



The association between military sexual stress and psychiatric symptoms after controlling for other stressors

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ABSTRACT

Objective: Several researchers have identified associations between exposure to occupational sexual stressors (e.g., sexual harassment) and severer psychiatric symptoms in military personnel. However, few controlled for participants' exposures to other high-magnitude stressors, which could have confounded results. We examined the unique association between military sexual stress and severity of participants' psychiatric symptoms after controlling for their other high-magnitude stressor experiences. Organizational- and individual-level predictors of military sexual stress were also assessed.

Method: We surveyed by mail all active duty troops registered in the Department of Veterans Affairs' Enrollment Database (2001–2003). The questionnaire contained well-validated measures.

Results: Eighty-four percent responded (total sample $N = 611$); of these 56% reported at least one sexual stressor exposure. A highly significant association between military sexual stress and psychiatric symptoms attenuated by two thirds and lost statistical significance once other stressor experiences were controlled. Besides sociodemographics, the strongest correlates of military sexual stress were working in an environment perceived to tolerate sexual harassment, reporting severer childhood maltreatment, and reporting more high-magnitude stressors. A gender-stratified analysis generated similar findings for men and women. **Conclusions:** Little unique variance in psychiatric symptom reporting was explained by military sexual stressor exposure after controlling for other stressors. Childhood maltreatment and other high-magnitude stressors acted as risk factors for and confounders of military sexual stress. Understanding how and why these stressors inter-relate could lead to better, more effective interventions to reduce them all—and their sequelae. Findings also highlight the need to routinely include men in sexual stress research.

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More than 1.5 million United States citizens currently serve in the Armed Forces. These troops are exposed to many occupational hazards besides combat. For example, in a one- to two-year period, 74–80% of active duty men and women have reported sexually harassing experiences (Bastian et al., 1996; Rosen and Martin, 1998; Wolfe et al., 1998) and approximately 1–8%, sexual assault (Bastian et al., 1996; Lipari et al., 2008; Martin et al., 1998). Complications of military sexual stress are thought to be noteworthy health concerns, particularly for female service members (Murdoch et al., 2006a,b).

For example, well-described psychiatric consequences of sexual assault include increased odds of posttraumatic stress disorder (PTSD), depression, substance abuse, and suicide attempts (Cortina and Kubiak, 2006; Davis and Wood, 1998; Ullman, 2004). Additional to acute injuries, longer-term physical complications include heightened breast cancer risk and increased odds of reporting heart attacks, obesity, or asthma (Frayne et al., 1999; Stein and Barrett-Connor, 2000). Sexual harassment, another military sexual stressor, has also been associated with greater odds of reporting depression, anxiety, and PTSD (Kang et al., 2005; Murdoch et al., 2006a,b). Although men are rarely included in studies of military sexual stress, available findings suggest that they report adverse effects similar to women's (Street et al., 2007; Vogt et al., 2005).

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Many sequelae attributed to military sexual stressors have also been associated with other high-magnitude stressors, such as childhood abuse and combat, which are likewise common in military samples. Yet, few investigators have comprehensively controlled for such stressors when examining associations between military sexual stress and psychiatric disorders (Fitzgerald et al., 1999; Harned et al., 2002; Street et al., 2008). Particularly concerning is the frequent omission of childhood maltreatment, since it is both a risk factor for reporting military sexual stress and a risk factor for depression, anxiety, and PTSD (Moffitt et al., 2007; Rosen and Martin, 1998). Thus, childhood maltreatment and other stressors could confound observed associations between military sexual stress and psychiatric outcomes, mediate associations, or carry additive effects (Green et al., 2000). Failing to adequately control for such experiences could cause investigators to over- or under-estimate sexual stress' influence on psychiatric symptoms—possibly substantially so.

In the present paper, we extend a previous analysis (Murdoch et al., 2007) to examine the unique contribution of military sexual stress on psychiatric symptoms after controlling for other high-magnitude stressor experiences, such as prior childhood maltreatment and combat exposure. We hypothesized that, while there would likely be high co-occurrence across different stressor experiences (Murdoch et al., 2006a,b; Nishith et al., 2000; Polusny and Follette, 1995; Rosen and Martin, 1998; Sadler et al., 2003; Sadler et al., 2004; Wolfe et al., 1998), military sexual stress, childhood maltreatment, combat, and other high-magnitude stressor experiences would nonetheless each have unique, additive effects on psychiatric symptom reporting. Given well-described associations between cumulative sexual trauma and psychiatric outcomes (Follette et al., 1996), we also explore whether associations between military sexual stress and psychiatric symptom-reporting differed according to participants' childhood history of sexual abuse. We anticipated any associations between military sexual stress and psychiatric symptom-reporting would be stronger in troops with a history of childhood sexual abuse compared to those without such history.

