Sexual Assault and PTSD among US Women Soldiers:

The Importance of Community Interventions

by

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“Whoever survives a test, whatever it may be, must tell the story. That is his duty”- Elie Wiesel
Then who will listen?

INTRODUCTION

There is evidence of female participation in military and war in records from biblical times. This includes reports from the biblical stories of Jewish heroines, Greek documentation about the Amazons of Africa and Thrace, medieval crusaders and fighters, the female troops of Doheney, among others. (De Pauw p33-94). However, one significant difference from United States’ women’s experience in the modern military is no mention of sexual assault and humiliation by members of their own forces. The toleration and institutionalization of sexual references and lack of strict clear-cut consequences for harassment result in an atmosphere conducive to rape of women soldiers in the US (Hamed). Although there are similar “put downs” based on gender e.g., “Don’t walk like girls”, the Israeli military views women as integral to its abilities to provide services, and therefore enforces strict controls against sexually attacking or degrading individual women.

Such gender-related disparities are not universal; many woman soldiers have positive experiences. The prolonged psychological effects of sexism on soldiers undermine for many the value of these positive experiences, which, in one way or another, affect all who partake in military life. This paper focuses on US military women from WWI through the current Iraq War and Afghani peacekeeping missions. It contrasts the experiences of women in the various services, each of which has their own culture and differing rate of integration of women. Initially the reasons for joining military forces and expected and actual positives will be reviewed. Next,
the disillusionment and psychological costs from the sexual exploitation, exacerbated by participating in and witnessing death and violence, will be addressed.

The severe physical and mental health outcomes of sexual assault will be explored, particularly focusing on the chronic form of Post Traumatic Stress Disorder (PTSD). PTSD is a psychiatric diagnosis with trauma as an etiology characterized by three groups of defining symptoms: hyperarousal, intrusion of thoughts of the trauma, and emotional numbing or avoidance of situations that are likely to trigger painful memories. Other modifying factors, specific symptoms, and evidence-based therapies will be discussed. The provision of services and why they fail will be addressed. Healing modalities for these women will be reviewed paying particular attention to the importance of support networks and community. Finally areas of needed future research will be suggested.

Although the primary focus is related to the issues women experience, the paper will at times include the larger issues of PTSD as it applies to men and non-sexual abuse issues, since many of responses to trauma and community interventions are important in understanding fully human responses to trauma and successful psychological survival and recovery.

Demographics of United States Women in Military Forces

According to the Washington Times, as of June 2004, the United States had a force of 255,000 soldiers (8,700, 60% reserves) deployed in Iraq or Afghanistan. Of the total number, 28,142, or 11 percent, were women. In Operation Iraqi Freedom, women served in more combat roles in aircraft and ships than in any U.S. operation. They totaled 25,455 in a 269,000-troop invasion force, according to the Pentagon. During the period from January 2003 until July 2004, 500,097 post deployment physical and mental health screens were done; 56,433 women were evaluated. (MSMR 10:4) In comparison, approximately 400,000 women
served during the World War II era, 120,000 in the Korean era, 7,000 were deployed in theater in Vietnam, and 35,000 were deployed in Desert Storm. (Skaine, p 59)

Assumption of Military role: Reasons for joining the Military, Initial training, and Benefits

Women enlist in a military force for a variety of reasons. One of the most common ones, particularly in the South and in impoverished areas, is the lack of other good job opportunities. Teens, particularly Latina and other minorities, face what they perceive as high expenses for education and an inability to have a steady income without it (Feinman, p52) To someone from a poor family, $10,000 of debt looks like more than a $100,000 debt does to someone from a middle class or above family. Youths are seduced by promises of job training not understanding that the duration of most courses is short and many skills do not translate into civilian jobs. (Feinman p51) Recruits hope to have education both within the service, and then afterwards have enhanced career options in adult life. This is particularly true for those in the National Guard or Army Reserve, who may have doubted that they would ever actually go to war.

Often young women see marriage as the only other option for becoming independent from the family. Some may want to escape abusive situations either from home or a partner. Studies show that about 25-35% of women soldiers suffered attempted or completed childhood rape. (Martin) Others come from broken families and, after joining, remain in the military because it becomes the secure “family” network they previously didn’t have. Yet others feel that they are taking on too much of the family responsibility at home and want a way out.

On the other hand, some of the women come from military families and relish the opportunity to follow in the footsteps of a beloved relative. Others have been raised with either great patriotism, nationalism or idealism for a cause that sees one expression of these feelings as service in the military. Still others see the military as an opportunity for adventure and
advancement. Women who achieve appointment to military academies have high hopes of important leadership careers. The early acceptance of women pilots and officers may be the reason that the Air Force has the highest percentage of women, nearly twenty percent, while the Marine Corps, the most "macho" of the services, has the lowest at only 6%. (MSMR, 10:2).

Regardless of the reason that a woman enters the military, one commonality is a set of experiences that are coordinated to bind the new recruit into a cohesive group.

"The basic training camp was designed to undermine all the past concepts and beliefs of the new recruit, to undermine his civilian values, to change his self-concept—subjugating him entirely to the military system." Ben Shalit, The Psychology of Conflict and Combat (Grossman).

Boot camp involves both humiliation and strict control of all aspects of life. Historically this has included much sexually degrading rhetoric, such as this Marine chant:

Rape the town and kill the people, that's the thing we love to do! Rape the town and kill the people, that's the only thing to do! Watch the kiddies scream and shout, rape the town and kill the people, that's the thing we love to do! (Hallock p34)

Common verbal intimidation, often called "put-downs", includes being labeled as weak, effeminate, or soft—all characteristics that are usually ascribed to women. Sexual harassment of the girls and women reinforces this gender power differential; the organizational culture that these girls and women are initiated into values the characteristics traditionally attributable to men and suggest that those without them are inferior and unsuitable (Sadler), except for sexualized roles. "Women as a group are viewed as second class and are subordinated by men of the military." (Herbert, p 122)

A second imperative of the basic training (a verbal and representative image of atrocity-controlled initiation)(Grossman) is to inculcate a norm of absolute and reflex obedience. This is coupled with desensitization to killing (and other social norms which separate acceptable behavior from crime) in the military trainee. Life-size and lifelike models are used for target-
practice combined with positive reinforcement for actions that leave the adversary dehumanized and the perpetrators exhausted by harsh conditions.

In spite of often degrading conditions, there are some supportive commanders, both male and female. Women afforded proper leadership, achieve respect, skills, self-efficacy and independence. Many have a chance for adventure and a life free of uncomfortable control of father, boyfriend or husband. Women in the US military have opportunities for training and advancement as exemplified by female fighter pilots, heads of army hospitals, and a variety of commanding positions. Girls and women thus have a chance to explore the implications of their gender, and sometimes they can develop new, and often better, sense of their own identities.

