favorite Childhood Memory”

- A. Set up.** None.
- B. Review instructions.** Ask each group member to share a favorite memory from childhood. For any group members having difficulty thinking of a favorite childhood memory, you may ask them to share a favorite place to which they have traveled. **This exercise shows that nothing lasts forever, even the things that we love.** Group members may notice, when recalling the memory, a sense of joy and sadness. These feelings are a natural response to remembering a happy moment that we may wish still existed.

What It Means to Grieve

- A. Discuss Kübler-Ross’ (2005; 1972) stages of grief; elicit examples for each stage.**

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- **Denial.** We experience strong feelings of disbelief and may minimize the loss. This stage is characterized by feeling shocked, confused, fearful, or even elated. Avoidant behavior is not uncommon during this stage.
- **Anger.** In this stage, there is a focus on unfairness or revenge. As we adjust to our new reality, anger and outrage are usually the first emotions that are released.
- **Bargaining.** There comes a time when we feel desperate and are willing to do anything to ease the pain. We may make a variety of promises, often to a higher power, to get a better outcome. Self and other blame may persist during this stage.
- **Depression.** We come to realize that the loss really happened. No more bargaining takes place as we try to comprehend what happened. The sadness grows. We may withdraw for a period or begin reaching out for support.
- **Acceptance.** This stage involves no longer feeling pain of the loss or avoiding reality. Sadness and regret may linger, but denial, bargaining, and anger have subsided. We begin to find a new purpose in life.

B. Mention that the grieving process is not sequential. We can skip stages, get stuck at one stage indefinitely, or cycle through the process multiple times. You may ask group members which stage resonates with them the most in their efforts to heal from the impact of MST right now.

C. Discuss potential barriers to grieving the experience of MST.

- **One potential barrier is a need to delay grief until a more acceptable time.** Survivors of MST may need to maintain status quo, which can mean postponing their reactions to loss until a later time. Unfortunately, unresolved grief may fester making emotional reactions stronger with time.
- **Another potential barrier is that mourning after sexual trauma is “disenfranchised.”** Disenfranchised grief is mourning that is or cannot be openly acknowledged, publicly recognized, or socially supported by others. Survivors of sexual trauma are not afforded the same right to grieve openly in public as combat survivors, for example. This, however, may be changing with the rise of the #metoo movement.

D. Brainstorm other potential barriers with the group.

Grieving for What Should Have Been

A. Discuss types of losses following MST. You may ask (or have group members write on page 31 of the patient workbook) about any personal, professional, or health-related “injuries” they incurred because of experiencing MST. Another way of thinking about

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losses is having group members imagine how their lives would have been different had they not experienced MST. Examples of losses may include early separation from military, loss of career, compromised safety and trust, disruption in future plans, dishonorable feelings, low self-esteem, poor health, and unstable relationships. Specifically following a military sexual assault, survivors may also feel a loss of innocence if it was a first or early sexual experience.

Note: Be prepared for the possibility that group members may become emotional during this activity. It can be difficult accepting the reality of what happened and how it changed the course of their lives.

Honoring What You Lost

- A. Brainstorm ideas for acknowledging, recognizing, or commemorating MST-related losses.** Even if group members are not actively working toward the acceptance stage of the grieving process, they can think about ways to show appreciation for what was lost or never was because of the impact of MST. If it helps, ask group members to think about what they have gained since experiencing MST.

Closing Exercise - "Like A Tree" Meditation

A. Set up. None.

B. Read the following script at a slow, steady pace.

"To begin, find a comfortable position. You may close your eyes or look at a neutral point on the floor. Imagine that you are a mighty tree (pause). Plant your feet firmly on the floor, as though you are stretching your roots down into the ground. Notice the gentle tension in your feet as you press your soles against the ground (pause). Now straighten your spine and let your shoulders relax. Imagine yourself becoming more stable as your sturdy trunk rises upward toward the sky (pause). As you breathe in, feel yourself growing taller and stronger, planting yourself firmly in the earth (pause).

Slowly move your attention up your body, settling on your trunk. Your trunk includes your chest, shoulders, and stomach. Focusing on your trunk, take notice of your straight posture (pause). Breathe deeply and slowly, noticing the rise and fall of your chest (pause). Imagine air filling your lungs on the inhale, and gently release the air until your lungs are empty (pause). Take another deep breath (pause). And exhale (pause for 1-2 minutes).

Now expand your attention in every direction like the branches of a tree. Get a sense of where you are by noticing any sounds that you can hear (pause for 30 seconds). Now

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GRIEF AND LOSS

notice anything you can feel or touch (pause for 30 seconds). Notice any smells in the room (pause for 30 seconds). Notice how your mouth feels (pause for 30 seconds). And, lastly, imagine things that you saw in the room before this exercise began (pause of 15 seconds).

Take a few more deep breaths, embracing everything that surrounds you (pause). When you are ready, begin moving your attention back down the tree from your branches to your sturdy trunk to your firmly planted roots (pause). Take a final deep breath, and open your eyes.”

Homework (Optional)

- Practice the “Like A Tree” meditation once a day
- Complete the “Honoring What Was Lost Activity Planning Worksheet” SMART goals (found in Additional Resources section of patient workbook and Appendix B in manual)

SESSION 6

GRIEF AND LOSS

Session Goals

In this session, group members will:

- Review the functions and utility of anger
- Understand the different levels of anger and how they experience them
- Learn strategies for channeling their anger effectively

Session Content

Setting the Agenda

- A. Normalize that anger is a common reaction to MST.** Anger signals when something has gone wrong or shouldn't have happened. MST is a military experience that is wrong and should never happen. It violates core military values of honor, integrity, and loyalty. This leaves survivors feeling deeply hurt and betrayed – which may include those with whom they entrusted their lives, safety, and career. Survivors, therefore, have a right to feel angry. It is what we do with anger that can create problems. Turning it inward can lead to self-blame and depression. Directing it toward others who are not the offender(s) can result in aggression. These are examples of when anger becomes a problem.
- B. Review session objectives. The goals of this session are to recognize when anger is destructive and learn ways to effectively manage it.**

Opening Exercise (optional) – “Draw Your Anger”

- A. Set up.** You will need blank sheets of paper and crayons, color pencils or markers.
- B. Review instructions.** Ask group members to take a piece of paper, and then draw a picture of their anger. It can be anything they want it to be; it just needs to represent their anger. Encourage them to draw it in any way they can. Try not to give too much guidance. Allow 5-10 minutes for group members to complete drawing.
- C. Invite group members to share their pictures,** describing how they represent their anger.
- D. Briefly review the function of anger.** Anger has gotten a bad reputation, but it is not a “bad” emotion. It helps us know when something is wrong or not right. Or it signals when something valuable has been taken from us. For instance, physical and emotional safety may be compromised after experiencing MST, leading to feelings of anger or

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GRIEF AND LOSS

vengefulness. These feelings of anger are justified. Without anger, we might not have the “fire” we need to change or defend ourselves.

- E. Explain how anger can be a secondary emotion.** Primary emotions are “fast-acting” (i.e., emotions that are a direct outcome following an event). Secondary emotions come after primary emotions and are based on our interpretation of the event. Anger can be both a primary and secondary emotion. For example, someone might feel angry about getting cut off in traffic (*i.e., anger as a primary emotion*). Anger would be secondary if it is a response to an interpretation of the situation rather than a direct response to the situation. That is, the person is reacting to a belief that the other driver was being rude or driving while distracted. As a secondary emotion, anger may “cover up” other strong emotions like fear, sadness, shame, or grief. Toward this end, it is a good practice to explore how we really feel when we notice feelings of anger. We may be feeling other emotions that need to be dealt with first.

The Price of Anger

- A. Contrast the helpful and less helpful aspects of anger.** Anger is a powerful healing tool that feels effective when it is felt toward the offender(s) or those who failed to protect victims. Survivors of sexual trauma, however, may turn their anger inward and blame themselves for actions they did or didn’t take. Or they may lash out or act aggressively toward others in their life now. This is when anger becomes destructive and can hurt those closest to them. Because anger is such a powerful emotion, it is important for survivors to understand how it impacts their lives.
- B. Elicit examples of times when anger was helpful and when it was hurtful.** This point of this activity is to recognize the positive qualities of anger in contrast to its downsides.

The Experience of Anger

- A. Identify physical indicators of anger.** We all have an internal signals or warnings that tell us when we feel angry. Anger is a stress reaction to feeling threatened or wronged. When we feel angry, our brain coordinates rapid, automatic bodily changes that prepare us to fight, flight, or freeze. These rapid bodily changes include flushed skin, tense muscles, clenched jaw or fists, and a surge of energy and focus. **Note that these changes are adaptive and ensure survival.**
- B. Set up.** You will need page 35 of patient workbook and crayons or markers.
- C. Review instructions.** Ask group members to think about the last time they were angry. If they can’t think of a recent event, then ask them to think of a time in the past or a time

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when they were the angriest they have ever been. Pause to give group members sufficient time to think of a situation.