These research questions are set within a larger analytical framework examining potential risk and protective factors for military sexual stress. Sexual stressors are an avoidable occupational hazard, and eradicating them would obviously eliminate any downstream, negative sequelae. Identifying opportunities for intervention is thus an independently important enterprise. Furthermore, several posited risk factors for military sexual stress have been shown to directly affect psychiatric symptom reporting. For example, workplace tolerance of sexual harassment has been associated with greater psychological distress, even among employees not personally targeted for harassment (Fitzgerald et al., 1997; Glomb et al., 1997).

From prior models of occupational sexual stress, we hypothesized that military sexual stress would occur as a function of organizational characteristics and individual factors. In terms of organizational factors, we hypothesized that working in a unit where local social norms conveyed tolerance of sexual harassment, working with more men than women, having a male supervisor, and being a job “gender-pioneer” (the first of one's sex in an occupation) would each be associated with higher odds of reporting military sexual stress (Fitzgerald et al., 1997; Gutek and Morasch, 1982; Pryor et al., 1993; Tangri et al., 1982). We also anticipated that harassment-tolerant norms would have direct, increased effects on psychiatric symptom reporting, while working in a generally professional, supportive, and caring environment would be related to lower odds of reporting sexual stress and to reporting fewer psychiatric symptoms (Rosen and Martin, 1997). In terms of individual factors, we anticipated that sociodemographic characteristics often associated with lower

organizational power, such as younger age, female gender, minority race/ethnicity, unmarried status, lower education, and lower rank or fewer years in the service, would be related to higher odds of reporting military sexual stress (Tangri et al., 1982). Sociodemographic characteristics were also posited to have direct effects on psychiatric symptom reporting. Because sexual stress has been so rarely studied in men, a secondary goal was to evaluate whether findings differed by gender.

1. Materials and methods

1.1. Sample and design

The Department of Veterans Affairs (VA) Enrollment Database is a national administrative database that tracks all individuals who apply for VA health care benefits, regardless of whether they actually take advantage of those benefits. The VA's national Outpatient Clinic Files (OPC) compiles all outpatient visits made by all individuals to any VA medical facility within fiscal years. All 681 persons confirmed as active duty in one or both of these databases between January 1998 and June 2002 who indicated willingness to complete a mailed survey were mailed a 22-page questionnaire, \$20 incentive, and cover letter between December 2001 and February 2003. Fifty-one other confirmed active duty persons refused participation. The cover letter described the study's risk and benefits and emphasized the confidential and voluntary nature of participation; return of the survey indicated subjects' consent to participate. We used follow-up mailings to maximize response rate, which was 84% ($n = 570$). An earlier pilot study yielded 41 more surveys, for a total of 611. The Minneapolis Veterans Affairs Medical Center's Human Studies Subcommittee approved the study's protocol.

1.2. Measures

1.2.1. Psychiatric symptoms

Using structural equation modeling, respondents' psychiatric symptoms were modeled as a single latent variable underlying troops' symptoms of PTSD, depression, anxiety, and somatization. PTSD symptom severity was assessed using the Penn Inventory for Post-traumatic Stress Disorder (Hammarberg, 1992); scores of 35 or higher identify PTSD in military veterans with approximately 93% accuracy ($\alpha = 0.91$). Depression was measured using the 5-item RAND Mental Health Battery (Berwick et al., 1991); scores of 17 or more have 48% sensitivity for major depression, but almost 95% specificity ($\alpha = 0.80$). Anxiety and somatic concerns were assessed using the 3-item and 16-item PRIME-MD screeners (Spitzer et al., 1994), respectively. These have 94% sensitivity and 53% specificity for any anxiety disorder ($\alpha = 0.63$) and 100% sensitivity and 37% specificity for somatization disorder ($\alpha = 0.83$). For all psychiatric measures, higher scores indicate severer symptoms.

1.2.2. Military sexual stress

Military sexual stress was conceptualized to include three related, but distinct stressor types: sexual harassment, sexual assault, and sexual identity challenges. Sexual identity challenges, in particular, have never been systematically assessed in a military sample, yet would likely be highly salient to them (DuBois et al., 1998; Magley et al., 1999). These behaviors challenge service members' sexual orientation while establishing and reinforcing hypermasculinized, heterosexist ideals. Originally described in men and thought to be more upsetting to them than sexual harassment per se (Stockdale et al., 1999; Waldo et al., 1998), they are also common in women (Murdoch et al., 2007).

The Sexual Harassment Inventory (Murdoch and McGovern, 1998) assessed respondents' sexual harassment and sexual assault

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