

From Distrust to Distress: Associations Among Military Sexual Assault, Organizational Trust, and Occupational Health

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Objective: Workplace violence is underreported, in part due to lack of *trust in the system*—an organization’s ability to protect victims’ safety, confidentiality, and dignity. We focus on military sexual assault—a form of workplace violence—aiming to (a) identify factors that relate to employee trust in the organization’s sexual assault response system and (b) determine how trust in this system (or lack thereof) is associated with well-being. **Method:** Participants were drawn from a representative sample of U.S. military personnel (542 victims of past-year sexual assault and a random sample of 1,000 individuals who did not experience sexual assault in the past year). **Results:** Trust differed by personal and organizational characteristics. Notably, trust was higher among men (vs. women), nonvictims (vs. past-year victims of sexual assault), members of the air force (vs. other service branches), and personnel who recalled comprehensive training related to sexual assault prevention and response (vs. minimal or no training). Further, lower trust in the system predicted lower work satisfaction and coworker satisfaction, more negative health perceptions, more greater symptoms of depression and posttraumatic stress, and lower intent to remain on active duty. These negative outcomes emerged beyond the effects of past-year sexual assault and combat. **Conclusions:** Trust that an organization will protect employees’ safety, confidentiality, and dignity if they report violence is important to both mental and occupational health, for both victims and nonvictims alike. In short, workplace violence can be devastating and so can (non)responsiveness to violence by the larger institution.

Keywords: sexual assault, trust, mental health, job attitudes, military personnel

Workplace violence refers to nonlethal acts of aggression or assault that occur while on duty (Bureau of Justice Statistics, 2011). Rates of workplace violence are higher in certain occupations, including the military (Bureau of Justice Statistics, 2011). Sexual assault—a form of workplace violence—occurs more frequently in the military than in the civilian context, and it is rarely reported in either (Bostock & Daley, 2007). General Amos has stated that military personnel underreport sexual assault “[b]ecause they don’t trust us” (Chapman, 2013, p. C23), illustrating the importance of institutional leadership and policies and employees’ trust in those entities. We describe such beliefs as *trust in the system* or confidence in the organization’s ability to adequately support victims. The current study has two objectives. First, we examine individual-level (sex, sexual assault history) and organizational-level (service branch, training) factors that relate to employees’ trust in the system.

Second, we test whether this trust links with well-being, among recent assault victims and nonvictims alike.

Military Sexual Assault and the Sexual Assault Response System

Department of Defense (DoD, 2012b) Directive 6495.01 defines *sexual assault* as “[i]ntentional sexual contact characterized by use of force, threats, intimidation, or abuse of authority or when the victim does not or cannot consent” (p. 21). In this article, *military sexual assault (MSA)* refers to any of these acts committed against active-duty military personnel. Although the term survivor is often preferred over victim when referring to individuals who have endured sexual assault (Hockett & Saucier, 2015), to maintain consistency with DoD terminology, we use the terms *past-year victim* (referring to personnel who have experienced at least one incident of MSA in the previous year) and *nonvictim* (referring to those describing no past-year experience of MSA, though they may have been sexually assaulted before that).

Experiencing MSA is associated with negative consequences for health and work, including greater symptoms of depression and posttraumatic stress disorder (PTSD), impaired productivity, and lower organizational commitment (Harned, Ormerod, Palmieri, Collinsworth, & Reed, 2002; Holland, Rabelo, & Cortina, 2016). Victims of sexual assault—unlike other crimes—are frequently blamed for or accused of fabricating their assaults (Edwards, Turchik, Dardis, Reynolds, & Gidycz, 2011). Further, victims in close-knit work communities (such as mining, farming, and the military) often reside and work alongside their assailants, increasing the distress associated with violence (Defense Manpower Data

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Center [DMDC], 2013). Thus, there are unique outcomes of violence (including MSA) above and beyond the stress of standard work life.

In 2005, the DoD created the Sexual Assault Prevention and Response Office, which increased resources for trainings to help personnel report and prevent MSA. Despite these resources, only about 13% of sexual assault cases were formally reported in 2010 (DoD, 2014). This estimate rose to 25% in 2014, but the vast majority of assault incidents go unreported (DoD, 2014), as with most episodes of workplace violence (Bureau of Justice Statistics, 2011). Most victims therefore never receive justice. Common reasons why victims of MSA do not report assault include fears that retaliation will follow, the perpetrator will not be penalized, the case will be ignored or mishandled, or confidentiality will be breached (Burns, Grindlay, Holt, Manski, & Grossman, 2014; Turchik et al., 2013). In short, it appears that (dis)trust in the system plays a critical role in victim response behavior.

