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Innovation: The Use of Yoga and Meditation in Healing PTSD associated with Sexual Assault and Sexual Harassment

Executive Summary:

Sexual assault in the military has garnered widespread attention over the last two decades. Reports of sexual assault by active duty service members, students at military service academies and veterans have continued to increase, and the program for prevention and response has grown in proportion to the need. Most recently, the Marines United Facebook scandal and the #MeToo international movement has brought the discussion from a whisper to a mainstream debate on the world stage. What is not open to debate is the devastating impact that sexual assault and sexual harassment have on the mission readiness of our force. The energetic and financial resources that are expended after a sexual assault is reported in the military are enormous. Many of its victims never fully recover and represent an unnecessary and unplanned loss of human capital that often never fully reintegrates back into society. As leaders we must be willing to think outside the box and explore any options that can contribute to restoring our service men and women to a “mission ready status”.

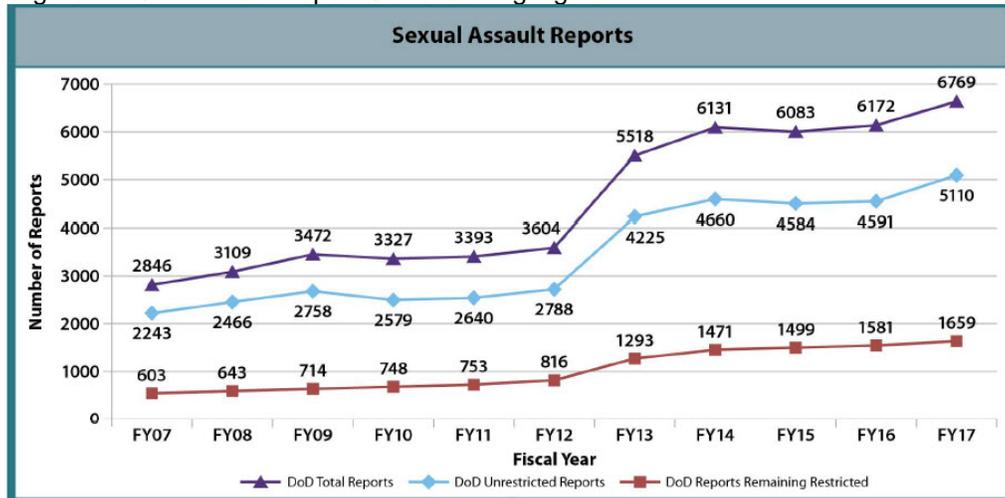
“While casualties on the battlefield are understood to be consistent with our military duties, I accept no casualties due to sexual assault within our ranks.” – US Defense Secretary Jim Mattis

Introduction

Section 1631 of the National Defense Authorization Act for Fiscal Year (FY) 2011 mandates an annual report detailing sexual assaults for members in all the Military Departments. In FY17 the Military Services received 6,769 reports of sexual assault involving service members as either victims or subjects in FY17, representing a **9.7 percent increase** over the previous fiscal year. Of the 5,864 Service member victims, 10 percent made a report for incidents that occurred prior to them entering military service. With sexual assault universally recognized as a significantly underreported crime, this higher proportion of reporting is a potential indicator that victims continue to gain confidence in the sexual assault prevention and response and military justice systems, especially when increased reporting is paired with decreased sexual assault prevalence (occurrence). Since FY12, sexual assault reporting has increased by over 88 percent within the Department, while its prevalence has decreased by almost 45 percent for the same period. FY17 also saw a three percent increase over the previous year of reports that converted from restricted to unrestricted (Department of Defense, 2018). These numbers imply an increased victim trust in the system - certainly a good news story - but that trust implies an increased responsibility to respond as leaders and resource providers with the most effective tools available to mitigate the very real effects of Post-Traumatic Stress Disorder (PTSD) associated with sexual assault and prolonged exposure to sexual harassment. In August 2017 the DoD released clarifying guidance to Military Discharge Review Boards and Boards for Correction of Military/Naval records that were considering requests by veterans to modify their discharge characterization of service due to mental health conditions (including PTSD),

Traumatic Brain Injury (TBI); Sexual Assault or Sexual Harassment. The memorandum recognized that these conditions and experiences “impact veterans in many intimate ways that are often undiagnosed or diagnosed years afterwards, and are frequently underreported.” This represents a dramatic step in addressing lawmaker concerns that many veterans were discharged without benefits due to conduct issues stemming from undiagnosed brain injuries, military sexual trauma (MST) or recurring PTSD. The VA officials estimate as many as 300,000 veterans nationwide may have been improperly dismissed from the service, leaving them more vulnerable to depression and suicide because of a lack of veterans’ health services. (Shane, 2018)