**MILITARY SEXUAL ASSAULT (MST) AND HARASSMENT**

“Currently, one of the most volatile issues confronting female veterans is that of sexual trauma. Indeed, the assault itself and the trauma associated with it is, for many female veterans, just the beginning of the so-called trauma cycle—one exacerbated by the military or VA’s failure to consistently identify and fully prosecute perpetrators. Even when the perpetrator has a history or reputation for violating or intimidating women in the military, the reaction of government agencies can sometimes be slow, inadequate or nonexistent.”

- Velma R Hart, AmVets Magazine Fall 2004

“What Women Want From Their Service And Aren’t Getting”

Recruiting material, family pride, patriotism and idealism don’t prepare young women for the sexually charged world they enter. In the years 2002 and 2003, there were more than 2000 rapes reported among female soldiers. For those cases in which the age of the service member victim was available, ages 17 – 24 represented, on average, 87% of Air Force victims, 85% of DON victims, and 83% of Army victims for the two years reported. (Task Force Report, Care for Victims of Sexual Assault) Historically, only 25% reported assault to a ranking officer (Sandler). If this remains true in these years, the actual rate would be 40/1000/year among the young women in the services, which would approach a 25% chance in six years of service. In a random survey of women’s health care registries, 79% of the soldiers had experienced sexual
harassment and 30% experienced one or more rapes or attempted rape (Sandler). In another study at the VA, the incidence of rape was 23% - these women had a three times higher incidence of depression (40%) and a 2 times elevated incidence of alcohol abuse (Hankin). This factor could explain the excess of depression that Hourani found in Navy and Marine women (22%), as compared to men (9%). (Hourani, 1999)

"By April 2004, rapes and assaults of American female soldiers were epidemic in the Middle East. But even after more than 83 incidents were reported during a six-month period in Iraq and Kuwait, the 24-hour rape hot line in Kuwait was still being answered by a machine advising callers to leave a phone number where they could be reached.... Military stupidity at its finest, or senior male brass who chose to shrug and look the other way? Reports of assault... were mostly not investigated because commanders had other priorities. The attitude of Lt. Gen. Ricardo Sanchez (then the ground commander in Iraq) permeated the entire chain of command: The women asked to be here, so now let them take what comes with the territory. Brig. Gen. Michael J. Diamond, then commander of the 377th Theater Support Command in Kuwait, followed Sanchez’s lead and refused to take any proactive steps toward stopping the rapes. When I tried to discuss the gravity of the situation with him, he responded, 'It's not always easy being me, you know,'”

Brig. Gen. Janis Karpinski, then commanding general of the 800th Military Police Brigade in AzStarNet, Arizona Daily Star Published: 09.23.2004
http://www.azstarnet.com/dailystar/printDS/40136.php

Although almost a third of rape victims sought medical care, there was a low incidence of reporting rape to their commanders, a required first step to achieving redress of this violation. A commander often will minimize and encourage her to keep silent in order not to interfere with group morale. Often the rape victim will have to continue to work with the perpetrators, producing a feeling of shame. Indeed, the perpetrator may be a friend of the commander or the commander himself. Unless she is granted a change of work or leaves the military she is forced to stay in contact with her perpetrator. Therefore the victim feels her situation will only get worse through reporting.

Should a pregnancy result from rape, she can either chose to carry the child, have an abortion in a military hospitals at her own expense (having to prove that it was indeed a result of sexual assault), or be faced with a risky or expensive private abortion. About 10% percent of military women become pregnant each year; among enlisted women, 60% of pregnancies are
unplanned. Data was not available on how many of these were the product of an assault. By June 2004, 163 army soldiers had become pregnant in Iraq. The Air Force and Marines don’t track pregnancies; the Navy didn’t answer questions posed by reporters. (military.com)

**POSTTRAUMATIC STRESS DISORDER**

Anger and grief are normal responses to trauma. There also may be initial anxiety. Acute Post Traumatic Stress Disorder is diagnosed after symptoms persist for one month. Only when symptoms last more than 3 months and are characterized by (1) Re-experiencing (recurrent and intrusive recollection, subjective experience or dreams, or psychological distress or physiological reactivity to cues that are reminders), (2) Avoidance (protecting oneself from exposures to reminders, feelings of detachment or estrangement from others, and a restricted range of affects, numbing), and (3) Increased arousal (sleep difficulties, irritability or anger, difficulty concentrating, hypervigilance, and exaggerated startle response), does the full diagnosis of PTSD develop.

**MODERATING FACTORS IMPACTING ON WHETHER MST LEADS TO PTSD**

There are a number of moderating factors that influence the long-term outcomes of the girls and women who are exposed to sexual assault. Twenty years of study have shown it is not only the event, but also what the women bring to the event, and what happens after that are important. In comparison with a woman with no assault history a soldier suffering military sexual assault was 9.3 times more likely to have PTSD, one with childhood sexual assault 7.3 times more likely, and civilian sexual assault only 4.6 times more likely (Suris). Other traumatic experiences, younger age, lower education, childhood adversity including previous molestation or physical abuse, some pre-existing psychiatric disorders, and poor social support make a soldier more likely to experience PTSD (Schnurr)(Suris). Alternatively, in several studies, good
home support reduced the incidence of PTSD, even in those exposed to severe trauma. Therefore, it is theorized that community interventions after the response can be mitigating factors in the development of PTSD.

The context in which the trauma occurs, the age and stage of life of the traumatized person, the associated losses of family and cultural coherence, characteristics of the person prior to the trauma, the conditions of life after the traumatic encounter, and the symbolic and moral meanings attached to the traumatic events all affect the expression and experience of post traumatic stress responses. (Kroll)

**Trauma**

During deployment, particularly in the army environment with underlying gender and sexual hostility and attack, women are faced with multiple traumas. The line between combatant and non-combatant is blurred. Many women from the First World War until today find that jobs “behind the front” are targets and there is no respect in these days for medical immunity. Many jobs are in units where women are required to carry weapons and move into combat areas (e.g., military police and logistics). Like sexual assault, exposure to combat conditions as in the Persian Gulf War increases the incidence of depression from a baseline of 11%, 12½% (regular military, reserve & guard) to 16½%, 19½% (Iowa Persian Gulf Study Group). Military trauma combined with sexual assault carry additive effects in women. (Murdock, Hodges, Aug 2003)(Ursano pp 494) Among female combat veterans applying for PTSD disability benefits, almost two-thirds also suffered in service sexual assault. (Murdock, 2004) Those who suffered with both also have more severe interference with functioning. (Murdock, Hodges, Aug 2003)

In today’s guerilla warfare, there is no “safe zone”. Landmines and bombs can detonate anywhere. In this state of perpetual fear, it is easy to be uncentered and tense, which leads to both injuries and accidents. At anytime one can witness death and maiming. The stories one hears and the conversations shared are full of graphic details. The contrast between safe non-combat jobs and combat jobs is becoming less distinct.
"The United States bans women from ground combat units, which include artillery, infantry and armor. They may, however, serve on combat ships and aircraft. And they serve as military police, a job that in Iraq puts them close to counterinsurgency operations." (Washington Times, 12/31/03 “A promotion for female soldiers”, Joshua Mitnick)

The 1994 repeal of the "risk rule" barring women from combat launched a national debate over a woman's fitness to serve and the danger her perceived weaknesses posed to male co-combatants. Military women and their supporters fought long and hard to win the repeal and they are still under fire for it.