Predictors of Trust in the Military Sexual Assault Response System

The current study examines a particular form of trust—*trust in the system*, or confidence in the military's ability to ensure safety, privacy, and respect following sexual assault. We conceptualize MSA as a key factor in the establishment (and violation) of trust in organizations. Given the importance of trust, it is essential to identify *who trusts (or distrusts) the sexual assault response system*. There are many individual factors that may affect service members' perceptions of trust, including gender and sexual assault history. However, ecological models illustrate the importance of considering factors beyond the individual, such as the communities and institutions in which people are embedded (Campbell, Dworkin, & Cabral, 2009). According to social referencing theory, employees gather cues from their environment—such as coworkers and cultural norms—to evaluate their level of safety (Festinger, 1954; McLain, 2014). Personnel may receive or seek information about MSA in many ways, such as attending trainings for awareness and prevention (Holland, Rabelo, & Cortina, 2014). Information about MSA can also spread through word of mouth, whether from a peer or an officer in one's chain of command. Given the relatively high incidence of MSA, even an employee who personally has not been assaulted likely knows someone who has been. Therefore, we examine how employees' trust is predicted by both individual (sexual assault history, gender) and contextual/organizational (service branch, exposure to sexual assault training) factors.

Sexual Assault History

Organizations frequently disappoint and further traumatize victims of violence. For example, when MSA victims try to report assault, they are often met with doubt and blame or told to drop their complaints (Burns et al., 2014; Campbell & Raja, 2005). A DoD report found that among women who experienced (but did not report) MSA, half believed that no action would be taken, and over 40% had heard about other victims' experiences of inaction or retaliation (DoD, 2012a). Anecdotal evidence also suggests that the military's system for handling assault can be problematic. When air force member Cassandra Hernandez reported being gang-raped by three of her coworkers, she was charged with

dereliction of duty (for underage drinking) and indecent behavior (Johnson, 2007). According to Benedict (2009), "the military attitude is to 'suck it up' when it comes to pain and trauma" (p. 200). Therefore, victims may be hesitant to trust their organization's response to assault. Further, people who have experienced assault will be more likely to have actually used, or considered using, the military support system; thus, their previous victimization may influence organizational trust. Given the data regarding victims' problematic interactions with this system, we hypothesize that past-year sexual assault victims will report less trust in the system than nonvictims.

Gender

Gender is another important individual-level factor. Feminist theorists postulate that the intimidating and harmful effects of sexual assault extend beyond victims to affect all women (Brown-miller, 1975). For example, when female college students with no history of rape were asked to think about an assault that occurred on their campus, they demonstrated decreased trust in other people (Schwarz & Brand, 1983). The military—like other industries such as construction and mining—is a traditionally male and hypermasculine work environment, and characteristics associated with femininity (e.g., sensitivity) and victimization (e.g., vulnerability) are denigrated. Women, who are already viewed as outsiders in these organizational contexts, may have more reasons than men to be distrustful of the system. Therefore, we hypothesized that women would report less trust in the system than men.

Service Branch

Despite the organization-wide implementation of resources for assault victims, rates of and responses to assault differ across branches (Harned et al., 2002; National Defense Research Institute, 2014). For instance, MSA rates appear to be higher in the marine corps and navy and lower in the air force (National Defense Research Institute, 2014). In addition, content and delivery of prevention efforts vary across service branches. Holland et al. (2014) found that, of the five branches, personnel in the air force report greater access to comprehensive training, including information about the military's support system for MSA (e.g., training on reporting options available). Although there is good reason to believe that trust in the system might vary by branch, the lack of branch-specific information makes it difficult to develop directional hypotheses. We therefore posed the following research question: Does trust in the system differ across military branches, and if so, how?

Sexual Assault Training

As suggested previously, exposure to training is another organizational factor that may predict trust in the system. In 2010, the DoD was committed to training all personnel to increase knowledge of policies and improve responses to MSA reports (DoD, 2010). Despite military intentions, training quality still varied across personnel. Holland et al. (2014) found that nearly 1 in 10 employees could not recall *any* training during the past year. About one third of personnel described receiving *minimal* or *partial* training, which omitted key topics related to MSA. Still others

(54%) perceived their training as *comprehensive*, covering actions that are considered MSA as well as reporting options. Drawing from the social referencing theory, we would expect that personnel who have experienced high-quality, comprehensive training would use this information to evaluate their trust more favorably.

Institutional Betrayal: Implications of Trust for Occupational Health and Job Attitudes

Many organizations, including the military, avow that trustworthiness is crucial to occupational functioning. We argue that violence—including sexual assault—is a pervasive and powerful threat to employees' trust in their organizations. Specifically, we hypothesize that trust in the system will relate to health and occupational outcomes, for MSA victims and nonvictims alike. To understand these associations, we turn to the theory of *institutional betrayal*.

In recent years, researchers have attempted to understand how institutions shape victims' posttraumatic symptoms. Drawing from an ecological model, researchers find that negative contact with medical and criminal justice institutions exacerbates sexual assault victims' psychological distress (Campbell et al., 2009). Institutional betrayal occurs when an organization's actions (or inactions) are complicit in a person's trauma, especially when the traumatized person depends on the institution (Freyd & Birrell, 2013; Smith & Freyd, 2013, 2014). Thus, coping with trauma is a matter of how individuals, as well as institutions, respond to trauma (Campbell et al., 2009; Smith & Freyd, 2013, 2014). Betrayal can take several forms. MSA is itself a form of betrayal: Assault violates the expectation that they can trust their coworkers. Institutional betrayal is also reflected in perceptions that leadership has failed to take appropriate action to prevent and respond to sexual violence (Smith & Freyd, 2014).