- D. Next, have group members mark on the figure using crayons or markers where they noticed changes in their body.** For example, they might color their cheeks red to represent feeling “flushed” or color their hands blue to represent “sweaty” (see **Figure 6.1**). The point of this activity is to increase group members’ awareness of physical changes that take place when they are angry. Knowing this information can help them use coping strategies to decrease their anger before it gets destructive. Be mindful that these bodily changes are not specific to anger and can occur with other strong emotions (e.g., sadness, joy).

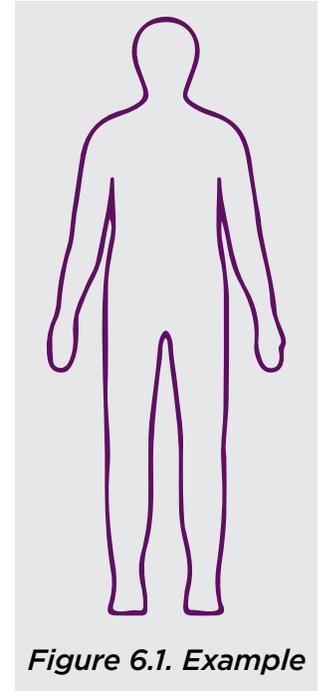


Figure 6.1. Example

The Dark Side of Anger

- A. Discuss the varying degrees of anger and the associated consequences.** Many people confuse the emotion of anger with aggressive behavior. Anger is a strong feeling of annoyance or discontent. Aggression is hostile or violent behavior or attitudes. Note that feeling angry is different from the resulting behaviors. It is possible to feel angry without being violent.
- B. Elicit examples of aggressive behaviors,** such as yelling, hitting, and throwing things.
- C. Explain the relationship between anger and rage.** Rage is the most destructive form of anger. It is an explosive, aggressive, and loud eruption of fury that peaks then subsides followed by a period of calm. Rage is like a hair trigger; the slightest annoyance can set it off. Once it starts, it is hard to shut down. When we experience rage, we may feel “out of control” or “misunderstood.” Many times, rage leads to regrettable behaviors like fighting or self-harm.
- D. Elicit examples of situations that may lead to someone to act in rage.**
- E. Summarize main points:** (1) Feeling anger is distinct from aggressive behavior or rage. It is possible to have the emotion of anger without hurting ourselves or others. This is important to understand because anger is a normal, healthy human response. Behaving aggressively or hurting others is not. (2) We can embrace anger while learning to control our behavior.

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How to Manage Your Anger

- A. **Reiterate the importance of having anger.** We need anger. It is a normal human emotion that we all experience that warns us when something is wrong. So, we don't want to get rid of anger. Instead, we need to find effective ways to cope with anger or express it more appropriately.
- B. **Review instructions.** As a group, brainstorm ways to manage different levels of anger – frustration, anger, and fury.
- C. **Ask group members for strategies they have used in the past or have seen others use that seem to work.** Write responses on a white board.
- D. **Encourage group members to list strategies that they think will help them at the different levels of anger.** No group members' lists are expected to be exactly the same.

Closing Exercise – Diaphragmatic Breathing Technique

- A. **Set up.** None.
- B. **Review instructions.**
 1. **Ask group members to sit comfortably in an upright position.** Encourage them to try and relax their shoulders, head, and neck as much as possible.
 2. **Next, have them place one hand on the upper chest and the other just below the rib cage.** This will allow them to feel their diaphragm move as they breathe.
 3. **Ask them to inhale slowly through their noses until they feel their stomach move out against their hands.** The hand on the chest should remain as still as possible.
 4. **Next, they will exhale through their mouths while tightening their stomach muscles.** Again, the hand on the upper chest should remain as still as possible. Repeat this a few minutes.
 5. **Encourage group members to let go of any thoughts or images that come to mind.** When this happens, they can gently turn their attention back to their breathing.

Homework (Optional)

- Review the “How to Manage Your Anger” worksheet, and revise plan as needed.
- Practice diaphragmatic breathing two to three times a day (instructions found in Additional Resources section of patient workbook).

SESSION 7

TRUST

Session Goals

In this session, group members will:

- Discuss how MST may violate trust and contribute to feelings of betrayal
- Learn about the varying degrees of trust
- Learn how to identify and work through difficulties with trust

Session Content

Setting the Agenda

- A. Explain how MST may impact trust.** There are many ways to “trust” in this world – we can trust ourselves, trust the world, or trust other people. After experiencing MST, survivors may begin to second-guess themselves and their ability to manage things. They may doubt their ability to feel safe in the world or believe that the world won’t respond to or meet their needs. Most importantly, they may lose their ability to trust others and have difficulty being vulnerable with other people.
- B. Review session objectives.** The goals of this session are to discuss any changes in trust after MST and strategies for re-establishing trust in oneself, others, and the world.

Opening Exercise (optional) - “What if...”

- A. Set up.** You will need blank sheets of paper and pencils/pens.
- B. Review instructions.** Present the following scenario to the group: “Imagine this. You were specially selected to receive \$1,000,000. There is only one catch. You have to survive on a deserted island for one month. You will receive some basic survival training and a kit of supplies to help with securing food, water, and a shelter. To increase your chances of surviving, you may bring up to three other people. Who would you bring and why? You could go by yourself, but think of the consequences of doing so. Choose carefully. Your life depends on it!”
- C. Give group members a few minutes to write down their answers.** Ask for volunteers to share whom they would invite along with their reasons for bringing those specific people. Responses will illustrate the degree to which group members trust others or simply rely on themselves.

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Betrayal and MST

- A. **Explain how different instances of MST may be considered betrayal trauma.** A betrayal trauma is when a person's trust is violated in a relationship where the victim depends on the offender(s) for survival or basic needs. There are two instances in which MST may qualify as a betrayal trauma.
- B. **Describe individual betrayal.** An experience of MST may be considered a betrayal trauma when the offender(s) is also a member of the Armed Forces. Servicemembers are taught to rely on one another for survival in combat and to treat each other like a "family." This may leave survivors of MST feeling deeply hurt by those whom they believed would keep them safe.
- C. **Describe institutional betrayal.** Survivors of MST may feel betrayed by the military institution for not preventing MST and/or responding in a supportive way regardless of who the offender(s) is. For example, institutional responses to MST that seem like a cover-up or that blame the victim may evoke feelings of institutional betrayal.
- D. **Elicit reactions to individual and institution betrayal.** Note that feelings of betrayal may make it challenging to rebuild trust in oneself and others.

Trust Isn't All-or-None

- A. **Discuss group members' views of trust.** You may ask, "How has the experience of MST impacted your ability to trust yourself and others?" or other general questions about trust (e.g., "What does it mean to trust?," "What does it take for you to trust someone (or yourself)?"). It is possible that some group members were struggling with trust before experiencing MST due to other premilitary trauma.
- B. **Discuss how changes in perceptions impact trust following MST.** There are two aspects to trusting relationships – how trustworthy the person is and how much we trust them. Experiencing MST may impact survivors' ability to trust others but may not impact how trustworthy the person is. So then what has changed? Often, survivors' perceptions of trust may have changed but not necessarily how trustworthy people in their lives are. When something bad happens to us, it's natural to question safety issues and try to determine how we can prevent it from happening again. That's a very adaptive quality. But sometimes we become overly protective.
- C. **Brainstorm pros and cons of not trusting at all vs. trusting too much.**
- D. **Summarize main points.** (1) Trust is on a continuum. Trust isn't all-or-none. It is on a continuum. We can trust someone 100%, just a little, or not at all. (2) Most trust lies

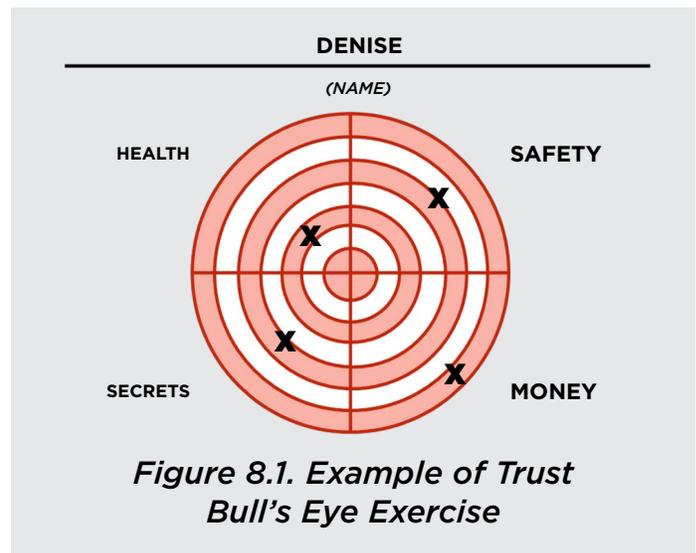
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somewhere in the middle. Trusting too much or too little is not the best idea. It is unusual to trust someone 100% with anything and everything. It's also unusual (and not helpful) to trust that the world will be 100% safe. Finding moderation is the key.

