

## Sexual Trauma in the Military: Needed Changes in Policies and Procedures

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### ABSTRACT

Being sexually harassed or sexually assaulted in the workplace is one of the most devastating experiences one can have there. The very high rates of reported sexual assault in the military, the stakes for the victims, and the seriously deficient and even damaging ways in which the military too often deals with these cases warrant major policy changes both within the military and elsewhere.

### INTRODUCTION

It is devastating to be serving in the military and be sexually assaulted by another servicemember. According to a U.S. Department of Defense (DoD) report, 90 percent of the targets of such assaults are women (U.S. Department of

Defense 2011). The authors of that report call those committing the assaults not perpetrators but "subjects," 89 percent of whom are men, 2 percent women, the rest "unknown" (U.S. Department of Defense 2011). Female victims are the focus in this paper, although much of the content also applies to male victims. I will use the term military sexual trauma (MST), defined by the U.S. Department of Veterans Affairs (VA) as "experiences of sexual assault or repeated, threatening acts of sexual harassment" that, according to U.S. Code (1720D of Title 38), involves "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty or active duty for training." Sexual harassment is further defined as

“repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character” (U.S. Department of Veterans Affairs 2010).

Some consequences of MST come from the assaults themselves, and others come from the further anguish, even trauma, that results from the way reports of the assaults are—and are not—handled. They include, but are not limited to, the increased likelihood that survivors will become substance abusers and have trouble finding post-military employment (Skinner et al. 2000). Furthermore, 53 percent of homeless female veterans have experienced MST, compared to one in five female veterans in general (Washington et al. 2010).

The award-winning documentary *Invisible War* (2012) shows attorney Susan Burke—who filed suit on behalf of MST survivors against, among others, former Secretaries of Defense Donald Rumsfeld and Robert Gates and current Secretary of Defense Leon Panetta—saying that for MST victims, “the professional retaliation in their chosen career” is even worse than the assault. In the film, one female victim describes feeling “too humiliated to come to work” after being raped while working at the high-status Marine barracks in the Washington, D.C., area. Members of her unit told her that she deserved the assault because, like the men, she had worn regulation shorts to play volleyball.

In 2011 alone, 3,192 military sexual assaults were reported. That figure reveals only the tip of the iceberg; the DoD estimates that only 13.5 percent of such assaults within the military are reported (U.S. Department of Defense 2011). According to attorney and MST expert Wendy Murphy, major reasons for not reporting are fears of retaliation, harsh judgments, and reprisals from the chain of command (Murphy 2011). “The military legal system is dysfunctional,” Murphy points out (Murphy 2011). As noted in a Service

Women’s Action Network (2011) document, “Reporting assaults anonymously is almost impossible for victims of MST.” Until recently, the victim had to report to her commanding officer. Although now the report goes higher up the chain of command, many officers ignore, divert, or dismiss the charge; they fear giving their unit a bad name or being blamed for failing to create an environment where MST does not happen, or they are the perpetrator or are friends with the perpetrator (Burke 2012). They may fear that the team spirit of the unit will break down and interfere with military readiness. Whatever the reason, the effect of their (in)action is to blame and punish the victim. According to the Manual for Courts-Martial, “Each commander has discretion to dispose of offenses by members of that command” (U.S. Department of Defense 2012a). Protect Our Defenders (POD) notes, “Unit commanders—whose promotions are dependent on the conduct and performance of the troops they supervise—have an incentive to see that allegations are few and convictions are fewer” (POD 2012).<sup>1</sup> POD says that in the military, “Judges won’t and can’t hear cases until the commander refers them. If the commander decides to go the non-judicial route, a judge has no role in the case. And service members have only limited access to civilian courts to address their grievances” (POD 2012).

Some women may be aware that if they do report, the probability that the perpetrator will even be charged with the crime is low, and the probability that any perpetrator will be convicted and severely punished is miniscule. DoD statistics show that of the 3,158 MSTs reported in 2010, only 1,614 were even investigated, and in only 187 of those cases were courts-martial initiated (U.S. Department of Defense 2011). Outcomes of those courts-martial appear not yet available, but the prosecution rate of just under 6 percent contrasts

starkly with the 40 percent prosecution rate in the civilian world (Mulhall 2009). Furthermore, one-third of convicted military sex offenders remain in the military (U.S. Department of the Navy 2009); according to the Service Women's Action Network, currently, the Navy is the only military branch that discharges all convicted sex offenders (Service Women's Action Network 2012).