The concept of institutional betrayal emerged out of betrayal trauma theory (Freyd, 1996) to explain the experiences of direct victims of trauma. However, a sense of institutional betrayal can extend to *anyone* embedded within an institution that tolerates violence toward its members. If violence is known to be common in that context, then all members can lose trust in their institution to protect them, regardless of whether they themselves have ever been victimized; the result can be distress, dissatisfaction, and other adverse consequences, among victims and nonvictims alike. In support of this view, research finds that many service members with no recent experience of sexual assault nevertheless feel unsafe from assault, which fuels symptoms of depression and post-traumatic stress (Holland et al., 2016). Similarly, perceptions of an institution as tolerant of sexual harassment relate to lower well-being (Miner-Rubino & Cortina, 2007), even among employees with no personal history of having been harassed (Miner-Rubino & Cortina, 2004). Building on this literature, we investigated outcomes of (dis)trust in the system—an important facet of institutional betrayal—among both victims and nonvictims. That is, we expected to observe direct (and positive) effects of trust on well-being.

Health Outcomes

MSA can trigger a host of mental health problems (e.g., depression, PTSD). Negative experiences with the sexual assault re-

sponse systems can exacerbate these mental health consequences (Campbell & Raja, 2005). Conversely, positive experiences with formal support systems can be protective for victims' well-being (Campbell, 2008). Although no previous research has directly examined the impact of trust on health, we propose trust in the system to be important for the health of employees, both women and men, victims and nonvictims. In fact, effects should extend over and above the impact of other trauma, including sexual assault victimization (Campbell & Raja, 2005; Smith & Freyd, 2013). We therefore expected that greater trust in the system would be associated with (a) fewer posttraumatic stress symptoms, (b) fewer depressive symptoms, and (c) more positive general health perceptions.

Occupational Outcomes

Previous research shows that trust is important for health and safety (Gunningham & Sinclair, 2009). When employees' trust has been violated, they report poorer job performance and higher turnover intentions (Robinson, 1996). MSA may violate this psychological contract of trust for direct victims and nonvictims alike. However, the organization's response to this act of violence can either reestablish or further break that trust. For example, MSA victims who experience additional mistreatment from the system report even greater distrust of others as a result (Campbell & Raja, 2005). In our research, we expected that trust would relate to occupational outcomes, beyond the impact of MSA and other occupational trauma (i.e., combat).

In summary, we propose the following research question and hypotheses:

Research Question 1: Does trust in the system differ across military branches, and if so, how?

Hypothesis 1: Past-year sexual assault victims will report less trust than nonvictims.

Hypothesis 2: Women will report less trust than men.

Hypothesis 3: Personnel who recount comprehensive MSA response/prevention training will report the greatest levels of trust, followed by those who recall partial, minimal, and no training.

Hypothesis 4: Greater trust will be associated with (a) fewer posttraumatic stress symptoms, (b) fewer depressive symptoms, and (c) more positive general health perceptions.

Hypothesis 5: Greater trust will be associated with greater (a) coworker satisfaction, (b) work satisfaction, and (c) intention to stay in the military.

Method

Every few years, the DoD administers the Workplace and Gender Relations Survey of Active-Duty Members (WGRA). In 2010, the survey was administered to 90,391 active-duty members of the U.S. military, sampling evenly across gender and service branches. A total of 26,505 (29.32%) service members provided complete surveys. For more information concerning sampling procedures and survey items, refer to Rock, Lipari, Cook, and Hale (2011).

The current study involved secondary data analysis of the 2010 WGRA, focusing on the following two subsamples: all respondents describing at least one experience of sexual assault in the past year (i.e., *past-year victims*; $n = 430$ women, 112 men) and a random sample of 1,000 respondents reporting no experience of assault in the past year (*past-year nonvictims*; $n = 500$ men, 500 women). We drew this random sample to maintain similar sample sizes when comparing victims and nonvictims, yielding a more balanced design. Collectively, our sample comprised 612 (39.7%) men and 930 (60.3%) women. These personnel were affiliated with the following military branches: army, $n = 417$ (27%); air force, $n = 369$ (24%); marine corps, $n = 342$ (22%); navy, $n = 297$ (19%); and coast guard, $n = 117$ (8%). For the current study, we focused on enlisted personnel ($n = 1,123$, or 73%) and commissioned officers ($n = 351$, or 23%).