Trust Is a Moving Target

- A. Discuss differences in how we trust others.** It is not customary to trust one person with everything. We may trust our friend who is an accountant to give sound financial advice but wouldn't ask him or her to fix our car. Nor would we tell our car mechanic our deepest secrets.
- B. Introduce activity.** This exercise represents how much group members trust others and with what. To begin, group members will write down the names of two people they trust to some degree. For individuals who deny having anyone that they trust, you may point out that they likely trust others with more than they realize. For example, they trusted you enough to come to the group. Next, group members will mark an "x" in each quadrant to demonstrate how much they trust the person in the preselected areas of health, safety, secrets, and money. The more they trust the person in a certain area, the closer the "x" should be to the bull's eye. An example is provided in the patient workbook on page 41 (also see **Figure 8.1**). **Complete worksheet. Process reactions to the activity.**



Learning to Trust

- A. Acknowledge that building trust after MST is hard.** It may feel impossible to trust new people or give someone the benefit of the doubt. Trust is built like a brick wall - one brick at a time. In the beginning, the wall lacks structure and is not strong. But as time goes on and we keep adding bricks, we will have a solid brick wall that is firm. Sometimes people give us a reason to believe they are not trustworthy. This doesn't mean we have to stop building the wall completely, unless the integrity of the wall is jeopardized.
- B. Elicit group members' thoughts about what it will take for them to be more trusting in their relationships. Points to emphasize during the discussion:**

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TRUST

- **Start small.** Ask people to do simple tasks before harder ones; slowly share information about yourself.
- **Be fair.** Don't ask people to do impossible tasks.
- **Keep track.** Be mindful of how well people follow through on their commitments.
- **Don't give up so quickly.** Give people a real chance to earn your trust. Even baseball allows three strikes.

Closing Exercise - "What's Your Motto?"

- Set up.** None.
- Review instructions.** Part of learning to self-trust is keeping the promises we make to ourselves. Another part is not being too harsh when we break those promises. Showing ourselves kindness when we make a mistake or don't meet our goals can be motivating. It is not about "letting us off the hook" but recognizing that we are trying our best.
- Have group members share an encouraging phrase or life motto that can help them combat self-doubt** (e.g., "I am trusting myself not to be perfect," "Life is about the journey not the destination.")

Homework (Optional)

- Complete one additional "Trust Bull's Eye" worksheet (found in Additional Resources section of patient workbook and Appendix B in manual).
- Write down an encouraging phrase or life motto on a post-it note, and hang it in a visible place (e.g., bathroom mirror, refrigerator, bedroom door).

SESSION 8

SELF-ESTEEM

Session Goals

In this session, group members will:

- Discuss the relationship between the experience of MST and self-esteem
- Recognize the influence of self-criticism on self-esteem
- Learn new ways to boost self-esteem

Session Content

Setting the Agenda

- A. Introduce potential changes to self-esteem associated with experiencing MST.** Survivors may question their self-worth and integrity as a person. Self-worth may be undermined by self-criticism and self-blame. Survivors may fluctuate between feeling okay about themselves and feeling worthless.
- B. Review session objectives. The goals of this session are to understand the ways in which self-esteem has changed since the individual experienced MST and to learn self-compassionate techniques to enhance one's self-worth.**

Opening Exercise (optional) - "Pick a Number"

- A. Set up.** You will need blank sheets of paper and pencils/pens.
- B. Review instructions.** Ask group members to pick a number between one and five. Don't give any more direction than that. It doesn't matter which number they select or if someone else has already said the number. Next, have group members write down the number one and continue writing in numerical order until they reach the number they selected (e.g., four, three), each on a new line. For example, if someone picked four, they would write one to four on the sheet. Lastly, have group members write one positive quality about themselves next to each number. Positive qualities may include "I am trustworthy," "I am loyal," "I am a good cook," "I am handy," or "I am strong." Give group members a few minutes to write down their qualities.
- C. Have each group member share at least one of their positive qualities.** If someone can't come up with enough, you could have the group help him or her. But only allow this if there is time. This activity should not exceed 25-30 minutes.

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SELF-ESTEEM

D. Acknowledge any difficulty group members experienced trying to think of their positive qualities. Many of us have no problem sharing our flaws and faults, but we struggle with telling others about what we do well. If it is helpful, ask group members to share what others (e.g., romantic partners, children, parents, co-workers) say they like about them.

Who Are You?

A. Have group members write about who they perceive themselves as. Encourage them to describe who they are, not who they want to be or believe they should be. Their self-descriptions may include things they like or don't like about themselves, strengths and weaknesses, and personal values. This should take two to three minutes.

B. Next, ask group members where their self-image comes from. Potential discussion points:

- ***Offenders may send messages to control their victims.*** Survivors may have received messages from the offender implying that the sexual trauma was their fault. The offender might also make statements that cause survivors to feel powerless, worthless, and damaged. These are attempts to exert control over their victims.
- ***Victim-blaming is common after sexual trauma.*** Victim-blaming is when others feel the victim of a crime or wrongful act is responsible for the actions of the offender. Survivors of sexual trauma may be accused of inviting the act because of what they wore, how they behaved, or how they responded during the incident.
- ***MST can diminish one's military identity.*** While some Veterans may feel a sense of pride for serving in the military, survivors of MST may feel ashamed. They may try to conceal this aspect of their history or identity. Or they may have been performing well in the military prior to MST exposure and find that performing after MST was very hard.
- ***The experience of MST may become one's identity.*** Identities are ever-changing and defined by our social roles and personal characteristics. When individuals overidentify with a particular identity (e.g., victim, survivor), they limit how they see the world. They focus only on those aspects of a situation that fit with their chosen identity and ignore any contradictory evidence. For example, someone who identifies as a "victim" may pay more attention to situations in which he or she has been hurt by others to the exclusion of times when others treated him or her with respect and love. Our identity informs our behaviors and beliefs, such that our resulting actions may lead to a cycle of self-fulfilling prophecies. In the above example, it may be that the person is self-sabotaging relationships, which leads to being hurt by others.

SESSION 8

SELF-ESTEEM

Thanking Your Inner Critic

- A. Discuss the connection between self-esteem, self-criticism, and MST.** Survivors of MST may find that they are more critical of themselves after the experience. Maybe they blame themselves for what happened or believe negative messages that the offender(s) or others told them. High self-criticism influences lower self-esteem. One way to boost self-esteem is to confront our inner critic directly and with kindness.
- B. Review instructions.** Have group members answer the question, “What is your inner critic trying to help you do?” This question is intended to increase awareness about the purpose of having an inner critic. We don’t want to get rid of our inner critic. It has valuable feedback and keeps us motivated. However, we don’t have to listen so intently to everything it says. Next, have group members practice showing appreciation to their inner critic by acknowledging its efforts to help us – not intentionally harm us.

Closing Exercise – A Letter of Compassion

Note: You may consider adding diaphragmatic breathing or a grounding activity after this exercise if group members are still emotionally activated.

- A. Set up.** You will need pens/pencils and pages 47-49 of the patient workbook.
- B. Read the following instructions.**
- “The purpose of the following exercise is to help you discover your compassionate inner voice. We are not trying to make the inner critic go away. We’re simply making space for the compassionate voice and training our minds to listen to that part of ourselves. Everyone has something about themselves that they don’t like. This may be especially true after you experience sexual trauma. There may be things about yourself that cause you to feel ashamed, insecure, or not ‘good enough.’ Take a few minutes to describe an issue that has made you feel bad about yourself since you experienced MST.”
- C. Allow two to three minutes for group members to write a brief description of the issue.**
- D. Next, continue reading the instructions.**
- “Now, think about a person who is unconditionally loving, accepting, kind, and compassionate toward you. This could be a real person, like a significant other, relative, or good friend; or it could be an imagined person. Imagine that this person can see all your strengths and weaknesses. He or she loves you exactly as you are, including your flaws. He or she knows your life story and is kind and forgiving toward you.
- You’re going to write a letter to yourself from the perspective of this person. With unlimited compassion, what would this person say to you about your issue (or ‘flaw’)?

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The point of this letter is not to tell you what you should or shouldn't do. In other words, it's not about giving advice. Instead, this letter is about receiving support. Think about what words of kindness this person could use to give you the emotional support and encouragement needed to help you do your best?

If you have trouble finding the words, that's okay - it may take some time. You might try thinking about what you would say to a dear friend struggling with the same issue as you."

- E. Allow 5-10 minutes to write the letters.** As group members finish, have them read the letters silently without editing, letting the words sink in.
- F. Process reactions to the exercise.** Group members are not expected to disclose the content of their letters. Processing should focus on how it felt to give themselves support (e.g., felt selfish, good, scary).
- G. Encourage them to re-read their letters at home when they need support.**

Homework (Optional)

- Reread the "Letter of Compassion" every day for a week.
- Do at least one nice thing for oneself (without contingencies) every day for a week.