### The Special Circumstances, the Effects, and the Aftermath

**M**ilitary training focuses on creating powerful bonds among unit members. In some ways, to be sexually assaulted by a member of one's service unit is similar to being sexually assaulted by a family member: in both cases, the victim fears that disclosing the attack will create trouble and feels that she would be betraying or accused of betraying someone close to her—often someone with power over her, who was supposed to care for and help to protect her. Since many women join the military in part because they expect, as servicemembers, they will be regarded with respect, it is painful to be blamed and mocked. MST carries particular stakes, since military service often involves great danger and thus intense reliance on those with whom, in the words of one veteran, one has “breathed for months” (Caplan 2011b). The prospect of losing the closeness of those relationships in retribution for being a “traitor” can be devastating; and for one who can no longer count on those people for help and protection, the stakes in combat zones can literally be life or death.

These are some reasons it is hard for victims to report being assaulted, whether by seeking help from a military therapist or by making a formal report. If they do take either route, still more dangers lie in wait.

### Blaming the Victim Through Pathologizing Her

**W**hen victims go to military therapists, distraught about the assault, they often suffer further harm, which survivors can also experience with non-military therapists. Military culture includes tremendous pressure on military therapists to suppress the facts of MST. Instead of listening to the victim's story, assuring her that her reactions to the trauma are normal, and providing care and support, many military therapists instead do tremendous damage by classifying her as mentally ill. Documentation about which psychiatric diagnoses are most commonly used in such cases is not available, but based on what women have told me in my work with veterans, the ones that seem most frequent are Bipolar Disorder (BD: a mood disorder) and Borderline Personality Disorder (BPD).<sup>2</sup>

Surprising though it may seem, it is well-documented that psychiatric diagnoses overall are not scientifically grounded and that assigning these labels does not improve outcomes (i.e., does not reduce suffering) but does carry enormous risks of harm. (Some kinds of harm specific to the military are discussed here.) Women, whether a victim of sexual assault or in the general population, are more likely than men to be labeled with BD and BPD (American Psychiatric Association 2000). For BPD, the female-to-male ratio is three to one. BD is subdivided into Bipolar I and Bipolar II. According to the American Psychiatric Association, Bipolar II is more commonly diagnosed in women, and Bipolar I's depressive form is more commonly diagnosed in women, a particularly relevant statistic given the despair and sense of helplessness rape victims experience (2000). But having such feelings after being assaulted is deeply human, not “sick.”

Another relevant psychiatric diag-

nosis is Post-traumatic Stress Disorder (PTSD), often referred to as one of the two “signature injuries” of the Afghanistan and Iraq wars (American Psychiatric Association 2000). When the category for that label was created, the aim was admirable: to call attention to the largely ignored suffering of Vietnam veterans (Caplan 2011b). The title conveys the notion that the suffering has been caused by trauma, and when it first appeared in the psychiatric manual, it was described as a normal reaction to trauma. From subsequent editions, the sentence that contained that statement was removed. Before its removal, its presence created the bizarre circumstance that something explicitly called “normal” appeared in a manual of mental disorders. Presumably, the category’s creators felt that getting it into the manual was a way to communicate that Vietnam veterans needed help. Unfortunately, its presence there conveyed the inaccurate notions that being devastated by war was a mental disorder and that psychotherapy and, increasingly, psychotropic drugs were the best or only way to reduce that suffering.<sup>3</sup> In many cultures, the default assumption is that when someone is traumatized, including by war or sexual assault, the community provides help; listens to the troubled person’s story; offers support and understanding; and helps them find ways to come back into the community, to connect, create, and begin to heal. Advantages of community approaches and other similar approaches, including the arts, meditation, physical exercise, and service animals,<sup>4</sup> include that they are low-risk, unlike psychiatric drugs, and do not add to the sufferers’ burdens by making them feel that because they are not yet “over it,” they are therefore mentally ill.

The use of “PTSD” as a consequence of MST—especially now that there is no note in the diagnostic manual that the characteristics listed therein for PTSD (such as hypervigilance, nightmares, flash-

backs, and emotional numbing) are normal responses to trauma—causes harm in three ways. First, like the labels BD and BPD, labeling someone with PTSD labels her mentally ill, with all the harm that can follow from that. Such harmful consequences include loss of custody of a child, loss of health insurance or skyrocketing premiums if a pre-existing condition affects insurability, loss of the right to make decisions about one’s medical and legal affairs, and the tendency for real physical problems to be overlooked or dismissed as figments of the imagination (Caplan 1995, 2012b). Second, the term “post-traumatic” is vague and masks the fact that the source of the trauma in the cases in question was sexual assault. Third, the word “stress” in the label minimizes the effects of sexual assault; stress is more appropriate to worry about being late for a meeting; here words such as terror, grief, and shame, and feelings of loss of innocence and a sense of powerlessness and helplessness are more appropriate.