Figure 1: 2017 Annual Report Statistical Highlights



(Department of Defense, 2018)

Military Sexual Trauma (MST) Definition and Prevalence

Military sexual trauma (MST) is the term used by the Veterans Administration (VA) to refer to experiences of sexual assault or repeated, threatening sexual harassment experienced during a veteran’s military service. MST is an experience not a diagnosis, and as such treatment needs will vary. The definition used by the VA comes from Federal law and is “psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, 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.” More concretely, MST includes any sexual activity where a service member is involved against his or her will - he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or with implied better treatment in exchange for sex), may have been unable to consent to sexual activities (i.e., when intoxicated), or may have been physically forced into sexual activities. Other experiences that fall into the category of MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person’s body or sexual activities; and threatening and unwelcome sexual advances. The identity or characteristics of the perpetrator, whether the service member was on or off duty at the time, and whether he or she was on or off base at the time do not matter. If these experiences occurred while an individual was on active duty, active duty for training, or inactive duty for training, they are considered by the VA to be MST. For those veterans who have chosen to seek the VA health care, 1 in 4 women and 1 in 100 men respond “yes” when screened by their VA provider (Veteran’s Administration, 2015).

Sexual trauma, including MST, is often viewed as primarily a women’s health issue and the proportion of positive screens among male patients is significantly lower than among women, only slightly over one percent. However, because the majority of VHA patients are men, this prevalence results in a detected clinical population of 31,797 patients, comparable in size to the MST population of female patients. Given

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the size of the clinical population of veterans reporting these experiences, it is clear that medical knowledge relevant to providing care for victims of sexual assault and sexual harassment is an important issue within VHA, for male as well as female patients (Kimerling, 2007). It is important to note, however, that MST is the primary mental health issue reported by female veterans.

PTSD defined

The term post-traumatic stress disorder was first coined in 1980 when a group of Vietnam veterans assisted by New York Psychoanalysts Chaim Shatan and Robert J Lifton, lobbied the American Psychiatric Association to generate a new diagnosis to term a cluster of symptoms that described the horror and sense of helplessness experienced by trauma sufferers. Ironically, the VA declined funding a study for veterans stating “It has never been shown that PTSD is relevant to the mission of the Veteran’s Administration” (Van Der Kolk, 2014).

PTSD is defined as an anxiety disorder that can develop after exposure to a terrifying event or ordeal in which grave physical harm occurred or was threatened or in cases where these events were witnessed. It is a truly normal response to an extraordinary event(s). Events that may cause PTSD: Combat exposure, child sexual physical abuse, terrorist attack, sexual or physical assault, serious accidents (i.e. a car wreck), and severe natural disasters like a volcano, tornado, hurricane, earthquake, etc. Although most people have stress-reactions to traumatic events, it is not entirely clear while some individuals develop PTSD and others don’t (Warriors at Ease, 2017).

PTSD has a range of symptoms that usually start after the traumatic event, but in some instances the symptoms won’t manifest for months or even years. There are four clusters of PTSD symptoms: 1) Intrusion, when you are re-experiencing the event through nightmares, flashbacks, obsessive thoughts, 2) Avoidance, which involves isolating yourself from people, places or experiences that remind you of the event 3) Hyper-vigilance/arousal, when you are in a high state of alert, excitability, essentially “on guard” for the traumatic event and lastly 4) Cognition and mood symptoms i.e. a lack of interest in the things you are doing and the people you are with. The trauma survivor may change the lens with which they see themselves and may harbor feelings of guilt, fear and shame (National Institutes of Health, 2018).

Your Brain on Trauma

Research reveals that trauma creates quantifiable physiological changes, including the recalibration of the brain’s alarm system, an increase in stress hormone activity and mutations in the systems meant to filter the relevant and irrelevant information. In other words, the trauma survivor’s brain is rewired, constantly revisiting the moment that the trauma (s) occurred, with each new experience viewed in the context of the old trauma. Traumatized people become “stuck”, stifled in their ability to grow because they are unable to integrate new experiences into their lives. After a traumatic experience, survivors operate with a different nervous system, as their energy is now diverted to suppress the chaos within.