"Due to religious and cultural beliefs in Iraq, female soldiers serving as de facto infantrymen have become a necessity. Soldiers serving as gate guards must pat down civilians coming through the gate to ensure that someone does not smuggle a weapon or explosive device onto the U.S. compound downtown, while soldiers on patrol (outside of the gate) search people suspected of looting or other crimes. ...Therefore, Army leaders requested female soldiers to volunteer to work with infantry units, whose duties include patrolling the streets and guarding the gates to coalition posts in Baghdad. . (Female Soldier Patrols Baghdad Streets with the 1st Armored Division, By U.S. Army Spc. Ryan Smith 372nd Mobile Public Affairs Detachment http://userpages.aug.com/captbarb/patrol.html)

American women in mine-cleaning and transport missions, similarly, face bodily risk. Therefore, there are very large numbers of individuals, who are exposed to trauma or at risk for the psychological consequences of atrocities, war, and violence.

**Age and Education**

Since sexual assault is more commonly perpetrated on young women, more often in the marines and army, it is not surprising that PTSD is more common among younger and less-educated women who are more likely to be in these services. This often reflects an outcome of a psychological pecking order where the youngest women are at the bottom, particularly those who have less affiliative social skills and a smaller repertoire of responses to harassment that might protect them. This is similar to hazing, and includes sexual abuse of vulnerable young men.

Also, there is some evidence that trauma experienced in the adolescent and young adult years, the age of identity formation, may cause a young woman to respond with one of two opposite responses: (1) “Combat never ends: the Paranoid Adaptation” leading to ongoing McGahey
hyper-vigilance and aggression – an angry and continuous perception of danger as ever present or (2) the perception of Irretrievable loss, a triumph of death over-life leading to social withdrawal and isolation, “Mourning Never Ends: The Depressive Adaptation.” (MacNair,p15) 

Women veterans experiencing MST have 56-60% incidence of depression (Suris)(Hankin). Those then diagnosed with PTSD have 62% depression (8% for women without PTSD) (Dobie).

For sexually traumatized US women soldiers, the institutional roadblocks keeping her perpetrator from being brought to justice exacerbate both anger and depression. Furey concluded that loss is more profound when attacked by a “comrade-in-arms whom in common cause swore to uphold their country’s peace and safety.” (Murdock, 2004)

The next developmental task the young adult soldiers face is “Intimacy vs. Isolation”. Traumatic responses at this stage include distorted understanding of death and “bad events”, risk-taking behaviors and emergence of adult psychopathology. Motor vehicle accidental deaths are higher among women post-deployment veterans of both the Vietnam and Gulf War compared with both male veterans and non-war deployed. The accidents were characterized by greater risk taking. (Bond). Eighteen percent of women experiencing MST had concomitant Substance abuse disorders, (Suris) compared to 9% of active duty Navy and Marine Corps personnel (Hourani, 1999). In a cross-sectional sample of general veterans, those who developed PTSD had 31% incidence of substance abuse compared to 20% of others. (Dobie)

They also seem to have more problems with relationships. Forty-two percent are divorced or separated compared to 31% of veterans without PTSD; 13.5% have multiple partners compared to seven percent; 58% are victims of domestic violence compared to 33.5%. (Dobie) Those who screen positive for PTSD have a lifetime risk of 30.5% for STD (non PTSD 18.6%).

Inadequate Social Support from the Military Hierarchy

McGahey
The systemic denial of justice and fear of disclosing exacerbate the insult of military sexual assault, the most highly predictive traumatic etiology for PTSD (45-52% incidence) in US women soldiers (Hourani, Yehuda, Murdoch, 2004). It is curious that none of the many articles on military sexual assault and the development of PTSD compared the incidence in three groups: those who reported and had an appropriate system response; those who had an inappropriate or non-existent response; and those women who were too fearful to report at all.

Our servicewomen in Iraq continue to make reports of sexual assaults, and DoD puts out a report that talks about convening summits and developing policies...These victims need support, not summits. They need confidentiality in reporting. They need DNA evidence kits available and trained personnel to administer them. They need to know that if they report an assault, they will not be put through the ringer by the military and possibly kicked out. And they need these things now. (Representative Maloney)

"When the Pentagon winks and nods at sexual assault, it weakens our military as much as enemy bullets. In the twenty-first century, women are an integral part of our fighting forces. They need to spend their time defending America from Al Qaeda, not defending themselves from sexual predators.” (Representative Watson)

"Abuse often goes without criminal punishment. In many cases, military officers choose to dole out administrative punishments, and offenders remain in the military, while their victims are at times forced out. (Press Release http://www.house.gov/malonev/press/108th/20040709RumsfeldLtr.htm )

Previous childhood or adolescent adversity including molestation or physical abuse

From the neurobiological studies and data it appears that women who have had a previous history of abuse are more likely to develop PTSD after military sexual assault. One study of Navy recruits showed that 35% had been raped prior to service and 57% had suffered physical or sexual abuse. (Bond) It appears that cumulative trauma changes neurobiology to create the classic symptoms of re-experiencing, hyperarousal, and avoidance. The hippocampus is thought to mediate the neurobiological response that causes PTSD. This area of the brain serves to set up perceptual patterns. If previous life events have left the young women with some indication that the world is a fearful and threatening place, a new event of rape by a “buddy” or superior may tip her over into a life path of anxiety, always being physiologically prepared to recognize danger early and “fight or fly.”
Prior or coexistent psychiatric Disorder

According to predeployment studies about six% of soldiers have preexisting psychiatric conditions, (MSMR 10(4)) but not severe enough to cause separation from the military or inability to function. These women might be less able to pick up subtle clues to protect them from assault and more likely to abuse substances, which puts them at greater risk for assault. Women with PTSD are four-five times as likely to have depression as women without and two-four times more likely to have another anxiety disorder (Brady). In another study Depression was present in 62% of female veterans with PTSD, but only 8% without it (panic disorder 47%, 4%) Many studies have shown that pre-existing psychiatric conditions, especially depressive and anxiety disorders, increase the severity of post traumatic stress responses as do individual differences in personality and temperament. (Kroll)

Community and Family Social Support

Most studies found social support back home to be protective. Data from the National Vietnam Veterans readjustment Study showed that home support was associated with less PTSD in both those who had high and low level trauma. (Fontana, Nov 1997). Likewise, those with previous family stability appear to be more resistant.