Measures

Trust in the system. The following three items assessed trust in the system: “If you are sexually assaulted, you can trust the military system to . . .” (a) “protect your privacy,” (b) “ensure your safety following the incident,” and (c) “treat you with dignity and respect.” Response options were “true,” “false,” or “do not know.” To disambiguate the meaning of the “do not know” response, we followed the procedures pioneered by Smith, Kendall, and Hulin (1969). First, response options were recoded such that 1 = *false*, 2 = *do not know*, and 3 = *true*. Responses to the three scale items were summed to create a total score. Next, we conducted a mean split on this total score, creating the following two groups: low trust and high trust. Then, we conducted a series of chi-square tests to analyze whether participant responses of “do not know” were more likely to appear in the low-trust group or high-trust group. Overwhelmingly, participants who responded “do not know” were members of the low-trust group. For the item “protect your privacy,” 84.6% of the respondents who selected “do not know” fell into the low-trust group. For “ensure your safety,” 97.7% of the respondents who selected “do not know” fell into the low-trust group. For the “ensure your safety following the incident” item, 94.2% of the respondents who selected “do not know” fell into the low-trust group. In other words, the “do not know” response option was used by individuals low in trust more than by those high in trust, suggesting that this response option should receive a more negative weighting. These results echo those of Smith et al., so we implemented the same scoring system: 0 = *false*, 1 = *do not know*, and 3 = *true*. After scoring, responses to the three items were summed, so composite scores ranged from 0 to 9 ($\alpha = .90$).

Sexual assault history. Participants indicated whether, over the past 12 months, they had experienced any of five types of “intentional sexual contacts” that were against their will or without their consent. Behaviors queried ranged from unwanted touching to attempted rape to completed rape: (a) “*sexually touched you* (e.g., intentional touching of genitalia, breasts, or buttocks) or made you sexually touch them”; (b) “*attempted to make you have sexual intercourse, but was not successful*”; (c) “*made you have sexual intercourse*”; (d) “*attempted to make you perform or receive oral sex, anal sex, or penetration by a finger or object, but was not successful*”; and (e) “*made you perform or receive oral sex, anal sex, or penetration by a finger or object*.” For each of these five sexual assault behaviors, they responded either “yes” (they had

experienced at least one of the five behaviors in the past year; coded 1 = *past-year victim*) or “no” (did not have any of these experiences in the past year; coded 0 = *past-year nonvictim*).

Gender. We used sex as a proxy for gender, which was either self-reported or inputted from employee records (0 = *male*, 1 = *female*) and included as a control variable in analyses of outcomes, because women relative to men are more likely to report symptoms of posttraumatic stress (Tolin & Foa, 2006) and depression (Nolen-Hoeksema, Larson, & Grayson, 1999).

Service branch. Service branch was inputted from employee records (*air force, army, coast guard, marine corps, or navy*).

Training exposure. Participants indicated (yes or no) whether they had received “any military training during the *past 12 months* on topics related to *sexual assault*” (emphasis in original). Those who responded “yes” completed follow-up items, rating (from 1 = *strongly disagree* to 5 = *strongly agree*) the extent to which their training covered 10 different content areas (e.g., “provides a good understanding of what actions are considered sexual assault”; “explains the reporting options available if a sexual assault occurs”). These 10 items were averaged ($\alpha = .98$). In previous analyses of WGRA data, Holland et al. (2014) cluster-analyzed these 10 training items, identifying the following groups: personnel recalling no training in the previous year, those describing past-year training that missed critical topics, those recounting training that addressed some important topics, and those reporting comprehensive training. We used these four clusters to classify participants’ perceptions of past-year training: 0 = *no training over past 12 months*, 1 = *minimal training*, 2 = *partial training*, and 3 = *comprehensive training*.

Health outcomes. The 17-item PTSD Checklist (Civilian version; Weathers, Litz, Huska, & Keane, 1994) assessed *posttraumatic stress symptoms* paralleling the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* PTSD Criteria B, C, and D. Service members indicated the extent to which they were bothered (from 1 = *not at all* to 5 = *extremely*) by each problem over the past month (e.g., “having repeated, disturbing memories, thoughts, or images of a stressful experience”; “Avoiding activities or situations because they remind you of a stressful experience”; emphasis in original). Items were summed to create a composite score, which ranged from 17 to 85 in the full sample ($M = 31.72$, $SD = 15.64$). The DMDC did not release item-level data, precluding computation of Cronbach’s alpha. The depression module from the Patient Health Questionnaire (Kroenke et al., 2009) assessed service members’ *depressive symptoms*. Employees indicated the extent to which they felt bothered by each of eight problems over the past month (e.g., “little interest or pleasure in doing things”; “poor appetite or overeating”). Response options included 1 = *not at all*, 2 = *several days*, 3 = *more than half the days*, and 4 = *nearly every day*. DMDC analysts averaged across the eight items to create a composite depression score; scores ranged from 1.00 to 4.00 in the full sample ($M = 1.70$, $SD = 0.75$). Again, the DMDC did not release item-level data, so no alpha coefficient is available. A modified version of the Short-Form Health Survey and Medical Outcomes Study questionnaire (Ware & Sherbourne, 1992) assessed *general health perceptions*. Service members rated four statements (e.g., “I am as healthy as anybody I know”) using a 4-point scale (1 = *definitely false*, 2 = *mostly false*, 3 = *mostly true*, 4 = *definitely true*), which were then averaged ($\alpha = .79$). Higher scores indicate greater levels of these three constructs.