The trauma now becomes the defining moment, ultimately compromising the section of the brain that translates the physical, embodied sense of being alive, trading it for a state of hypervigilance that supplants experiencing the day to day moments of life. It should come as little surprise that the trauma survivor will manifest negative repetitive behaviors, and what appears to be an inability to learn from mistakes. These are not moral failings or a reflection of compromised character; PTSD affects the entire organism—body, mind and brain—as the body continues to defend itself against a past experience (Kolk, 2014).

The Trauma Trifecta of MST and Correlation with PTSD

The question that bears asking, however, is what is it about MST that makes it so devastating? There are three primary characteristics referred to as the “Trauma Trifecta” that consistently manifest in the MST survivor. First, is the simultaneous loss of both personal and professional identity since the MST survivor is immersed in the military culture; the military service is “simultaneously an employment, residential and social” environment. The personal and professional identities become intertwined as bootcamp (or a commissioning program) breaks down young recruits and remolds the individual into a military team that

for many becomes a surrogate family in almost every sense. When an assault occurs within the military structure, the fundamental contract of trust is shattered, as what should have been the “safest space” (i.e. the military fraternity) has now become the scene of the crime (Northcut & Kienow, 2014). In some circles, Military Sexual Trauma has been likened to incest, because Sexual Assault within the military family goes against the code. Moral Injury is defined as “an act of serious transgression that leads to serious inner conflict because the experience is at odds with core moral and ethical beliefs” (Maguen, Shira and Litz, Brett, 2012). Betrayal on either a personal or organizational level can also precipitate a sense of moral injury and is often accompanied by a sense of guilt, shame and anger. Many survivors of MST fall into this category as well, though PTSD and moral injury are not necessarily co-morbid (i.e co-occurring).

The second characteristic is marked by a survivor’s self-damaging attempts to regain control, often manifested as cutting, burning, disordered eating, or in some other deliberate physically injurious behavior (Northcut & Kienow, 2014). This behavior is often a misguided attempt to express the feelings that have left the survivor “out of touch” with his or her body, and it provides a connection with the body and the feelings that have not been processed. In one case study, an MST survivor engaged in multiple destructive behaviors to include overspending, unprotected sex, and cutting or hitting her legs, but the ones that resonated, and frequently brought the most relief, were the assaults on her physical body.

The third and final aspect of the trauma trifecta is the frequent “re-traumatization” that occurs when reporting within the military culture. Re-traumatization occurs when a common stimuli or events trigger the experience of the earlier trauma leading to re-experiencing, hypervigilance, and or avoidance of the trauma-associated stimuli. In the case of MST, re-victimization occurs in many ways. Not only is there a sense that the military broke faith with the survivor, but there is also the implied suggestion that the service member brought it on themselves, is lying, and/or has betrayed the unit by reporting the sexual assault in the first place. (Northcut & Kienow, 2014) There is a reason that sexual assault is one of the most underreported crimes; often the victim is scrutinized more rigorously than the alleged offender. This role reversal, known as victim blaming, contributes to an ongoing reluctance of sexual assault victims to report the assault and seek the help they need. In the case of male sexual assault, the prevalence of reporting diminishes even further; a 2010 study by the Defense Manpower Data Center found that 85 percent of military men who experienced unwanted sexual contact did not report the incident (O'Brien, 2015).

Figure 2: Military Sexual Assault, PTSD and Service Utilization in Female Veterans

		Experienced MSA	Probable PTSD	Received immediate treatment	Received MH care within the past year
Pre-9/11 (n = 149)	Yes	48%	53%	10%	81%
	No	52%	10%	N/A	27%
Post-9/11 (n = 178)	Yes	30%	65%	18%	76%
	No	70%	24%	N/A	32%

Note. MSA = military sexual assault; PTSD = posttraumatic stress disorder; MH = mental health.

(Kintzle, 2015)

Figure 2 appears to clearly and convincingly convey a direct link among MST and PTSD, at least in female veterans. Women who experience a sexual trauma in the military are 4-9 times more likely to suffer PTSD. With a 76 percent utilization rate of post 9/11 veterans to Mental Health services at the VA, this number implies the enduring and long-term impact of MST on health and well-being (Kintzle, et al. 2015).