EARLY INTERVENTION

There is evidence that if emotionality and symptoms are addressed early and caregivers avoid pathologization, with an assumption that the soldier can recover, the outcome improves. Because of this mental health services are provided at the battlefield. There are two barriers to these interventions working. The first is that if the results from one study of returning soldiers, mostly men, hold true for women, then only 23-40% of those having severe symptoms will seek help. (Hoge) Second, caregivers label the patients in order to provide psychoactive medication
to help soldiers return to their jobs and also want to treat because of fear that the symptoms may be so bad that the soldiers will hurt themselves. (Iraq War Clinician Guide) In 2003 there were 24 suicides, 2 of them women, in Iraq. Ten percent of the over 20,000 soldiers evacuated from the OIF theatre have mental health problems. The data do not show the percentage of women.

**Psychological Debriefing.**

Psychological debriefing (PD) is a single session provided soon after a potentially traumatizing event. Although there is a great desire to help at this time, several studies have shown no efficacy from this; therefore there should be no compulsory requirement that victims of trauma must be debriefed. In fact, two of the most rigorous studies showed that PD likely created an exacerbation in PTSD symptoms over time, with more anxiety and depression than the control group. This is in spite of the fact that participants reported it was helpful in the immediate time, possibly related to making them feel validated about their suffering. The efficacy may be less because it provides a one-size fits all solution, not taking into account various risk factors (Litz).

**Post-trauma support**

On the other hand, it is hypothesized that systems in place to give sexually assaulted women help in regaining a sense of self and safety might alleviate some of the globalization of hostility. These appropriate responses include confidentiality and victim advocates. This is why in the civilian sector patient advocates from Rape Crisis Centers meet patients at the hospital and support them during the period of interrogation and examination. They also provide psychological first-aid by describing what to expect and how and where to get help. (Litz) These skilled workers or volunteers also assure that the patients are given the most up to date evidentiary evaluation and current treatment to prevent STDs and unwanted pregnancies. They
support the victim in enabling her to start working through her shame and self-blame. It is also important in this early period to identify those that have higher risk of developing PTSD secondary to other vulnerability factors. Individual differences in coping style, symptom severity, past-trauma and other co-morbidities are acknowledged.

The May 2004 Department of Defense Sexual Assault Task Force Report did nothing to remedy this lack of immediate support for the 160 women who have already been sexually assaulted in the field and the increasing numbers that are sure to follow, given unchanged conditions. This continued lack of response and fear of reprisals exacerbate the chronic anger and grief predisposing these women to PTSD. Results from a general population study comparing incidences of mental illness in 14 countries, suggests that mental pathology might be related to failed expectations. This may explain the higher 12-month prevalence in the United States than in Nigeria or Mexico of anxiety and mood disorder (US 18%, 10%; Nigeria, 3.3%, 1%; Mexico 7%, 5%), which may be related to disappointment in our country where one expects that life will be smoother. (WHO). The high rate of PTSD following MST may be resultant from the unmet expectation that others in her unit would treat her with respect.

According to the analysis of Christine Hansen, Executive Director of the Miles Foundation, The Memorandum on of Secretary of Defense Donald Rumsfeld to the Secretaries and commanders of the military departments fails to acknowledge the crime of sexual assault, rather assigning "unacceptable behavior" status to sexual assault. The Report’s recommendations neglect the immediate needs of victims serving in the current theater of operations, such as rape evidence kits; testing supplies for STDs, HIV and pregnancy; victim advocates; victim witness liaisons; transportation protocols; emergency contraception; and medication.” The staffing levels for victim advocates are not stated, so availability and
accessibility to victims and survivors may not be assured. The report ignores potential contributions of Sexual Assault Nurse Examiners (SANEs) as evidenced by the decades of service within the civilian community. Even though Congress in 1994 authorized a headquarters program manager and chain of command for victim advocates and victim service specialists serving in the military departments, it remains undone. There still is no policy of confidentiality or long-term policies and protocols including establishing standardized care and services as supported by Congress since 1998. “The Report does not recommend development of an infrastructure and foundation of law and policy to sufficiently address sexual assault among the ranks.” (Hansen, 2004) In an attempt to remedy the situation, recently Air Force Brig. Gen. K.C. McClain, a woman, was named to a newly created position as policy chief for all matters related to sexual assault prevention and response.

Not only is confidentiality needed and lacking in Sexual Assault services, according to Hoge’s recent NEJM article, soldiers do not receive needed mental health services for severe symptoms secondary to fears of being stigmatized, thus limiting their careers, because this has been the case both for those with diagnosed mental disorders as well as those who have reported sexual assault. (Dean)(Moffeit)(Skaine)(Feinman) “Confidential counseling,” is hampered because the first line caregivers are equally responsible to the patients and to the needs of the military. (Hoge) Also, “in a war zone where commanders must have constant updated accountability for their troops, and where travel is often limited to military convoys, it is difficult for military patients to access mental health services unnoticed.” (Iraq War Clinician Guide)

**Early four-session Cognitive Behavior Therapy**

Cognitive Behavior Therapy (CBT) is an approach that not only works to correct incorrect cognitions leading to the symptoms of PTSD but also teaches new behaviors to avert
those symptoms. In this brief version, the program consists of education about common reactions to assault, relaxation training, imaginal and in vivo exposure, and cognitive restructuring. In one study, two months later women experienced fewer symptoms of PTSD, but at 5.5 months this difference faded, possibly due to statistical factors. Nevertheless, there were significantly fewer symptoms of depression. Although both PD and CBT involve recall of trauma, CBT also provides behavioral help in handling the vivid memories. (Litz) In addition the increased number of sessions with the same provider gives profound support for recapturing lost feelings of self-efficacy. The “treatment homework assignments” help by giving constructive modes of focusing and controlling ruminant thinking.

**DIAGNOSIS AND TREATMENT OF CHRONIC PTSD**

**Diagnosis**

According to current VA/DOD Practice Guidelines all new patients should be screened for symptoms of PTSD. Several well-validated screening instruments identify easily and quickly the possibility of a PTSD. Patients, especially those who have experienced trauma, have substance abuse or depression, or who have unexplained symptoms, should be rescreened frequently. The Posttraumatic Checklist-Civilian (PCL-C) is a seventeen-item questionnaire with a five point scale that in simple language asks about past trauma with questions about reexperiencing, autonomic symptoms (hyperarousal), avoidant behavior of both thoughts or places, psychological numbing, dysthymia, negativity about the future, sleep disturbance, irritability or anger, and concentration problems. (Carlson) It identifies those with both combat and non-combat related trauma and has been used in many research studies.

Other possible screening instruments include the Screen for Posttraumatic Stress Symptoms (SPTSS), the Primary Care PTSD Screen (PC-PTSD) and the PTSD Brief Screen
(four questions). (DOD/VA Core Module Summary). The SPTSS has a very low reading level and asks about symptom frequency rather than distress, so may be useful in those people who are more externally aware. A detailed clinical interview also can be done, but often this is an adjunct to initiation of therapy.