SESSION 9

RELATIONSHIPS AND INTIMACY

Session Goals

In this session, group members will:

- Identify how MST may affect relationships, both past and present
- Identify how MST may impact intimacy, including sexuality
- Learn how to gain more awareness and set appropriate boundaries in relationships

Session Content

Setting the Agenda

- A. Note how relationships and intimacy may change following sexual trauma.** Trust plays a significant role in relationships. MST violates survivors' trust, which can lead to questioning relationships. They might wonder "What if I get close to someone and they hurt me?" or "What if no one loves me?" The "What ifs" can scare people from taking risks, even if they are calculated risks. But we can't have meaningful relationships without some trust and risk-taking.
- B. Review session objectives. The goal of this session is to work toward restoring relationships and intimacy that were negatively impacted by MST.**

Opening Exercise (REQUIRED) - "Defining Intimacy"

- A. Set up.** None.
- B. Discuss what intimacy means.** Ask group members to give you one- to two--word descriptions of intimacy. By definition, intimacy is feeling close and connected to someone. We can share intimacy with family, friends, co-workers, and ourselves.

Healthy Intimacy

- A. Distinguish intimacy from sex.** Making the distinction between intimacy and sex is essential. It takes pressure off survivors who may find physical closeness threatening or confusing. Intimacy and sex are often assumed to be the same thing. Although they influence one another, they are not the exact same. Sex can be a direct cause or consequence of being intimate with a romantic partner. It is possible, however, to have an

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intimate relationship with someone else (or us) that doesn't involve sex. Additionally, one could have sex without emotional intimacy.

- B. Describe characteristics of healthy and less healthy intimacy.** Healthy intimacy is based on trust, love, and unconditional acceptance. There is a balance between giving what the other person needs and receiving what we need. Less healthy intimacy involves too much taking or giving, lack of trust, and conditional love (i.e., love is withheld until certain demands are met).
- C. Normalize that many survivors of sexual trauma struggle with getting close to others.** It's a way to protect oneself from getting hurt again.
- D. Discuss ways to express intimacy with: a friend, family and children, and partner or spouse.** Examples include spending quality time, calling or videochatting, traveling together, or participating in a shared activity.
- E. When discussing intimacy with a partner/spouse, take some time to describe the possible need to reclaim one's sexuality.** Sexual difficulties are common after MST. These difficulties can be psychological or physical. Physical challenges include loss of sexual drive, erectile dysfunction in men, and pelvic inflammation and chronic pain for women. Psychologically, survivors may alter their appearance to be less sexualized, for example, by becoming very thin or overweight. Or they may experience increased anxiety, discomfort, or re-experiencing symptoms when engaging in consensual sexual activity, especially when their partner or the sexual acts bear any resemblance to the original MST experience.
- F. Elicit suggestions for how to communicate discomfort during sexual encounters.** Group members should not underestimate the emotional impact of a sexual touch or request. Some suggestions include asking one's partner to slow down or stop, taking a break from sex, or finding other ways to express intimacy.

Setting Limits

- A. Ask about the importance of setting boundaries.** Boundaries are the physical (e.g., personal space, touch), emotional, or mental (e.g., values, thoughts, opinions) limits that we set with others that determine what we will and won't tolerate. In other words, boundaries represent the "rules" of engagement. Sexual trauma is a serious boundary violation, which impacts the survivor's ability to either set clear boundaries or enforce boundaries. Sometimes it is difficult not to give in to what others want. On the other side, having such rigid boundaries that keep one separate from others feels alienating, isolating, and lonely.

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- B. Discuss what makes a boundary healthy.** Healthy boundaries allow both parties to maintain their self-respect while getting more of their individual needs met. Relationships with less healthy boundaries are often unbalanced, with one person giving too much and the other taking too much, and one or both persons' needs being neglected. Healthy boundaries are like rubber bands. They are solid and complete with no obvious weaknesses; they "hold things together." They are also flexible and can withstand a challenge or be "stretched" if needed without breaking. When we struggle with boundaries, others may see that and take advantage of us. Or if we are too firm and rigid, others may avoid dealing with us altogether.
- C. Describe "traffic light" activity.** A natural second step with boundaries is assertiveness. Assertiveness requires that we define our boundaries to some degree. This exercise is designed to help with setting clear, healthy boundaries.
- 1. Ask group members to think about a specific person in their life with whom they have unhealthy boundaries.**
 - 2. Next, they will write:**
 - **Green light:** A behavior(s) they want that person to keep doing
 - **Yellow light:** A behavior(s) they want that person to do less
 - **Red light:** A behavior they want that person to stop
- D. Encourage group members to be specific about the behaviors that they want the other person to do (or not do). This makes it easier to communicate needs and set clear boundaries.**

Closing Exercise - How to Communicate Your Needs

- A. Set up.** You will need page 53 of the patient workbook. Divide into groups of two to three people. (You may also complete this activity as a large group.)
- B. Review instructions.** There are different aspects of an assertive response - what we say, how we say it, and our body language. In this exercise, group members will practice making a request using different words, tone, and body language.
- **Round 1 (words):** First, Partner A will say, "Do the dishes." Next, Partner A will say "Will you do the dishes?" Partner B will repeat the activity.
- C. Briefly process group members' reactions to Round 1.** Did they notice a difference? Which request would they be more likely to respond to?
- **Round 2 (tone):** Partner A will say "Did you do the dishes?" two to three times, emphasizing a different word with each repetition. For example, "Did you do the dishes?" vs. "Did you do the dishes?" Partner B repeats the activity.

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- D. Briefly process group members' reactions to Round 2.** Did they notice a difference? Which request would they be more likely to respond to?
- **Round 3 (body language):** Partner A will do a pose that expresses an emotion (e.g., anger, disappointment, joy) before saying “Did you do the dishes?” For example, Partner A may make an angry face and cross his or her arms before asking if Partner B did the dishes. The next time, Partner A may pose like he or she is disappointed. Partner A will repeat this two to three times before Partner B repeats the activity.
- E. Briefly process group members' reactions to Round 3.** Did they notice a difference? Which request would they be more likely to respond to?

Homework (Optional)

- Complete two additional “Boundary Setting” worksheets (found in Additional Resources section of patient workbook and Appendix B in manual).
- Review the “Communication Tips” handout (found in Additional Resources section of patient workbook and Appendix B in manual).

SESSION 10

BREAKING THE SILENCE

Session Goals

In this session, group members will:

- Evaluate the benefits and drawbacks of disclosing experiences of MST to others
- Create a plan for disclosing to someone they trust if they choose to do so
- Discuss how to manage unexpected reactions from others

Session Content

Setting the Agenda

- A. Explain that group members may have been pressured or coerced into keeping their experience of MST a secret.** Silence is one way that offenders may maintain control. Survivors may also choose to remain silent to avoid backlash, retaliation, stigma, judgment, or to avoid the possibility of impacting unit cohesion. There may be added pressure from the military culture or society to keep quiet or risk being ostracized. Even after leaving the military, survivors may not share their experience of MST for years. Telling others about it is NOT required for healing, but it can be empowering.
- B. Review session objectives. The goal of this session is to help group members explore the option of sharing their stories of MST with others.**

Note: It is important to emphasize throughout the session that disclosure is a “challenge by choice.” That is, group members have a CHOICE as to whether they disclose about their MST. Additionally, it may help to set appropriate boundaries and clear expectations before sharing.

Opening Exercise (optional) - “Two Truths and a Lie”

- A. Set up.** You may use blank sheets of paper and pencils/pens.
- B. Review instructions.** To start, give each group member one index card and a pen/pencil. Allow everyone a few minutes to write down two truths and one lie about themselves in any order. Group members can share whatever they feel comfortable with others knowing about themselves. It is helpful if they share things that others in the group do not know. The objective is to deceive others into making the wrong selection. To begin, one person shares his or her three statements while other group members try to guess which one is the lie. Repeat this step until everyone has gone.

SESSION 10

BREAKING THE SILENCE

- C. **Briefly process reactions to this exercise.** You may ask group members to notice how it felt to share intimate details about themselves with others (e.g., nervous, excited, vulnerable).

The Power of Sharing Your Story

- A. **Normalize that many survivors keep the experience of MST a secret for years, even decades.** To illustrate this point, you may ask group members to raise their hands if they waited at least a year to tell someone (anyone) what happened. This includes family, friends, restricted and unrestricted reporting, etc.
- B. **Encourage group members to share reasons they find it hard to tell others about their MST experiences.** Write responses on a whiteboard and put tally marks next to repeated responses. Examples are listed on the handout (e.g., “I didn’t want to seem weak,” or “I didn’t think anyone would believe me”).
- C. **Remind group members that experiencing sexual trauma in a military context adds a layer of complexity to disclosing.** For example, survivors may deny, ignore, or minimize that MST happened to them so as not to seem weak. At the time, survivors may have continued to live near, work with, and rely on their perpetrator for an indefinite period. This may make telling risky, especially if the offender threatened retaliation or has authoritative power. Some survivors may have had bad experiences with telling, such as they were punished, others didn’t believe them, they were judged harshly, or the offender received a “slap on the wrist.”
- D. **Elicit reasons why it could be helpful for group members to share their story.** How might it help enhance relationships with family and friends? How could it help medical and other healthcare clinicians in doing their jobs? How might other survivors feel?