Very few studies have focused on the impact of military sexual assault on male survivors; studies in the civilian sector indicate the probability of receiving a PTSD diagnosis following sexual assault was higher for men (65 percent) than women (46 percent) (O'Brien, 2015), implying that the impact for both men and women in the context of the trauma trifecta is staggering. For males, the trauma trifecta is amplified by the Rape Myths within the military culture that imply male rape is “not serious”, male on male is about “homosexuality”, that “real/stong men don’t get raped”, and a man “can’t get raped by a woman” (O'Brien,

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2015). These reasons serve as a very real barrier for men to get the help they need after a sexual assault.

Overall In examining mental health diagnoses of all veterans with a positive VA MST screen, Kimerling and colleagues found that women with a positive MST screen were most likely to be diagnosed with PTSD, dissociative disorders, eating disorders, and personality disorders, whereas men were most likely to be diagnosed with suicidal behavior, personality disorders, PTSD, attention deficit hyperactivity disorder and conduct problems, dissociative disorders, and bipolar disorders. The link between MST and suicide and intentional self-harm (over twice as common among women and men who report MST) suggests the need for heightened awareness of and screening for suicide risk in this population (Kimerling, 2007).

Suicide Rates in Veterans and MST correlation

Suicide rates among veterans are increasing. In 2014, an average of 20 Veterans died from suicide each day. Six of the 20 were users of VA services. Since 2001, the age-adjusted rate of suicide among U.S. Veterans has increased overall by 32.2 percent, in veteran males the number increased by 30.5 percent, in female veterans the rate increased by 85.2 percent (U.S. Department of Veterans Affairs, 2016). Researchers with the department of Veterans Affairs found that men with a history of MST are 70 percent more likely than fellow veterans without such experience to commit suicide, and women veterans with MST are more than twice as likely as other female vets to do so. “The study found that those veterans who died by suicide were significantly more likely to be treated for mental health conditions that were related to their MST experience,” noted Susan McCutcheon, national mental health director for family services, women’s mental health and MST at the Veterans Health Administration. If mental health conditions like depression or post-traumatic stress disorder - which are themselves strong risk factors for suicide - stem from the MST experience, that may help explain the connection between MST and suicide”, said McCutcheon, who was not involved in the study but spoke on behalf of the VHA. Men and women veterans who experienced sexual assault or repeated, threatening sexual harassment while serving in the military are at heightened risk of suicide, according to a recent U.S. study, (Nelson, 2016) and female veterans ages 18-29 kill themselves at a rate of nearly 12 times the rate of the non-veteran population. (Zarembo, 2015)

Success of Yoga and Meditation Therapy on Post Traumatic Stress Disorder

The military does very good work in terms of initial response. To activate that response and support system, however, one has to file a report, and some service members are reluctant to report within the military system. Each branch of service has specific, effective processes in place to assist the service member who reports a sexual assault, from access to immediate medical care, assignment of civilian professionals in the form of victim advocates and sexual assault response coordinators, to specialized attorneys that help the survivor navigate the legal process. Once the immediacy of the trauma has been addressed, however, the survivor’s real work of healing remains to be done.

There are three primary ways to treat trauma related conditions: 1) Top down: talk therapy and social interaction 2) medication and 3) bottom up: mind body therapy (yoga, meditation, etc.) (Warriors at Ease, 2017). A combination of all three has often been the recipe for success, but the bottom up method has been particularly effective in addressing trauma. Of these three, mind-body therapy is the most cost-effective, and has no negative side effects - these methods and experiences optimize the brain’s neuroplasticity to help survivors connect fully to the present and move forward with their lives. Once a survivor has a positive physical experience that directly contradicts the anger, hopelessness, and helplessness that are an intrinsic part of the trauma, a sense of self-mastery and control is regained (Van Der Kolk, 2014).

With trauma survivors in general, continual reminders of the original trauma trigger the freeze, flight or flight reaction, and reactivate the body systems as if the trauma was actually occurring (Northcut & Kienow, 2014) Growing evidence supports the use of yoga to heal the effect of trauma on the autonomic nervous system (ANS) The ANS has two branches: the parasympathetic nervous system (PNS; also

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called the rest-and-digest system) and the sympathetic nervous system (SNS; also called the fight-or-flight system). When the SNS is engaged for long periods, as is common during the experience of trauma or PTSD symptoms, an individual can become “stuck” in a hyperaroused state without any means to dispel that energy. An optimally functioning ANS returns to homeostasis after SNS arousal; however, individuals with PTSD-related hyperarousal symptoms may take much longer than others to self-regulate and return to a more balanced physiological state. The inability to re-regulate after an SNS-initiated fight-or-flight response may negatively affect the PNS, which in optimally functioning individuals facilitates rest, grounding, and rehabilitation. An extreme PNS response may in fact lead to immobilization (a freeze or submit response) that fails to allow the individual to respond appropriately to a given stressor (Justice, 2018).