Occupational outcomes. To assess *coworker satisfaction*, service members indicated their level of agreement with five statements (e.g., “There is very little conflict among your coworkers”; $\alpha = .91$). *Work satisfaction* was also assessed by having service members indicate their level of agreement with five statements (e.g., “You like the kind of work you do”; $\alpha = .93$). Both of these scales used response options ranging from 1 = *strongly disagree* to 5 = *strongly agree* and included items adapted for use with a military sample (Drasgow, Fitzgerald, Magley, Waldo, & Zickar, 1999; Edwards, Elig, Edwards, & Riemer, 1997; Palmieri, Drasgow, & Ormerod, 2001; Spector, 1985). To assess *retention intentions*, employees were asked, “Suppose that you have to decide whether to stay on active duty. Assuming you could stay, how likely is it that you would choose to do so?” (1 = *very unlikely* to 5 = *very likely*).

Covariates. We included *past-year combat* as a control variable when predicting well-being outcomes (i.e., Hypothesis 4 and Hypothesis 5), which can be affected by exposure to combat and war conditions (Vogt et al., 2011). Respondents were asked to report their deployment status over the past year: 0 = *not deployed in the past 12 months*, 1 = *deployed to a nondangerous combat zone*, and 2 = *deployed to a combat zone or to an area where you drew imminent danger pay or hostile fire pay*. We included a single-item measure of *work stress* as a control variable in well-being outcome analyses, as work stress is also associated with our health and well-being (Nieuwenhuisen, Bruinvels, & Frings-Dresen, 2010). Personnel rated the current level of stress in their work lives, from 1 = *much less than usual* to 5 = *much more than usual*. We also controlled for *rank/paygrade*, which DMDC analysts imputed from personnel records. In the data set released to the public, this variable consisted of five categories: E1–E4, E5–E9, W1–W5, O1–O3, and O4–O6. Due to the small number and ambiguous status of warrant officers, we excluded cases in the W1–W5 category. We retained all enlisted personnel and commissioned officers, treating rank/paygrade as an ordinal variable (ranging from 1 = E1–E4 to 4 = O4–O6).

Results

Table 1 reports summary statistics and correlations among study variables. We observed significant correlations between past-year sexual assault victimization and our key study variables, with victims (vs. nonvictims) reporting lower levels of trust, coworker satisfaction, work satisfaction, and retention intentions; greater work stress, posttraumatic stress symptoms, and depressive symptoms; and more negative general health perceptions, all p values are $< .001$.

What Factors Predict Trust in the System?

We examined individual and organizational predictors of trust in the system using both subsamples (a total of 1,542 participants). More specifically, we conducted a factorial analysis of variance (supplemented with Tukey tests) to analyze trust as a function of service member gender, past-year MSA, service branch, and reported exposure to sexual assault training. Means, standard deviations, and F statistics appear in Table 2. Supporting Hypotheses 1 and 2, past-year nonvictims reported greater levels of trust than past-year victims, Cohen's $d = 0.63$, and men reported greater levels of trust than women, $d = 0.33$. Examining variation in trust across service branches, we found that members of the air force reported significantly greater trust in the system relative to members of the army, $p < .001$, $d = 0.41$, navy, $p = .006$, $d = 0.30$, marine corps, $p < .001$, $d = 0.34$, and coast guard, $p = .012$, $d = 0.37$. There were no differences in trust among members of the army, navy, marine corps, and coast guard. Hypothesis 3 examined trust in the sexual assault response system as a function of perceived training on MSA prevention and response. As expected, personnel in the comprehensive training group reported the greatest levels of trust, relative to those who had described partial training, $p < .001$, $d = 0.42$, minimal training, $p < .001$, $d = 1.36$, and no training, $p < .001$, $d = 0.89$. Also as expected, employees in the partial training group reported significantly greater trust compared with those who reported minimal training, $p < .001$, $d =$

Table 1
Correlations, Means, and Standard Deviations for Study Variables ($N = 1,542$)

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5	6	7	8	9	10	11
1. Gender	1.60	.49	—										
2. Rank/paygrade	1.89	.98	-.17***	—									
3. Work stress	3.44	1.03	.09***	-.07**	—								
4. Past-year combat	.97	.81	-.05†	.00	.00	—							
5. Past-year MSA	.35	.48	.29***	-.25***	.12***	.04†	—						
6. Trust in the system	6.50	3.34	-.16***	.11***	-.20***	-.04	-.30***	—					
7. Posttraumatic stress symptoms	31.72	15.64	.18***	-.26***	.35***	.03	.40***	-.40***	—				
8. Depressive symptoms	1.70	.75	.20***	-.23***	.35***	.01	.36***	-.37***	.86***	—			
9. Health perceptions	3.19	.63	-.08***	.17***	-.21***	.00	-.19***	.23***	-.43***	-.45***	—		
10. Coworker satisfaction	3.62	.88	-.19***	.25***	-.32***	-.09***	-.26***	.30***	-.40***	-.38***	.23***	—	
11. Work satisfaction	3.63	1.05	-.14***	.22***	-.26***	-.05*	-.23***	.33***	-.36***	-.37***	.26***	.47***	—
12. Retention intentions	3.54	1.46	-.15***	.21***	-.27***	-.05†	-.18***	.26***	-.35***	-.35***	.25***	.33***	.45***

Note. MSA = military sexual assault. Coding information for categorical variables: gender: 0 = male, 1 = female; rank/paygrade: ordinal variable {1 = E1–E4 to 4 = O4–O6}; past-year combat: 0 = not deployed in the past 12 months, 1 = deployed to a nondangerous combat zone, 2 = deployed to a combat zone; MSA (past-year military sexual assault victimization): 0 = no past-year victimization, 1 = past-year victim of MSA. Continuous variables were scored such that higher values indicate greater values of the construct, using the following response ranges: work stress {1–5}; trust in the system {0, 9}; posttraumatic stress symptoms {17, 85}; depressive symptoms {1, 4}; (general) health perceptions {1, 4}; coworker satisfaction {1, 5}; work satisfaction {1, 5}; retention intentions {1, 5}.