How to Share Your Story

- A. **Emphasize the importance of feeling safe when disclosing about MST.** Telling someone for the first time can be anxiety-provoking. Planning a disclosure to the extent possible can be helpful.
- B. **Complete the planning activity on pages 56-57 of the patient workbook.** The activity reviews identifying appropriate people, thinking through the details of the disclosure, and evaluating potential outcomes of the disclosure.

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BREAKING THE SILENCE

C. Allow time for discussion after each section.

- **Identifying whom to tell.** Discuss different types of people to tell, such as family, friends, healthcare professionals, and employers. We mention employers/supervisors here as group members who work may feel pressure to explain any excused/unexcused absences or difficulties that interfere with their ability to work. **Remind group members that disclosing is a choice not an obligation.** Encourage group members to select one person to tell. If someone has difficulty identifying **one** person, he or she can still complete the remaining questions on page 57 of the patient workbook.
- **Planning how to tell.** Encourage group members to think about the best time and place to tell. What would they say? How would they want the person to respond? **Discuss the pros and cons of telling someone in-person.** It may be intimidating but telling someone in-person is beneficial. When we use other forms of communication like text message/email, social media, skype/facetime, or call, we can miss out on important social cues. Social cues (e.g., facial expressions, body posture, direction of gaze) tell us if the person is paying attention, if he or she seems confused or uncomfortable, etc. Other forms of communication may limit our access to this information and leave more room for misunderstanding. On the other hand, this may be the most comfortable or the only feasible way for survivors to disclose their experience while maintaining self-care.
- **Evaluating the potential outcomes.** It may be helpful for group members to consider their reasons for disclosing in the first place. That is, what do they hope comes from sharing? They may also think about potential reservations they have about telling their chosen person. This may help them prepare for how the individual might respond.

D. Summarize the major points of the planning process, which are:

- **Disclosing about MST is a choice, not an obligation.** Before disclosing, group members should consider their motivation for sharing and evaluate the potential consequences of doing so. Specifically, they can think about what they want from the other person after disclosing about their experience.
- **Choose wisely whom they tell if they make this choice.** It is best to select someone that group members deem as trustworthy. Evaluating the relationship beforehand can help with this decision. (*What happened before when I've shared personal information with this person? Does this person care and respect me? Does this person make me feel safe?*)
- **Pick a time and place to share.** Group members might not want to share that they have experienced MST to others without warning or context. This can feel overwhelming to the person receiving this news. Instead, they might ask the person

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BREAKING THE SILENCE

when a good time would be to discuss “something important.” Even if the person says “now,” group members can decide if they need more time to prepare. Whenever possible, they should select a location that feels comfortable and safe.

- **Practice what they want to say.** Levels of disclosure can vary from simply saying “I have experienced MST” to giving more details. No one is required (and it may not be advisable) to give too much detail. Rehearsing the disclosure may help group members to plan what they say and how they say it. It is more about delivering the message as intended vs. finding the “right words.” If it is helpful, they can write it out or say it aloud to themselves. They may even prepare for how they will respond to different reactions, such as a prolonged silence, an unexpected hug, or tears.
- **Say what they need.** Before disclosing, group members may verbally want to set clear expectations about what support they are looking for. Do they just want the person to listen? Are they expecting the information to be kept confidential? Would they be open to being physically comforted with a hug or hand on their shoulder? Can the person ask questions afterward?

What to Expect When You Share Your Story

- Discuss how the experience of sharing with a loved one may not feel the same as sharing with a therapist.** Therapists are trained to respond with compassion and respect. Loved ones, on the other hand, may not know how best to respond and may be impacted by their own emotions. Page 58 lists a range of potential reactions loved ones may have.
- Ask group members how they might respond to someone who reacts in these ways.**
- Acknowledge that survivors may not get the reaction that they want.** Although telling others about one’s sexual trauma can result in great relief, it can also feel like a mistake at times. Sharing this part of one’s personal history can be risky and may leave survivors feeling vulnerable. The other person may also react in a way that makes the survivor wish he or she had never told. When situations like this occur, survivors can be left feeling weak, confused, frustrated, and embarrassed. Furthermore, these encounters may reinforce unhelpful beliefs about trust (e.g., “No one can be trusted”) and self-esteem (“I always screw things up”) that have a considerable impact on other areas of functioning, such as relationships, work, and health.
- Present negative disclosure experiences as learning opportunities.** You may reference the opening quote on page 58 of the patient workbook (see **Figure 10.1**). It is important to acknowledge that unexpected outcomes happen and, when they do, there may be

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valuable lessons to learn. Page 58 of the patient workbook provides some questions that group members may ask themselves after a difficult disclosure to understand the situation better. Regardless of the outcome, encourage them to be courageous in sharing with someone else.

**WISDOM COMES FROM LEARNING.
LEARNING COMES FROM EXPERIENCE.
EXPERIENCE COMES FROM MISTAKES.**

Figure 10.1. Opening Quote for Session 10

Closing Exercise - “Pat on the Back”

- A. Set up.** You will need blank sheets of paper and pencils/pens.
- B. Review instructions.** Have group members write their names on the top of blank paper and then draw an outline of their hand. Next, have each person pass their paper to the person on the left. Have everyone write something positive about that person before passing the paper to the left again. This will continue until everyone has written something for each person.
- **Alternate instructions.** To start, pick one person from the group and ask other group members to say something positive. Continue this process until each person has had a chance to receive compliments. Encourage the receiver of the compliments to refrain from saying anything, or simply say “Thank you.” You may have the receiver write down the compliments to review later.

Homework (Optional)

- Re-read responses from the “Pat on the Back” exercise each day (if possible).

SESSION 11

SELF-FORGIVENESS

Session Goals

In this session, group members will:

- Define what forgiveness is and what it means to forgive oneself
- Learn how to apply the four phases of forgiveness to oneself
- Discuss ways to express self-forgiveness

Session Content

Setting the Agenda

- A. Explain that forgiveness is not “black-or-white” but rather a process.** Forgiveness is a choice that is more about the forgiver than the offender. It is about taking back power and control of one’s life. It is also about letting go of the strong emotions (like anger and shame) that have hindered one from moving forward. Survivors are not required to forgive their offender(s) to heal, but it may be worthwhile to grant themselves mercy for holding onto the pain, guilt, and shame of their past.
- B. Review session objectives. The goals of this session are to learn more about forgiveness as a process and how to extend it to one’s self.**

Opening Exercise (optional) - “The Miracle Question”

- A. Set up.** You will need blank sheets of paper and pencils/pens.
- B. Review instructions.** Before starting the activity, let group members know that what they write down will not be shared with the group. Ask group members to write down something painful that they have been holding onto for a while. Have them crumple up the paper and hold it in one hand. Next say, “If you had a chance to let go of what is in your hand and never feel that pain again, would you?” Likely group members will answer “yes.” For group members who say “no” or who are unsure, you may gently ask their reasons for continuing to hold onto that pain – What purpose does that serve? (If possible) Have group members toss the paper in the trash and say, “Now it’s gone. You’ve gotten rid of the pain. What are you going to do with yourself now?” **This exercise is intended to help group members identify important values or behaviors to strive toward as they continue through the healing process.**

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SELF-FORGIVENESS

What is Forgiveness?

- A. Discuss what forgiveness means.** Some group members may hold a simplistic view of forgiveness as a “black-or-white” concept. Others may feel obligated to forgive due to personal, cultural, and spiritual beliefs. When people feel forced to forgive, they may harbor greater feelings of resentment or be disingenuous about forgiving the wrongdoer. Some may see it as a choice. There are no right or wrong answers. This is an opportunity for group members to explore their feelings toward the idea of forgiveness.
- B. Review forgiveness as defined by Richard Enright (2001).** Main points are:
- Forgiveness is **not**:
 - » ***Forgetting what happened.*** The saying “forgive and forget” is misleading. Forgiveness doesn’t undo what happened. It also doesn’t mean that we need to deny or suppress how we feel about the offense (in this case, MST). Part of working through forgiveness is acknowledging that an injustice occurred. Without this recognition, emotional change cannot take place.
 - » ***Excusing what the offender did.*** Forgiveness is not saying that what the offender(s) did was okay. No one deserves for MST to happen to them.
 - » ***Wishing or seeking revenge.*** Revenge-seeking or fantasies of retaliation against offenders are common after MST. This is especially true for men who have experienced MST. But forgiveness is not about getting even. It is about mercy.
 - Forgiveness **is**:
 - » ***Deciding to overcome the pain caused by the offender(s).*** It takes courage to confront the emotional pain inflicted by someone else. Forgiveness begins with honoring those feelings of anger, resentment, and anything else that shows up as we come to terms with past wrongs.
 - » ***Letting go of anger, resentment, shame, and other strong emotions.*** We have a right to these feelings after we have been wronged. There comes a point, however, when holding onto them is harmful to us. When this happens, it is best to find effective ways to release our emotional pain.
 - » ***Giving compassion, whether or not it has been earned.*** We don’t have to forgive those individuals who have wronged us. But if we do, it is because we **want to, regardless** of whether they have earned it.
- C. Discuss what self-forgiveness is and why it may be needed.** Enright (2015; 2001) describes self-forgiveness as trying to love yourself after not treating yourself very

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SELF-FORGIVENESS

well. One reason why this session focuses on self-forgiveness (as opposed to forgiving the offender) is that some group members may still be struggling with feelings of self-blame or shame for things they did (or didn't do) in response to MST. Building on earlier sessions, the purpose of this session is to help group members learn how to release their anger, resentment, hurt, shame, and self-blame and strive toward living a more meaningful life.