Yoga, as a mind-body practice, engages downregulating practices that emphasize activation of the PNS as well as upregulating practices that stimulate the SNS. Mindful use of up- and downregulating practices over time helps individuals learn to discern cues from their ANS, recognizing when they are either hyper- or hypoaroused, and teaches them how to recalibrate or balance their ANS. A healthy ANS requires use of both the PNS and SNS. Trauma sensitive, also referred to as a trauma informed yoga, is a safe and effective way to introduce the trauma survivor to mindfulness practices.

Elements of trauma sensitive yoga include an emphasis on creating a welcoming, safe space where the trauma survivor is able to feel at ease. The instruction is permissive with an emphasis on choice (eyes open or closed, invitations to deepen into the posture or stay where you are), the language is invitational in nature with an avoidance of Sanskrit and words potentially suggestive of death and war (i.e. corpse pose or “surrender and melt”), and an avoidance of potentially sexually suggestive postures such as “happy baby” or other postures where the hips are positioned in vulnerable ways. Additionally, hands on adjustments are strongly discouraged to maintain a clear sense of boundaries. Ultimately the goal is to create a fuller sensing of the present body and a connection between body and breath through mindful, deliberate movement. (Cushing, Braun, Alden, & Katz, 2018) In these moments, yoga can become “a tool for self-regulation, self-investigation, and self-awareness, a means to engage in the world in an authentic way.” The movement, coordinated with the breath, allows trauma survivors to get in touch with unexpressed impulses and emotions and process them through connected movement of body and breath (Corne, 2015).

With the active duty and veteran community, working through gender and cultural barriers to a yoga practice is a definite consideration. Veterans in particular are prone to gender related barriers, and it may be hard to overcome the idea that yoga is immasculating, or for women and “sissies”. Furthermore men may feel intimidated in a yoga class, because they are stereotypically stronger, but less flexible. Once they experiences the benefits, these biases begin to shift (Justice, 2018).

There are many choices for courses in trauma informed yoga, but one in particular stands out from the rest. Warriors at Ease is a National Non-Profit that trains yoga and meditation teachers to serve our nation’s active duty members, veterans and their families, allowing this population to experience first hand the very real benefits of yoga and meditation. Warriors at Ease methods are trauma sensitive, evidence-based and military culture informed. Their cadre of teachers create a safe and welcoming environment that encourages those with limited or no exposure to yoga and meditation to give it a try. The only known side effects include a sense of well-being in body and mind, a reduction in stress and anxiety, a tool for chronic pain management, decreased symptoms of PTSD, and improved quality of sleep (Warriors at Ease, 2017).

Trauma informed yoga, such as that promulgated by Warriors at Ease, provides students with practices that help them access the ANS in general (e.g., through breath control) and re-engage the PNS in particular (e.g., through calming guided mediations). Deliberate engagement of the ANS (via breath, movement, and meditation) may help individuals with trauma histories recover and rebalance their nervous systems after exposure to a stressful circumstance or environmental cue. Yoga, as a practice that activates both the SNS and PNS, may help trauma survivors learn to distinguish between the two with greater discernment and skill. In other words, as practitioners learn to identify internal sensations of calm and focus, they may reside in those sensations for longer periods. Likewise, as practitioners identify

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internal sensations that remind them of trauma symptoms, they may employ grounding techniques or mindfulness practices to help mitigate negative reactions. Many forms of yoga currently exist that emphasize downregulation and grounding (e.g., Yin Yoga, Restorative Yoga, Yoga Nidra), and are recommended for those with trauma histories (Justice, 2018).

One form of meditation in particular, iRest® Yoga Nidra, has been particularly effective in resolving symptoms of PTSD. Integrative Restoration, or iRest for short, evolved from a 2006 DoD research study on the efficacy of yoga nidra, an ancient meditation practice. This modern variation is *integrative* in nature, addressing both psychological and physical issues such as stress, insomnia, trauma and chronic pain, as well as *restorative*, in that it helps you reconnect with your inner resources of joy, peace and well being. This guided meditation has a specific, ten step sequence that is duplicable for consistency, secularized in languaging and requires no background in yoga or meditation to harvest the benefits of feeling a greater connection to self, others and the outside world. The US Army Surgeon's General Pain Management Task Force characterized iREST yoga nidra as a primary approach for pain management in military health care, and the Defense Centers for Excellence endorsed iRest as a complementary and alternative medicine (CAM) in the treatment of PTSD (Miller, 2015).