† $p < .10$. * $p < .05$. ** $p < .01$. *** $p \leq .001$.

Table 2
Factorial Analysis of Variance for the Effects of Individual and Organizational Variables on Trust in the System

Predictor	<i>n</i>	<i>M</i>	<i>SD</i>	Pairwise comparisons ^a	<i>df</i>	<i>F</i>
Gender					1, 1269	7.01**
Man	575	7.13	2.91	a		
Woman	844	6.07	3.54	b		
Past-year MSA					1, 1269	63.04***
Nonvictim	958	7.18	2.93	a		
Victim	461	5.08	3.69	b		
Service branch					4, 1269	3.64**
Air force	354	7.34	2.80	a		
Army	373	6.02	3.64	b		
Coast guard	111	6.19	3.37	b		
Marine corps	314	6.28	3.39	b		
Navy	267	6.43	3.31	b		
Sexual assault training					3, 1269	72.86***
Comprehensive	644	7.62	2.58	a		
Partial	429	6.35	3.40	b		
Minimal	145	3.64	3.22	c		
No training	128	4.74	3.76	d		

Note. MSA = military sexual assault.

^a Within each predictor category, a different letter indicates a significant mean difference at the $p < .05$ level (based on Tukey's post hoc pairwise comparisons).

* $p < .05$. ** $p < .01$. *** $p \leq .001$.

0.82, and no training, $p < .001$, $d = 0.45$, groups. Contrary to our hypothesis, personnel who received minimal training reported significantly *less* trust than those who had received no training in the past year, $p = .016$, $d = 0.31$.

Given the substantial gender difference in past-year MSA victimization, we conducted a supplementary analysis of variance to examine trust as a function of the interaction between gender and MSA. We observed significant main effects of gender, $F(1, 1415) = 5.80$, $p = .016$, and MSA, $F(1, 1415) = 80.21$, $p \leq .001$, but no statistically significant interaction between gender and MSA.

Does Trust in the System Predict Health Outcomes?

Next, we ran three linear regressions to test our fourth hypothesis, examining how trust was associated with health outcomes. In the first step, we entered control variables (gender, rank/paygrade, work stress, past-year combat, past-year MSA). In the second step, we entered trust in the system. Dependent variables included posttraumatic stress symptoms, depressive symptoms, and general health perceptions (see Table 3 for regression coefficients and R^2 values). We found full support for Hypothesis 4. Controlling for gender, rank/paygrade, work stress, past-year combat, and past-

Table 3
Standardized Regression Coefficients From Regression Analyses Predicting Personal Health Outcomes

Variables	Posttraumatic stress symptoms		Depressive symptoms		General health perceptions	
	Step 1	Step 2	Step 1	Step 2	Step 1	Step 2
Covariates						
Gender	.02	.00	.05	.04	.00	.00
Rank/paygrade	-.15***	-.14***	-.12***	-.12***	.13***	.12***
Work stress	.29***	.25***	.30***	.26***	-.21***	-.18***
Past-year combat	.02	.01	.00	.00	.00	.00
Past-year MSA	.32***	.26***	.28***	.22***	-.12***	-.09**
Predictor						
Trust in the system		-.26***		-.23***		.16***
Adjusted R^2	.27	.33	.24	.29	.09	.11
ΔR^2	.27***	.06***	.24***	.05***	.09***	.02***

Note. MSA = military sexual assault. Gender was coded 0 = male, 1 = female; for past-year MSA, 0 = no past-year victimization and 1 = past-year victim of MSA.

** $p < .01$. *** $p \leq .001$.

Table 4
Standardized Regression Coefficients From Regression Analyses Predicting Occupational Outcomes

Variables	Coworker satisfaction		Work satisfaction		Retention intentions	
	Step 1	Step 2	Step 1	Step 2	Step 1	Step 2
Covariates						
Gender	-.08**	-.07**	-.03	-.02	-.07**	-.06*
Rank/paygrade	.19***	.19***	.17***	.16***	.17***	.16***
Work stress	-.28**	-.25***	-.21***	-.17***	-.23***	-.20***
Past-year combat	-.09***	-.08**	-.04	-.03	-.03	-.03
Past-year MSA	-.16***	-.12***	-.15***	-.09**	-.06*	-.02
Predictor						
Trust in the system		.17***		.25***		.19***
Adjusted R^2	.20	.23	.13	.18	.11	.14
ΔR^2	.21***	.03***	.13***	.05***	.12***	.03***

Note. MSA = military sexual assault. Gender was coded 0 = male, 1 = female; for past-year MSA, 0 = no past-year victimization and 1 = past-year victim of MSA.