Note. For group members who may be interested in learning how to forgive their offenders, you may recommend Enright's (2001) *Forgiveness is a Choice* or his 2015 book entitled, *8 Keys to Forgiveness* (full citation can be found in reference section).

How to Forgive Yourself

A. Review Enright's (2001) four phases of forgiveness (found on pages 61-64 of the patient workbook). The worksheet contains questions and commentary to further group members' understanding of each phase as it applies to them. Below, **Table 11.1** provides an overview of the phases that you may reference during the activity and discussion.

Table 11.1. Detailed Description of the Four Phases of Forgiveness Applied to the Self

FORGIVENESS PHASE	DETAILED DESCRIPTION
Uncovering Phase	The focus is on understanding the offense (in this case MST) and how it has impacted one's life. The emotional toll of an offense is fully recognized. Feelings of anger, hatred, and resentment typically surface as individuals consider all the ways in which the injustice has impacted their lives. Confronting these emotions opens space for healing to begin. Increased emotional distress is a common outcome.
Decision Phase	The focus shifts from anger to motivation to move forward. Individuals work on developing a deeper understanding of forgiveness while entertaining the idea of forgiving oneself (or the offender). Thoughts of revenge or retaliation have lessened.
Work Phase	Active attempts are made to forgive oneself (or the offender). The work may include paying greater attention to the influence of one's personal history or the context in which the offense occurred. Broadening one's self-perception (or views of the offender) may lead to feelings of understanding, compassion, or empathy that replace anger and resentment.
Deepening Phase	Emotional relief is a hallmark of this phase. Individuals may find a new purpose in life or recognize their personal growth, which may cause them to feel less burdened by the offense. They discover the healing powers behind showing mercy and compassion to themselves (and possibly their offenders).

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SELF-FORGIVENESS

- B. The activity ends with discussing ways to express self-forgiveness.** This may be in the form of better self-care or expressions of self-compassion. If it is easier, group members may think of strategies they have used to show forgiveness to loved ones or friends.

Closing Exercise - “Loving-Kindness Meditation”

- A. Briefly introduce the loving-kindness meditation.** Anger cannot co-exist with kindness and compassion. The loving-kindness meditation is a great exercise for increasing feelings of compassion for oneself and can be adapted to extend compassion toward the offender(s) (if group members are interested in doing so).
- B. Read the following script at a slow, steady pace.**

“To begin this practice, let yourself be in a relaxed and comfortable position. Sit with your feet flat on the floor and your spine straight. Close your eyes and take a few deep breaths (pause). Breathe in (pause). And breathe out (pause). Again, breathe in (pause). And breathe out. Relax your whole body (long pause).

Now, check into your body and notice how you are feeling right now. Try to let whatever is here be here (pause). Breathe in (pause). And breathe out (pause).

Keeping your eyes closed, start thinking about someone close to you who loves you very much. It could be a family member, a close friend, a child, even a pet (pause). Pick someone that it is easy to feel love for. Let the person come to mind (pause). Have a sense of him or her being in front of you (pause). As you imagine the person, notice how you’re feeling inside. Maybe you feel some warmth, or there’s some heat to your face, a smile, a sense of happiness (long pause).

Next, imagine the person wishing you well, saying:

I wish all the happiness to you (pause).

I wish that you are safe and protected from danger (pause).

I wish that you never have to suffer (pause).

I wish that you are always loved (pause).

As you receive these words, let them sink in (pause). Next, check in with yourself and see how you’re feeling inside (long pause).

Now let this loving kindness expand out – spreading, touching anyone you want to touch right now, in all directions (pause). This may include the people in the room,

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SELF-FORGIVENESS

other people you know or don't know, people who have hurt you. Just imagine expanding and touching (pause). If you want, you can silently repeat:

May everyone be happy, peaceful, and at ease.

May we all experience great joy and feel loved.

Take a few more deep breaths (long pause). And when you are ready, gently open your eyes.”

Homework (Optional)

- Re-read the “How to Forgive Yourself” worksheet at least once.
- Practice “Loving Kindness Meditation” two to three times a week.

SESSION 12

MOVING FORWARD

Session Goals

In this session, group members will:

- Celebrate treatment progress
- Participate in end-of-treatment planning
- Receive additional information about local and national resources

Session Content

Setting the Agenda

- A. Congratulate group members on reaching the final session.** Group members will reflect on what, if any, progress they have made during treatment. In preparation for this session, you may ask group members beforehand how they would like to celebrate (e.g., with light refreshments, having a formal ceremony).
- B. Review session objectives. The goals of this session are to process what group members' have learned and discuss where they go from here.**

Opening Exercise (optional) - "The M&M Game"

- A. Set up.** You will need a small bag of M&Ms. (You can substitute M&Ms for colored paper. You will need at least five different colors represented.) To begin, have group members sit in a circle (if possible). Print copies of the handout "The M&M Game Key" in Appendix A (or write on the board) what each color represents:
- For every **Red** M&M, say what your *biggest accomplishment has been*.
 - For every **Blue** M&M, name *three important skills you've learned*.
 - For every **Green** M&M, tell the group *one important thing you've learned*.
 - For every **Orange** M&M, finish the sentence "*When I think about the person I am today, I am ...*"
 - For every **Brown** M&M, say *what was meaningful* about this group experience.
- B. Review instructions.** Ask each group member to select at least one M&M (or colored piece of paper). Next, have each group member answer the question that corresponds with the color of their M&M (or paper), using the game key. For example, if a group

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MOVING FORWARD

member picks a **Red** M&M, he or she will tell the group what his or her biggest accomplishment was. **All answers should reflect treatment progress since participating in the group.** You may repeat this process two to three times as long as you do not exceed 20-25 minutes.

- **Alternate instructions.** You may ask group members to answer a select number of questions or to answer all questions as long as the exercise does not exceed 20-25 minutes.

Planning for Your Future

- A. Explain SMART goals.** You will use the SMART framework to help group members effectively develop an end-of-treatment recovery plan (on page 66 of the patient workbook; also in the appendix). **SMART** is an acronym that describes five steps to setting realistic, achievable goals:
- ***The S is for Specific*** – goals should be specific and not vague. “I want to start running” is too broad, while “I want to run a half marathon” is more specific.
 - ***The M is for Measurable*** – goals should have a clear endpoint or milestones that can be assessed. An example would be “I will run for 30 minutes each day.”
 - ***The A is for Achievable*** – goals should be something that can be reasonably accomplished within a certain timeframe. “I will run a half marathon in two weeks” is not very realistic for someone who has no prior long-distance running experience or training. In this case, “I will run a half marathon in four months” may be more realistic.
 - ***The R is for Relevant*** – goals should align with personal values. A person may choose to run to be healthier, get in shape, or feel good about himself/herself.
 - ***The T is for Time-bound*** – goals should have a deadline. Deadlines help motivate us and prioritize what is important. For example, “I want to run a half marathon by June 1st.”
- B. Normalize setbacks as a normal part of the healing process.** Life is full of stressors and surprises that can cause us to slip back into old habits (e.g., avoidant behaviors, isolation, lack of self-care). This happens because treatment doesn’t replace or erase old learned habits – it competes with them. Setbacks are not inherently problematic. **They are a warning that we may need to reinstate or step up with implementing their recovery plan.** Setbacks can happen gradually or suddenly. They feel like we are back to where we started. We feel like failures and may want to give up, none of which is true.

APPENDIX A

SUPPLEMENTAL READINGS AND ONLINE RESOURCES

Supplemental/Recommended Readings for Clinicians:

Bass, E. & Davis, L. *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse, Fourth Edition*. New York (NY): Collins Living.

Katz, L. S. (2016). *Treating Military Sexual Trauma*. New York (NY): Springer Publishing Company, LLC.

Zaleski, K. (2018). *Understanding and Treating Military Sexual Trauma* (2nd Ed.). In Focus on Sexuality Research Series (H. Hoffman, Series Editor). Cham, Switzerland: Springer International Publishing.

Publically Available Online Resources on MST

VA National MST Website includes information about MST, eligibility, treatment, and other resources. Visit www.mentalhealth.va.gov/mentalhealth/msthome/index.asp.

MakeTheConnection.net is a website that shares the stories of Veterans who have overcome mental health challenges, including those related to MST. Visit www.maketheconnection.net.