Often if PTSD or MST is not diagnosed early, an acute clinician can discover it in the chronic period by asking about trauma and sexual assault in patients who present with a variety of comorbid physical conditions. These include chest pain, difficulty breathing, elevated blood pressure, fainting, nausea and vomiting, fatigue, insomnia, grinding teeth, profuse sweating, rapid heart rate, excessive thirst, and generalized weakness. (VA/DOD Triage) Compared to women not experiencing military sexual trauma, women trauma survivors have increased menopausal symptoms (41% OR 2.4), severe pain with menses (53% OR 1.8), Premenstrual syndrome (67% OR1.8), severe headaches or Migraines (43% or. 2.2), Chronic Fatigue (43% OR2.0), and Endometriosis (12%OR 2.5)(Frayne) Other diseases are much more common: fibromyalgia (19%, OR 3.0, Irritable bowel syndrome (37%, OR 2.8) and obesity (47%, OR 1.8). In this group, the prevalence of myocardial infarction or coronary artery disease is almost twice as high as the non-affected. (Dobie)

There also are a number of disturbing behaviors including increased alcohol consumption, antisocial acts, emotional outbursts, inability to rest, explosive anger, and increased suspiciousness. Therefore in those diagnosed with PTSD additional screens for substance abuse, particularly alcohol, for depression, and for maladaptive anger should be done as indicated. (Carlson) In one survey of general health, women veterans with PTSD were seven times as likely to have poor emotional role functioning and almost four times as likely to have poor social functioning than those without. (Dobie) In the National Comorbidity Survey more
than one-third of the cases of PTSD never recovered. The median time to remission was 36
months (50% recovered) (64 months in non-treated group). (Schnurr)

**Treatment**

With appropriate and timely diagnosis, Chronic PTSD has a number of treatments with
evidence-based positive results. They fall into two categories: Present-focused psychosocial
treatment and Trauma-focused psychotherapy. Historically the VA system has done better at
providing the former, which includes coping skills training, psycho-education, addressing beliefs
about safety and trustworthiness of the current environment, anger management, sleep hygiene
and psychotherapy of current psychological and social problems using a treatment manual
(manualized therapy). In a study based on data from 1999 and 2001 that was published in
2004, the above core was provided with these frequencies: 55-89% receiving coping skills
training, yet only 35-65% addressing anger management or sleep hygiene issues, and less than
10% used manualized psychotherapy. (Rosen)

Appropriate trauma-focused psychotherapy was even less likely to be provided, based on
questions to PTSD specialists (2001) about discussing trauma in therapy (40% occasionally, 15%
rarely), restructuring trauma beliefs (35%, 15%), and multiple exposure to stress producing
situations (9%, 3%) (Rosen) The proven evidence-based therapies including Cognitive Therapy,
Exposure Therapy, and Stress Inoculation Training utilize the above components. Eye movement
Desensitization and Reprocessing is another evidence-based therapy very rarely used.
Pharmacotherapy is also indicated in some patients. Very promising is the use of treatment
manuals for both group and individual patients. (VA/DOD Clinical Practice Guidelines) Many of
the behaviors that they use are similar to behaviors taught in a variety of community setting.
(VA Interventions Module) Attached are three modules developed by the VA to help
Community physicians, the first on triage/assessment, the second on PTSD in Primary Care, and the third on Interventions.

**Pharmacotherapy**

Although reducing symptoms in the short term, none of the medications has proven to have significant benefit in preventing or curing PTSD. Many of the acute anxiolytics, particularly when used to keep soldiers on the battlefield, may have a numbing effect and predispose to worsening later symptoms or substance abuse. They also may predispose to bad choices by inhibiting natural wariness. Improved sleep function is beneficial, but not if it decreases cognitive clarity as many of the medications do.

**Cognitive Behavior Therapy**

Cognitive Behavior therapy aims to treat both the dysfunctional thoughts about the trauma, oneself, others, and the world and replace them with more accurate thoughts. (DOD/VA Interventions). This includes a stepwise series of homework and behavior exercises to help the veteran habituate to disturbing stimuli. In the VA system this is the most common evidence-based therapy proved effective in Random-controlled trials in use; however only one third of the PTSD specialists use it occasionally and only 15% regularly. (Rosen)

**Exposure Therapy**

Exposure therapy commences with graded exposure first to mental images of fear stimuli and then progresses to actual disturbing stimuli. In a recent study CBT plus exposure was compared to exposure alone in female assault survivors and there was no difference in efficacy. Symptoms of reexperiencing, avoidance numbing, and arousal decreased although not to the normal level. (Foa) This effective treatment is only being used regularly less than 5% of the time and occasionally less than 10% in the VA system. (Rosen)
Eye Movement Desensitization and Reprocessing

The patient is asked to identify a disturbing image that encapsulates the worst part of the traumatic event, associated body sensations and a negative self-referring cognition about what the patient "learned" from the trauma, and then a positive cognition to replace the negative cognition. The patient holds the disturbing image, sensations, and negative cognition in mind while tracking the clinicians moving finger back and forth for about 20 seconds. Gradually the negative cognitions stabilize and then the positive cognitions come in and are reinforced. The patient does not need to disclose the trauma only the cognitions and what change is happening (VA/DOD Interventions). Unfortunately this very effective therapy is not currently being used in VA hospitals, possibly due to a lack of training. (Rosen)

Co-morbid Substance Abuse

A challenge for everyone dealing with returning traumatized or sexually abused veterans is the high incidence of substance abuse as mentioned above. Often former soldiers and others who have been traumatized, self-medicate with drugs to numb the feelings of being emotionally out of control. However, this actually works in reverse because often the loosening of inhibitions result in more psychosocial problems, can lead to isolation from families, and create an inability to maintain work or carry-out life functions. People with the comorbid diagnosis of PTSD and substance abuse are harder to treat and also may exhibit depression and self-destructive behaviors.

It appears important to treat the substance abuse before beginning therapies involving trauma narratives or sequential exposure to bothersome situations or thoughts. Lisa Najavits has developed a structured manual. Many of the topics also can be covered in community education programs. Most of the research studies are clear that a variety of different approaches are
needed and that the same treatment modalities or interventions will not work for all girls and women (Iraq Clinician Guide) (VA Intervention Module) (Wolf) (Dean). The meaning a person ascribes to an event can be important in determining outcome (Hernandez) as can the social mores that face women which have been shown to reinforce the propensity for silence and maintenance of caretaking roles. (Wolfe) It is illuminating that this appears to be true across cultures and ages.

COMMUNITY INTERVENTIONS

It is important to engage communities where these female soldiers came from and for them to give support to the women - encouraging them to address troubling symptoms rather than hiding from them. Both the affected individuals and the establishments involved in reintegration may be overwhelmed by the magnitude of the problem and often see the easiest solution as not seeking help and not aggressively seeking out those in need. Women's health clinics are accessible at VA hospitals, but veterans may not know they qualify and in some places the wait is very long. The more people in the community who are aware of distress reactions, the more likely that those in need of help will be identified quickly and then barriers to services can be addressed.