* $p < .05$. ** $p < .01$. *** $p \leq .001$.

year assault, trust in the system accounted for a significant 6% of the variance in posttraumatic stress symptoms. Posttraumatic stress symptoms were lower among those with higher trust in the system, $\beta = -.26$, $p < .001$. After entering control variables, trust explained a significant 5% of the variance in depressive symptoms. Personnel who held greater trust reported fewer depressive symptoms, $\beta = -.23$, $p < .001$. Beyond the controls, trust accounted for 2% of the variance in general health perceptions, $p < .001$. More positive health perceptions were reported by individuals with higher trust in the system, $\beta = .16$, $p < .001$.

Does Trust in the System Predict Occupational Outcomes?

Our fifth hypothesis investigated relationships between trust and occupational outcomes. Again, we conducted three linear regressions, entering control variables on the first step (gender, work/paygrade, work stress, past-year combat, and past-year MSA) and trust on the second step. Dependent variables included coworker satisfaction, work satisfaction, and intention to stay. See Table 4 for regression coefficients and R^2 values. Results fully supported Hypothesis 5. Over and above effects of control variables, trust in the system accounted for a significant 3% of the variance in coworker satisfaction. Personnel holding greater trust in the system reported more satisfaction with their coworkers, $\beta = .17$, $p < .001$. Trust in the system explained 5% of the variance in work satisfaction. Employees reporting more trust also reported higher work satisfaction, $\beta = .25$, $p < .001$. Above and beyond controls, trust in the system accounted for a significant 3% increase in variance explained in intention to stay. Employees holding greater trust were more likely to express a desire to stay on active duty, $\beta = .19$, $p < .001$.

Discussion

With so much of adult waking life spent in the workplace, violence in this environment has profound implications for occupational and mental health. In organizations such as the military, this violence often manifests as sexual assault; in response, the military has developed elaborate systems of sexual assault prevention and response. Which employees trust those systems—are

confident in the military's ability to ensure safety, privacy, and respect following sexual assault? Under what circumstances? When trust is lacking, what ramifications does this have for personal and professional well-being? These questions motivated the current project.

We found that women (whether victims or not) were less likely to believe that their employer would protect their privacy, ensure their safety, and treat them with dignity and respect if they experienced sexual assault. In addition, past-year victims reported significantly less trust in the system than nonvictims. These findings echo qualitative research finding that women and men are wary of organizational responses to MSA disclosures (Burns et al., 2014; Turchik et al., 2013). For instance, the employees in Burns and colleagues' study expressed concern that their confidentiality would not be protected if they came forward about a sexual assault. Servicemen interviewed by Turchik et al. voiced fears about support providers' negative responses if they disclosed (e.g., ridiculing their manhood). Lack of trust in the system could inhibit employee help-seeking, which could slow their recovery from sexual trauma.

We also found that perceptions of trust varied by two organizational factors, namely, service branch and perceived training exposure. Employees in the air force reported greater trust in the system. Previous research suggests that the air force may provide more comprehensive training around sexual assault prevention and response (Holland et al., 2014) and may have lower rates of assault than other branches (National Defense Research Institute, 2014). Our results further suggest that those in the air force may be more likely to believe that the military can handle reports of sexual assault in a safe, respectful manner. For future research, it would be important to examine precisely how air force response efforts differ compared with other branches. The Sexual Assault Prevention and Response Office centralizes responsibility and policy for sexual assault, but it appears that more can be done to improve the quality of responses across branches. Given the dynamic nature of trust, and the documented influence of organizational climate upon trust and procedural confidence (Gill & Sypher, 2009), it is important to understand how the context related to sexual assault and

trust varies across organizational units. Our study marks one effort to this end.

Perceptions of past-year sexual assault training also predicted greater perceptions of trust. Employees who described more thorough training (e.g., including information on where to obtain help, how to report) also reported greater trust in organizational response systems. Interestingly, employees who stated they had *no* training in the past year reported *more* trust than those who felt they underwent training with minimal content coverage. There are a few possible explanations of this finding. First, the DoD mandates periodic training for all employees (DoD, 2012b), so even though these personnel reported no training in the past year, they may have been trained previously. Alternatively, employees who perceived their training as minimal may extrapolate these beliefs to all MSA prevention and response efforts. In other words, receiving inadequate training may communicate that the organization makes inadequate efforts to prevent MSA and protect victims. Poor training may be more damaging for personnel trust than having no exposure to these resources. For instance, staff could believe that the organization is only making an effort for appearance, rather than actual concern for victims of sexual assault. Substandard training may signal to employees that they cannot trust organizational responses to sexual assault, including reporting mechanisms and resources.

Our results also demonstrate the importance of trust in institutions for employee well-being. Specifically, we found that having more trust in the system was associated with significantly fewer symptoms of depression, posttraumatic stress, and general health concerns. We also found that personnel who trusted the military system to handle MSA also reported higher satisfaction with their work and coworkers and greater desire to remain on active duty. This last finding suggests trust in the system is important for retaining military personnel.