VHA Sharepoint Resources on MST

(*must be logged onto the VHA network to access the following information)

MST Resource Homepage includes a variety of educational information for clinicians and patients, free trainings and webinars, and a free consultation program for VHA clinicians. Visit vaww.mst.va.gov. You may find the following sections helpful:

- **Overview of MST** provides educational materials broad MST topics, such as what is MST, how common is it, and basic details about VA policies and services. Materials are intended for mental health clinicians, administrators and support staff, medical professionals, and trainees (<https://dvagov.sharepoint.com/sites/VHAMST/resources/overview-of-mst>).

APPENDIX A

SUPPLEMENTAL READINGS AND ONLINE RESOURCES

- **Clinical Issues and Treatment** includes reference material on issues and approaches to MST screening and clinical care for MST survivors (<https://dvagov.sharepoint.com/sites/VHAMST/resources/clinical-issues-and-treatment>).
- **MST Consultation Program** is free one-on-one consultation to assist VHA clinicians who are working with Veterans who have experienced MST. Speak directly with experts by contacting MSTconsult@va.gov or calling 866-948-7880.
- **MST Teleconference Training Series** is a series of bimonthly training calls hosted by the MST Support Team for any VHA staff interested in learning more about MST-related issues (<https://dvagov.sharepoint.com/sites/VHAMST/training/teleconference-training-series>).
- **Survivors' Voices: What Racial and Ethnic Minority Military Sexual Trauma (MST) Survivors Want Mental Health Providers to Know** is a handout addressing clinical considerations for working with Veterans from different racial/ethnic backgrounds (https://dvagov.sharepoint.com/sites/VHAMST/Resources/Survivors%27%20Voices%20-%20What%20Racial%20and%20Ethnic%20Minority%20MST%20Survivors%20Want%20Mental%20Health%20Providers%20to%20Know/Survivors%20Voices_online%20viewing.pdf).

APPENDIX B

MATERIALS FOR OPENING AND CLOSING EXERCISES

Welcome to the Courage Group

Group Guidelines and Expectations

- What is said in group stays in group.
- We will respect each other.
- Group will begin and end on time.
- Participation is encouraged but not required.
- No threatening or abusive language will be used.
- No smoking, drinking, or drug use should occur before or during group time.
- Sharing details about specific MST experiences is not expected or required.

I acknowledge these guidelines and expectations.

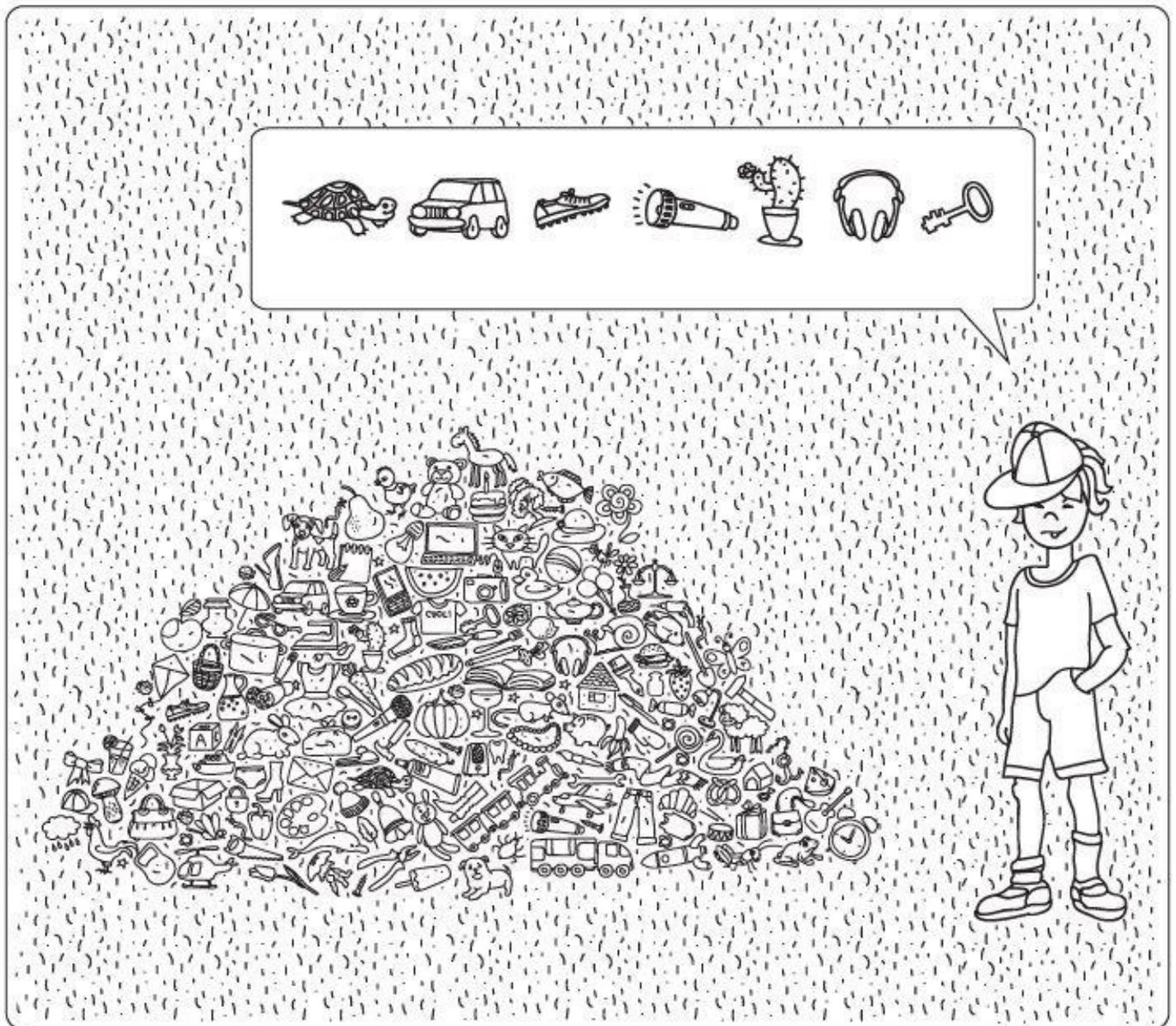
(Print and Sign)

(Date)