The pervasiveness of increased medical symptoms and illness and of increased incidence of substance abuse make it imperative to provide education about these co-morbidities to anyone who might be the first point of contact for these problems. A comprehensive program would prepare specific information for bars, Alcoholic Anonymous and Narcotic Anonymous, including ALA-non, Emergency Rooms, and private physicians offices, particularly the specialties of Family Practice and Obstetric and Gynecology. Although all physicians are urged
to take a trauma history in all patients, it is especially important in female veterans who have not had the usual support afforded to non-military women suffering sexual assault.

It is necessary to recognize that the trauma of killing and being a perpetrator (either personally or through identification with a group) can be as equally troubling as being a victim and can increase the likelihood of PTSD in those who were victims of MST. Helpful responses include welcoming and embracing soldiers as part of a family and community, careful listening, ritual events such as parades, helping the returned soldiers establish a place in the community either in education or jobs, working to help them establish a sense of self, and helping them access services. It is most important to encourage the young women to identify and take action against the perpetrator and know that she has support in the community.

Awareness of the Problem

Radio spots, newspaper articles on PTSD and other military related health issues can be aired or published particularly when units or soldiers are returning home. VA service officers have been advised that up to 50% of returning veterans may have disabilities. Family members may notice extreme emotionality, outbursts of anger, inappropriate trivialization of war and killing, trouble sleeping or eating and difficulty concentrating. In the work or education setting there may be persistent fatigue and frequent absences. Alcohol abuse is present in 20-30% of soldiers and marines recently returned from Iraq (Hoge). Technical schools and college counselors need materials to help them screen returning veterans with problems. According to a recent article in Newsweek, returning veterans also are not getting needed help with the transition back to school, which could exacerbate the response in the women affected. A recent study by McFall and others showed that outreach interventions can increase veterans use of PTSD
services from 7 to 24%. (McFall) If the important people who come in contact with veterans had information on asking appropriate questions, this might help some get the early help they need.

Additional Issues Surrounding Killing

War is by definition requires killing. Only recently has work been done on the psychology of killing (Grossman) or Perpetrator PTSD (MacNair). Grossman identified five psychological stages: Concern, the Kill, Exhilaration, Remorse, Rationalization and Acceptance. If Remorse fails to develop, the person becomes cold and hard and subsequently it will be easier to kill again. If Rationalization fails PTSD may develop. As more women are involved in combat, we don’t know if the stages will be similar or different for them. Recently a *Washington Post* story told about a Pvt Teresa Broadwell, a young police machine gunner involved in an ambush where she killed at least one Iraqi. According to her for two days after “all I could do was sit back and cry.” “I never thought I would have to take somebody’s life, but I had to.”

The factors that help may help keep her and others from developing PTSD are praise and assurance from peers and superiors that they did the right thing, receiving medals, or other recognition, continued presence of mature older experienced comrades, and a rear line or safe area to relax to during the tour (difficult to impossible in Iraq). For her killing a combatant when she knows that she has adhered to wartime conventions, will be easier to accept than questionable deaths like those of children, noncombatant women, or prisoners of war. The psychological costs will be stiffer on those who have tortured victims, such as such as the prison guards or others, violating community norms.

Welcoming and Embracing

When women come home one of the most important protectors against PTSD is the support from family, friends, and even communities at their homecoming. Maercker in a recent
article showed that “Social acknowledgement” of survivorship was more protective of decreased symptoms of PTSD than duration or intensity of trauma was a factor in increased symptoms. Social acknowledgement includes community recognition of the soldier, general approval, and family approval. Social support, measures of emotional and instrumental help also are protective but not as highly correlated in this study. (Maercker). The recent series “Betrayal of Trust” in the Denver Post makes clear to these young women, who are often isolated that they are not alone and that what they face is not individual but societal factors. (Moffeit) Similar articles should be widespread in the magazines likely to be read by this group. It is very difficult for survivors of sexual assault to ask for help because they often feel dirty or contaminated. It is important for the message that PTSD is a real problem to be widely disseminated and normalize the message that help is needed in order for recovery to occur. People who come in contact with these veterans need to be helpful themselves and have referral numbers for professional help.

The positive impact of social support is true for individuals experiencing both high and low levels of trauma. Social support includes both being available to talk and provide emotional support and well as to help with the instrumental necessities of life such as transportation, access to childcare, etc. (Fontana, Feb 1997) Home social support is a more important predictor of outcome than support in the military via unit cohesiveness or the type or severity of trauma. (Fontana Nov 1997) In all of the studies on returning soldiers, the presence and support of a family correlated with a much better outcome (Kaspwersen).

Many of the returning soldiers may not have family support. Women with unstable or insecure living conditions seem more likely than those with more stable situations to volunteer as a means of escape. Some families may not like the fact that their daughters have become soldiers, believing the old stereotypes that women in the military are either “Whores” or “Gay”.

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The military service, with frequent moves, may attenuate social ties. (Gamache) The tendency of young adults in the US to move out of the house on adulthood and the fact that over half of the women troops are single suggests a potential problem of support that should be addressed by the many who come in contact with them. (Ursano p38) This lack of ties may be one reason why women veterans are two to four times more likely than non-veterans to become homeless, even though they have more education (52% have completed high school compared with 26% of other homeless women) (Gamache)

For those who do have families, difficulties of reintegration must be anticipated. They may have children born of rape due to unavailability, inaccessibility or the expense of safe abortions. This October, the Defense Authorization bill continued the ban on DOD funding of abortions even in the case of those resulting from Military Sexual Assault or Rape. (Federal Employees Almanac, 2004)

After parents return home, young children often are angry with parents who have been away and may question authority. Alternate family patterns may have developed. Women may have become more self-confident and more independent. This might be seen as threatening to existing community and family structures – this is especially so if the returning soldier expects the home life to be the same as before the separation started. The Iraq War Clinicians guide has a handout for family members on welcoming their soldier. (Appendix 2) More community awareness and preparation programs can be helpful also addressing the needs of their young children as the adults in their family return home, particularly for reservists who are often unsupported by family services in their communities.

Those who have left a work or an education environment, or who are trying to enter into one, may feel inadequate to the tasks that they face. Their concentration may be decreased and
they may need clarification of simple tasks. Their perceptions may be altered causing them to perceive hostility when there is none. The VA has prepared handouts for both employers (Appendix 3) and coworkers (Appendix 4) to address these problems, but there is still no systematic way of distributing them, since there is no good follow-up once a soldier is separated and becomes a veteran. Counselors and advisors in educational institutions need education on what to expect from returning women soldiers and the resources that are available to help them.

A crucial factor in the veteran’s welcome is the current economic situation and the paucity of jobs. At this time in history, the jobs that provide a middle class income are shrinking, just as skilled factory jobs have been lost. Many of the other jobs, such as teaching and nursing require years of education beyond what the military provides.