Importantly, trust in the MSA system predicted health and occupational outcomes above and beyond the effects of other known impediments to military well-being. These included recent deployment status (to a dangerous or nondangerous combat zone) and recent sexual assault. In other words, we accounted for the impact of these stressful life events on employee health and job attitudes and still found trust in the MSA system to account for a significant proportion of variance in those outcomes. This suggests that trust in an organization's ability to protect its members from violence—and intervene appropriately should violence arise—is important not only for victims and/or women but also for all personnel throughout the organization.

Limitations and Future Directions

Like any research, the present study is not without its limitations. Data released from the 2010 WGRA survey included assessment of sexual assault only in the past year. Some participants may have faced assault before that, which could account for important factors in our study. For example, previous sexual assault could explain why women personnel reported lower trust than men. The measure of sexual assault in the 2010 WGRA also did not capture perceived severity of victimization, which may be important for trust as well as health outcomes. We also lacked contextual information about assaults, including the location of the assault and whether or not the perpetrator was a fellow service member. According to the betrayal trauma theory (Freyd, 1996), sexual

assault perpetrated by a close other (vs. stranger) is more devastating and can further exacerbate institutional betrayal. In the military, victims may experience MSA differently if the perpetrator is a fellow service member (within or outside of one's chain of command).

Further, the WGRA provides correlational data at one time point, so we cannot conclude causality. For example, it is possible that lack of trust in the system is symptomatic of PTSD. The measure of PTSD-related stress symptoms (PTSD Checklist–Civilian version) does not provide a PTSD diagnosis, so it would be important for future work to determine the causal relationships between PTSD diagnosis and perceptions of trust. However, a study of women reporting experiences of sexual assault found that loss of trust served as a barrier to subsequent pursuit of legal and health services (Burns et al., 2014); this suggests that distrust is a precursor to negative outcomes. Additionally, the DMDC only releases individual-level data with this survey. An interesting future direction would be to investigate whether and how MSA (or a culture that promotes such violence) erodes group-level outcomes (e.g., unit morale, cohesion).

The current study assessed people's trust (e.g., beliefs that the military will protect their privacy) and not acts of institutional betrayal (e.g., personal information about their assault being shared with others). Although trust is an important facet of institutional betrayal (Smith & Freyd, 2014), it will be important for future work to assess how the military institution's (in)actions relate to outcomes of MSA. Likewise, the measure of training assessed participants' perceptions of training content, and some may have forgotten what their training covered. To some extent this speaks to the effectiveness of their training (e.g., poorly delivered training may be poorly remembered), but future research should assess training exposure more directly.

Research Implications

More research is needed to understand how MSA operates similarly to—yet differently from—other impediments to organizational trust. This research is especially needed in contexts that require trust and dependency among members. For instance, people often live and work alongside one another in offshore oil drilling, mining, fishing, and farming. In insular communities such as these, personnel must depend on one another, sometimes for their safety and survival. However, violence victims in these contexts encounter many barriers (e.g., limited access to medical or legal resources, fear of stigmatization, concerns about the confidentiality of their report; Logan, Evans, Stevenson, & Jordan, 2005); most do not report violence (Wolitzky-Taylor et al., 2011). How does organizational trust operate in these remote or rural settings, and how does it relate to workplace violence, help-seeking, and well-being? These questions await future study.

Clinical and Policy Implications

Trust is “necessary to create highly effective organizations that also protect the dignity and well-being of employees” (Gill & Sypher, 2009, p. 54). Our results add to that literature by demonstrating the importance of trust in organizational systems for well-being. We accounted for the impact of stressful, if not traumatic, life events on employee health and job attitudes (e.g.,

combat) and still found that trust accounted for a significant proportion of variance in outcomes. This suggests that trust that an organization will prevent, and adequately respond to, violence is important for *all* personnel. Trust in the system might be boosted with efforts to increase victims' confidentiality, safety, and dignity. In particular, it is crucial that those involved with reports of sexual assault (and other forms of violence and trauma) exercise caution when handling reports and coordinating resources. Improving training of first responders who work with victims may be an important step toward increasing employees' trust and, as a result, their well-being. Our results also carry important implications for response systems (e.g., legal and mental health advocates). MSA is a multifaceted trauma—not only is one's body violated and safety threatened, but also one's ability to trust others. A major challenge for mental health providers is to rebuild victims' trust (Battaglia, Finley, & Liebschutz, 2003). This is especially pivotal in hazardous occupations like the military, where people are expected to entrust coworkers with their lives. To restore and maintain trust, leaders should provide accurate information related to violence, implement accessible support for victims, and strive to prevent violence altogether.

Conclusion

The military acknowledges that trust is crucial for employees, yet trust is undermined by sexual assault (Department of the Army, 2004). Our results demonstrate how perceptions of trust can be volatile—related to individual (gender, sexual assault) and organizational (branch, training) factors. Moreover, our findings illustrate that erosion of trust in institutional responses to MSA is not without consequence: Lower levels of trust are associated with declines in mental and occupational health—among victims and nonvictims alike. Workplace violence can be devastating and so can (non)responsiveness to violence by the institution.

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