APPENDIX B

MATERIALS FOR OPENING AND CLOSING EXERCISES

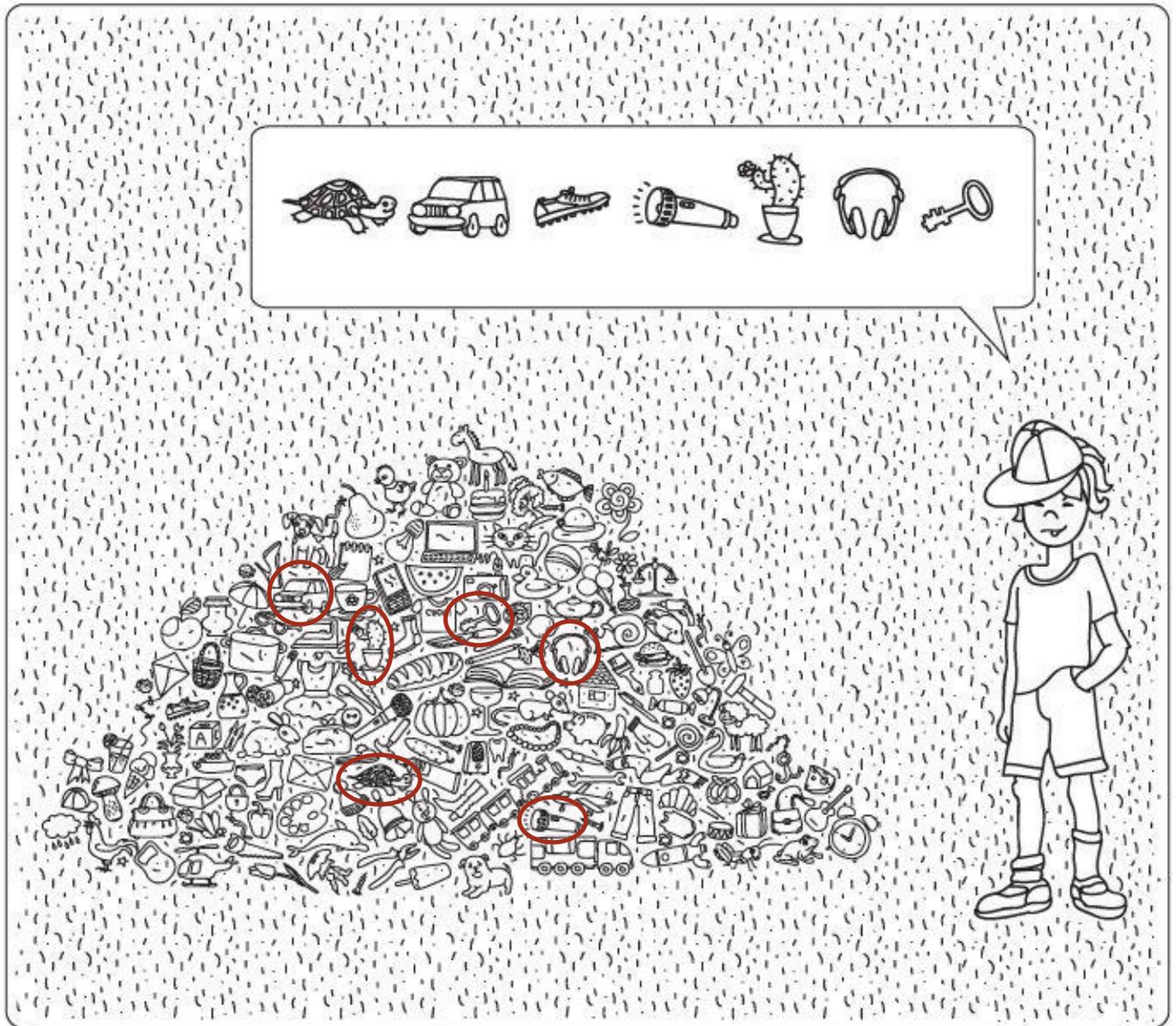
Hidden Objects Card



APPENDIX B

MATERIALS FOR OPENING AND CLOSING EXERCISES

Answer Key to Hidden Objects



APPENDIX B

MATERIALS FOR OPENING AND CLOSING EXERCISES

The M&M Game Key

Instructions: This exercise presents a fun way to discuss treatment progress and skills learned throughout treatment. To play, you will need a bag of M&Ms (or colored paper).

- For every **Red** M&M, say what your biggest accomplishment has been.
- For every **Blue** M&M, name three important skills you've learned.
- For every **Green** M&M, tell the group one important thing you've learned.
- For every **Orange** M&M, finish the sentence “When I think about the person I am today, I am ...”
- For every **Brown** M&M, say what was meaningful about this group experience.



APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Session Selection Worksheet

✓ Check all that apply	Brief Description of Additional Sessions
	Surviving Military Sexual Trauma: This session focuses on recognizing inner strengths that have helped you cope with the impact of MST.
	Grief and Loss: This session involves developing a deeper understanding of grief as it relates to losses related to MST. You will also discuss ways to honor what was taken from you, destroyed, or never was because of MST.
	Anger: This session reviews skills for recognizing when anger is becoming destructive and managing it effectively.
	Trust: This session explores strategies for rebuilding trust in yourself and others after experiencing MST.
	Self-esteem: This session reviews techniques to enhance your sense of self-worth.
	Relationships and Intimacy: This session focuses on increasing your ability to connect with others. In this session, you also learn how to set clear, firm boundaries.
	Breaking the Silence: This session provides strategies for sharing your story of MST if and when you are ready.
	Self-forgiveness: This session teaches you how to release anger, shame, or self-blame about your past.

APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Honoring What Was Lost

ACTIVITY PLANNING WORKSHEET

Instructions: Review the “Honoring What You Lost” worksheet and select one activity listed. You may also think of a new activity to honor what was taken away, destroyed, or never was because of MST.

Activity I want to do: _____

Be specific:

1. What will I do?
2. Who will be involved?
3. When will I do this (day, time)?
4. Where will I do this (location)?
5. How often will I do this?

Challenges: What might get in the way of completing the activity?

Solutions: How might I overcome these challenges?

What Happened: Did I complete the activity? What went well? What surprises or challenges came up? What can I do differently next time?

APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Changing Your Emotional Experience Worksheet

SITUATION	HOW I FELT	WHAT I THOUGHT	WHAT I DID	DID IT WORK?	WHAT ELSE CAN I DO?

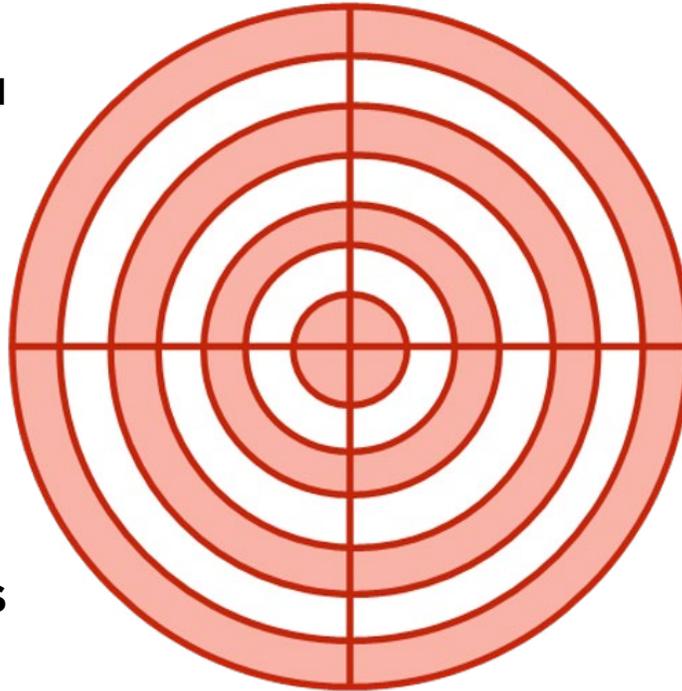
APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

(NAME)

HEALTH

SAFETY



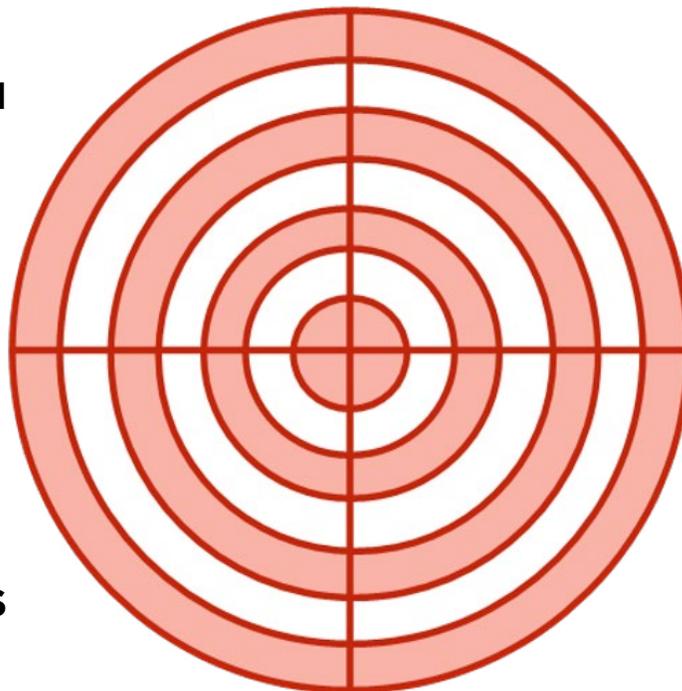
SECRETS

MONEY

(NAME)

HEALTH

SAFETY



SECRETS

MONEY

APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Boundary Setting

Think of someone with whom you have less healthy boundaries. For each light, you will write a behavior that you want him or her to (be specific):

**KEEP
DOING**

DO LESS

**STOP
DOING**

Now share these boundaries with the person and work toward keeping them in place.

APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Communication Strategies

Communication Tip #1: When asking someone else for something, ...

- **Appear confident.** Your body language, tone, and words make a difference in how someone hears you.
- **Be clear.** Use clear, short statements about what you need or want the other person to do.
- **Use “I” statements.** Saying “I” communicates directly what you need and want.
- **Make it a “win-win” situation, if possible.** People are more willing to meet your needs when they also get something in return.



APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Communication Strategies

Communication Tip #2: When someone challenges you, ...

- **Be a broken record.** Restate what you said again (and again and again if needed).
- **Negotiate.** Ask for other solutions or make some changes to your request.



Communication Tip #3: When someone asks you for something, ...

- **It's okay to say "no."** Giving too much in a relationship can make you unhappy.
- **Don't be afraid to say "yes."** You may need to break the habit of saying "no" when a relationship is important to you.
- **Say "Let me think about it" if unsure.** Take time to ensure you're making the best decision for you and the relationship.

APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Your Wellness Plan

What are your goals moving forward?

What steps and skills can you use to meet your goals?

What obstacles might get in your way and how can you address them?

Who can help you move forward with this plan?

APPENDIX C

PATIENT HANDOUTS AND WORKSHEETS

Exit Survey

Instructions: Please answer the following questions about how well you think the Courage Group went for you.

1. Overall, how much did you like attending the Courage Group.

Not at all	A little	A moderate amount	A lot	A great deal
1	2	3	4	5

2. How helpful did you think this group was in helping you learn useful skills for managing MST-related issues?

Not at all helpful	Not so helpful	Somewhat helpful	Very helpful	Extremely helpful
1	2	3	4	5

3. How likely are you to recommend this group to other Veterans?

Not at all likely	Not so likely	Somewhat likely	Very likely	Extremely likely
1	2	3	4	5

4. What did you like most about the group?

5. What do you feel could be done better or differently?

6. Other comments:

CERTIFICATE *Of* PARTICIPATION

is thanked for their effort, support and participation in the

COURAGE GROUP



Presented by

On this day



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