The findings in an iRest study conducted with women with sexual trauma at a Veteran's Medical Center are promising. In this study the 16 participants were 13 veterans and 3 service connected spouses. For the duration of the study participants agreed not to engage in individual or group therapy (with the exception of continued substance abuse treatment). They met for 19 sessions over a 10 week period. Pre and post treatment ratings of PTSD symptoms, self blame and depression scores were illuminating; Post traumatic symptoms reduced by 16 percent, thoughts of self blame reduced by 17 percent and the depression symptoms exhibited a significant 25 percent reduction. Study participants reported no adverse side effects. One hundred percent of the veterans reported they would enroll in an iRest class again. The women in this course had all previously participated in psychotherapy, cognitive and CPT therapies; iRest seemed to meet their needs in a different way and reduced a myriad of symptoms across the board (Pence P. K., 2014).

Although the knowledge of the body-mind connection and benefit of a mindfulness practice is becoming universally accepted, the targeted use of these techniques for treatment in chronically traumatized individuals is surprisingly infrequent, considering the body of evidence validating their general effectiveness. The research investigating the use of these tools with individuals with complex trauma is even rarer. A multifaceted approach incorporating body awareness, mindfulness, and associated skills, may be unequivocally demonstrated in the near future to have the greatest efficacy in the treatment of chronic trauma (Hartman, 2015).

Yoga contributes to "helping practice self care and integrate the mind, body and spirit allowing healing of the whole person." Currently almost 90 percent of VA centers provide Complementary and Alternative Medicine (CAM). Figure 3 shows the number of sites with alternative healing modalities. The efficacy has also been echoed in the experiences of the veteran's themselves "The yoga classes have lowered my back pain and are helping with my PTSD" and "the techniques have helped me daily to improve those interrupted sleeping episodes" (Pence, 2013/14 Vol1, No2).

Figure 3: Complementary Alternative Methods

Type of Therapy	Number of VA Sites Providing Therapy
Meditation	101
Stress Management/Relaxation Therapy	93
Guided Imagery	82
Progressive Muscle Relaxation	75
Biofeedback	70
Animal-Assisted Therapy	62
Music Therapy	60
Acupuncture	58
Yoga	44
Hypnosis/Hypnotherapy	41

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Conclusion

One in 4 females report instances of Military Sexual trauma to the VA, along with a numerical equivalent of male survivors. These numbers do not reflect the active duty population that is either actively seeking help for trauma related to sexual misconduct, or silently and autonomously working through invisible wounds. When faced with the magnitude of the prevalence and devastating impact of Sexual Assault, finding *effective* healing protocols becomes a moral imperative for leaders and service providers. Veterans report using integrative therapies emphasizing stress management 2.5 - 7 times more frequently than civilians, implying a willingness to embrace alternative therapies. Additionally, post 9-11 veterans indicated they would be more likely to seek care if that care is either underaken or used by their peers (Justice, 2018). Trauma informed mindfulness practices such as yoga and meditation are a cost effective, non-invasive approach that are not only remediating symptoms but perhaps hold the key to post traumatic growth, offering hope and the promise of future restoration of body and mind. The sons and daughters that have served, or are presently serving our great nation, deserve the very best opportunity to heal these invisible wounds and move forward to live fulfilling and productive lives.

“Hope is important because it can make the present moment less difficult to bear...”

-Thich Nhat Hahn, a Buddhist Monk, peace activist known for his work with veterans

Research Methodology:

This research paper was written to more fully understand the mind-body connection, and more specifically explore yoga and meditation as a healing modality and its applicability to active duty sexual assault, sexual harassment and military sexual trauma in veterans. I undertook a comprehensive review of government reports, academic research papers, periodicals, personal interviews, psychological journals and VA program materials, as well as specific books relating to trauma, PTSD and the mind-body connection. Additionally, my own personal experience as a yoga teacher, Sexual Assault Preventionist and more than thirty years of enlisted, US Naval Academy and commissioned service time informed my research for this paper.

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