The abused female soldier who may have been separated from the service because of her reporting of rape may dread coming home if she can’t envision a place for her to work in her community. If there are no other women veterans in her community who might be able to understand the world from which she is returning, and she may feel social and emotional isolation. (Ursano pp 32-36) The importance of the above factors can’t be overstated because research by Schnurr suggests “risk factors for persistent PTSD are primarily associated with such present variables such as emotional sustenance, current structural social support, and recent life events.” (Friedman) Particularly younger veterans who are unemployed face a more severe and chronic adjustment after trauma. (Magruder)

**Ritual**

There are few formal cleansing rituals in US society. Often women who have been assaulted feel tainted and accept some of society’s pressure that they themselves are at fault. One study of male veterans showed that inability to forgive oneself or the others might be
associated with PTSD. (Witvliet). If this is corroborated in women, then one can posit that healing rituals involving self-forgiveness and religious rituals of forgiveness to others may help prevent the chronicity of PTSD. Some group and individual work with traumatized women has focused on developing purification rituals, but no outcome study to evaluate this has been done. Even close friends can join in the ritual of welcoming and allow the woman an opportunity to ritually decrease the hold that MST has taken of her.

Returning soldiers relish festivals and religious events that bring people together. The long boat trips back from Europe after WW I and II gave soldiers a time to remake themselves as noncombatants as they sailed with trusted friends. This was denied to Viet Nam vets who were individually and rapidly flown home. The home coming parades were a visible welcome to the European veterans as contrasted by the bitter jibes the Vietnam returnees felt. Today’s Iraq vets are being greeted at airports and landing fields. They too treasure holidays with families. Monuments are another visual signs of recognized sacrifice and offer a ritual symbol to acknowledge and emotionally connect with dead colleagues. This is why Vietnam and women veterans were so focused to achieve these acknowledgements of their worth.

Listening

"It takes two to speak the truth - one to speak, the other to hear" -Henry David Thoreau

All therapies emphasize the importance of the traumatized telling their story over time and eventually constructing a clear trauma narrative. Often, rather than feeling upset at revealing many unpleasant things, women thank friends, family, or counselors for deeply listening. The soldiers that Grossman interviewed for his book on killing were uniformly thankful. Cognitive Therapy and CBT are both grounded in listening and reflecting back. (Najavits) (Ycomen)

According to Saltzman, one of the most important factors of healing and being able to normalize
emotions is to help the veteran to construct a complete coherent story of what happened - including the objective events, subjective feelings (Saltzman) and aftermath. This includes recognizing trauma reminders. To be a helpful supportive listener one needs to truly care about the affected person and listen without judging. They truly want the person to recover and believe them about the trauma. They have taken time and energy to learn about sexual assault and PTSD and know the difficulty for recovery in those most affected, particularly when they have concomitant substance abuse disorder. They encourage the person to become engaged in the community in a constructive way, but listen when the answer is “I’m not ready yet”. (Najavits)

Listening alone can help heal if it gives the veteran a chance to tell her story, encouraging her to identify and describe her feelings. Monson demonstrates that “disruption in the ability to identify, label, and express affective states”, referred to as Alexithymia, is consistently predictive of PTSD symptoms. The most significant predictor was “externally-oriented thinking.” Among the 85 male veteran trauma survivors, those who were “prone to direct their thinking to superficial, external events in lieu of internal emotional experiences have the most severe symptoms.” Part of the deficit resulted from the lack of affective language resulting in the inability to fully express and then habituate so that after time the thoughts will become less distressing. (Yehuda). The art of listening requires non-defensiveness and an ability to avoid giving suggestions wanting to “solve” the problem. It supports the veteran in what she needs to do to assert control. A good listener needs to be kind and respectful, especially for women who suffered both the experiences of war along with the experiences of military sexual abuse.

**Positive Responses to Anger**

Those who come in contact with veterans suffering PTSD need to remember that anger is normal in recovery. The soldier suffered a horrible wrong, often people she trusted did not help
her, and in many cases it appears that she, the victim, rather than the perpetrator, suffers the bad consequences and outcome of the events. (Dean)(Najavits). If the survivors anger becomes directed toward someone who is well intentioned, it should be not taken as a personal assault – it often results from the heightened fight response. The recipient should give clear feedback that the anger felt and state their own feelings involved. Sometimes it's just better to walk away and approach the situation later. It is important to help the veteran be able to state what she needs and how she feels, and learn take positive steps to redress some of the wrongs against her. Many county veteran service officers see their task to be an advocate for traumatized and unfairly treated veterans and so can offer help when the system seems impregnable.

Community Skill Resources

There are often a variety of places in the community to learn stress and anxiety management techniques, including yoga classes, church, and other group support activities. Veterans for Peace is establishing hotlines and support groups. There is a community program called Alternatives to Violence that presents weekend workshops giving people tools for self-esteem, communication, problem-solving, building trust, and win-win conflict resolution. Twelve Step programs provide support for ways other than use of substances to handle difficulty.

Recently international training guidelines have been formulated to ensure that those working with youths and others in the community are respectful of cultures and build capacity. (Weine) It may be good to measure interventions in black, Hispanic, and other minority communities to assure that interventions build rather than undermine both social adhesion and capacity.
Help in Gaining Access to Services

Women soldiers have historically faced an inequality in obtaining services. Studies have shown that women with PTSD are much less likely to get PTSD disability benefits than men, unrelated to the higher severity of the women’s symptoms. This is related to the fact that disability secondary to PTSD from combat trauma are much more likely to be awarded than that from sexual assault. (Murdock, Hodges, Aug 2003) Also Caucasians are more likely to get benefits than blacks or Hispanics. (Murdock, Hodges, Apr 2003) Even studies of more recent years’ applications reaffirm this trend of lower approval rates and lower degree of service connection for PTSD secondary to MST (Murdock, Nelson, 2003), showing ongoing discrimination. In addition some regions reported 25-50% lower rate of benefits for women without combat injuries than men without combat injuries and a 40-90% lower rate of women compared to men with combat injuries. (Murdock, Nelson, 2003) Recent guidelines should have changed this but recent newspaper reports reveal that there is far to go. (Moffeit)

Many of the women face secondary adversities such as problems with housing and jobs. In the US, community resources such as counselors and veterans service officers can help them enhance their coping skills, form pragmatic plans, improve communication skills, and learn problem solving strategies. One strategy that is particularly helpful for survivors is for communities to make a list of all the resources available locally – for physical, mental health, finances, housing, heating assistance, job training, substance treatment, twelve-step groups, weight management, legal aid, etc. (Wing) There are also lists of toll-free numbers to inquire about whereabouts of non-local services (Najavits)
Encouraging Sense of Self and Worth

Through media, community awareness, public pressure on military services and outreach, female veterans hopefully will get the message that there is a place for them in their communities. They need to be aided in overcoming the grief, regret, guilt, and shame that comes with sexual trauma or being around violence as observer, victim, or perpetrator. People working with them must recognize that some joined the military before they had completed their developmental tasks and that they might need help in developing adult morality, competencies, the ability to love, and motivation and will to create their future.

Their needs as survivors of sexual trauma and PTSD are to experience validation, sort through their confusion, become intentional about their present and future, and be empowered to affirm their experience self-affirmation. (Wing) Some will need professional counseling or group work to obtain these goals. It is up to all in the community with whom they come in contact -- doctors, beauticians, pastors, teachers of their children, counselors, professors among others to be watchful for pain that does not heal; to make sure they get to VA and other services that they are entitled to, and to establish those not available; and thereby try to decrease the number of young women who will become “collateral damage.”

FURTHER RESEARCH

Recently the topic of military sexual assault of males has begun to be acknowledged. Murdock reported that more than twelve percent of men with non-combat related PTSD have been sexually assaulted (Murdock, 2004). Reports in the Boston Globe and Florida Today have also highlighted the problem, reporting that in a recent survey of 1.67 million veterans, 22,500 male veterans, or greater than 1 in 100, have admitted to having been assaulted. (Snel)(Jacobs) Does the same dynamic of recovery and community help also work with these men?
It is important to continue to track sexual assault in both men and women and assure that there are working hotlines, alternate reporting mechanisms if the victim feels uncomfortable going to her commander, ways to assure personal safety, and confidentiality. It is important that in the military environment where there is much joking and many crude pranks, which has for too long diminished a sexual assault as only a "misbehavior", it must now be recognized as what it truly is – a crime. Poor and insensitive leadership about sexual and gender issues cannot be tolerated and needs to be replaced when it can’t be improved. Reviewing reporting rates and outcomes will be important studies to assess improvements.

It must be ascertained whether community listening structures combined with alternate communication and safety skills help keep veterans from remaining chronically ill? The studies about the relationship of PTSD to lack of forgiveness and alexthymia need to be replicated in veterans. A program called Alternatives to Violence seems to offer the improved self-esteem, anger management, trust building, and communication skills that these women need. Its place in working with these traumatized young women needs to be formally assessed and made known to relevant audiences.

CONCLUSION

War is not kind to anyone; this paper has focused on the particular way that aspects of the military are insensitive and unresponsive to some of our patriotic soldiers during times of both war and peace. While it has highlighted many of the structural problems that allow sexual assault to continue to take its toll on the victim and not the perpetrator, there are already many aggressive forces trying to remedy the problem.

Good evidence-based recommendations for treatment are highlighted in the materials from the Department of Defense and the Veterans Association. Unfortunately from the results of McGahey
a study released this year, the VA system still has much to do to implement these recommendations. (Rosen) Research sponsored by the Department of Defense is being done to provide the ongoing feedback for quality improvement but community advocates can do much to make sure that their individual VA resources are meeting the standards. There remains extensive regional and center-by-center variation with respect to both treatment offered and the awarding of disability for PTSD. All centers must be elevated to the same best-practices standard.

There is much work to be done in communities so that all who come in contact with the returning veterans recognize how widespread this problem is for women (and many men). Available resource people must prepare to offer either personal assistance in the many ways suggested, or at least to provide information about treatment options and other services. The full scope of problems facing returning men and women who suffered other traumas during their military experience is outside the scope of this paper, yet the above, with appropriate and honest “personal welcomes”, and listening ear, are needed and so important to all who have worn a uniform. This is especially so in our troubling times when, as during the Vietnam War, there remain many questions about what we are doing in Iraq, how long our military will be there, and at what continued enormous costs in productivity and social stability. As similar as many traumas can bê to all those in any war, there is a difference when the soldiers and the country are ideologically in favor of the war. This paper details the extra burden placed on those who are both at war and who also suffer sexual assault. When fellow comrades become their enemies through the crime of rape, it is unconscionable that women soldiers are not able to justice nor the same help that they can expect help when the trauma results from combat related violence.

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Appendix

Miles Foundation blasts Defense Department’s sexual assault report,

The decades of indifference to victims and survivors of sexual assault within the U.S. Armed Forces was confirmed, once again, by the Report of the Department of Defense Task Force on the Care of Sexual Assault Victims.

The findings include:
* Inability of the Pentagon to track reports of sexual assault;
* Inability of the Pentagon to determine trends in the handling of cases;
* Lack of privacy and confidentiality precludes reporting or accessing services for victims;
* Lack of uniform policy or programs to coordinate care for victims of sexual assault; and
* Lack of a definition of sexual assault.

The recommendations encompass:
* Combatant commanders conference;
* Summit within the next several months;
* Establishment of an advisory council, without disclosure of its membership; and
* More victim advocates.

The Memorandum of Secretary of Defense Donald Rumsfeld to the Secretaries and commanders of the military departments fails to acknowledge the crime of sexual assault, rather assigning "unacceptable behavior" status to sexual assault.

The Report’s recommendations neglect the immediate needs of victims serving in the current theater of operations, such as rape evidence kits; testing supplies for STIs, HIV and pregnancy; victim advocates; victim witness liaisons; transportation protocols; emergency contraception; and medication.

The recommendations do not outline staffing levels for victim advocates in order to ensure availability and accessibility to victims and survivors. The contributions of Sexual Assault Nurse Examiners (SANEs) to victims, law enforcement and criminal justice professionals, as evidenced by the decades of service within the civilian community, are ignored.

The recommendations fail to establish a headquarters program manager and chain of command for victim advocates and victim service specialist serving in the military departments as authorized by Congress in 1994. The recommendations do not detail a policy of confidentiality to ensure access to services, care and treatment as supported by Congress since 1998.

The Report does not detail long term policies and protocols including establishing standardized care and services; establishing a chain of command to provide privacy for victims and survivors; and establishing a chain of command to ensure timely and appropriate investigations.

The Report does not recommend development of an infrastructure and foundation of law and policy to sufficiently address sexual assault among the ranks.

The review, merely, confirms the findings of surveys, prior commissions and task forces, and antidotal reports contained within a long line of reviews through the decades concerning sexual assault in the U.S. Armed Forces.
The Miles Foundation awaits action by the U. S. Congress on a comprehensive plan to address the response of the military departments to sexual and domestic violence. The plan proposed by allied organizations includes a foundation of law and policy supporting an infrastructure with and among military and civilian communities. The legislative initiative includes, but is not limited to, the following:
* Transforming the Uniform Code of Military Justice to mirror Federal statutes;
* Establishing a privacy privilege or nondisclosure policy;
* Establishing an Office of the Victim Advocate;
* Establishing a Directorate of Special Investigations;
* Crafting policy changes relative to response of military law enforcement at the scenes of domestic or sexual violence; and
* Establishing offender and command accountability standards.

The Miles Foundation and allied organizations continue to seek Congressional support for the legislative initiative in order to ensure the safety and protection of American forces, at home and abroad.