Getting help ought not to be contingent on getting a psychiatric label. The consequences of receiving a psychiatric diagnosis for a victim of MST are numerous and profound, affecting both her personal life and her life in the workplace. Pathologizing her takes the focus off the fact that the assault caused the suffering and that the suffering should not be considered a symptom of a mental disorder. It thereby takes the focus off what is most likely to help the victim, because the increasingly common prescription for anyone classified as mentally ill is psychiatric drugs. The woman’s need for understanding, support, and validation is in consequence too often overlooked. Furthermore, being diagnosed as mentally ill often causes the woman to feel ashamed for allegedly coping badly, a danger intensified by military culture’s expectation for servicemembers to stay tough, no matter what (Caplan 2011b). So she often falls silent, afraid to speak openly

to friends, lest she “reveal” she is mentally ill. Furthermore, the frequently negative effects of psychiatric drugs—including but not limited to suicidal thoughts, panic attacks, confusion, and hallucinations—are often used as further “proof” that the woman is mentally ill (Caplan 2011b; Whitaker 2010).

Once given any psychiatric diagnosis, a servicewoman is at substantial risk of having her advancement in the workplace impeded or stopped and of having a decreased or eliminated opportunity to obtain or retain security clearance. For anyone in or out of the military, being diagnosed also carries the risks described earlier. People diagnosed with BD are automatically considered severely ill with unexplained problems of mood—either deep depression, serious mania, or both—that label easily causes harm. So does BPD, since any personality disorder is by definition a maladaptive organization of the entire personality. As for PTSD, for many veterans, getting that diagnosis is better than the more alarming sounding ones and potentially (though often not in reality) qualifies them for veterans’ disability benefits, which many need because the assault and its aftermath have left them unable to work full time or at all. However, the mental health services received are too often unhelpful<sup>5</sup> (Caplan 2011b).

Psychiatrically labeling a woman who has been sexually assaulted in the military constitutes a rewriting of history—if she had a serious mood disorder or a personality disorder, why did the military admit her to begin with? If a woman is said to have a mental illness not caused by MST, one might wonder why no one would have picked it up when she enlisted or noticed during basic training or soon afterward. Why would it only become obvious when she reported the assault?

### Harm to the Victim Through the Aftermath of Reporting

The deck is stacked against the MST victim who reports the assault, because even to get a hearing, she must persuade the officer(s) in her chain of command to proceed with the case, and the prosecution rate reflects that officers are rarely open to such persuasion. In 2011, fewer than 8 percent of reported cases went to trial (recall that only 13.5 percent of MST incidents are even reported). Of those that went to trial, 191 of the accused were convicted, and an estimated 10 percent of perpetrators resigned in lieu of courts-martial, which effectively means the military allowed rapists to quit their jobs to avoid facing charges (U.S. Department of Defense 2012b; Burke 2012).

The very act of reporting, especially if the woman has been given a psychiatric diagnosis, carries the risk that not only will the perpetrator go unpunished and the victim be treated badly by her peers and work superiors informally, but that she may be discharged, honorably or not, from the military. Attorney Susan Burke has said:

We have seen cases in which the military tries to push someone out on a dishonorable [discharge] for “disciplinary” issues, but once you dig into the facts, you realize it is not disciplinary issues but rather coping with the after-effects of both the rape and the lack of justice. It is a significant problem, though very hard to quantify.<sup>6</sup>

Once out of the military, the MST survivors encounters more problems in the VA system. In 2008–2010, the VA rejected two-thirds of claims for services for MST, and those female rape, sexual assault, and sexual harassment survivors who have used Veterans Health Administration (VHA) services reported a lower quality of

care and more dissatisfaction with VHA services than did women using outside care (Service Women's Action Network 2012). Furthermore, among MST survivors, women are more likely to receive VA compensation ratings of 10–30 percent, while men are more likely to receive 70–100 percent ratings, which means that men are more likely than women to get more VA benefits of various kinds (Service Women's Action Network 2012).

The problems related to psychiatric diagnosis dog the woman through all phases—reporting, investigation, court-martial, and navigation through the VA system—because being psychiatrically labeled makes it easy for one's credibility to be called into question (Caplan 1995, 2005, 115–26). This is why Patricia Lee Stotter, co-producer of the film “SERVICE: When Women Come Marching Home” and moderator of the Facebook page of that same name, uses the term “weaponized diagnosis.”<sup>7</sup>

## ESSENTIAL REFORMS

Attorney Wendy Murphy has said:

If there are reports made, and the response is respectful, that tends to provide a better future and a safer path to healing for the victim. All it takes for most victims is to be believed and to be respected. And you can't get that if you don't report. And you can't report if you believe the response is going to be harmful. (Murphy 2011)

Four changes in policies and procedures would go far to rectify the problems that Murphy discusses.

1. **Move reporting of MST outside victims' chain of command and directly into the military judicial system.**

Procedural changes within the military are essential. Due to recent changes in DoD procedures, MST reports are made to someone higher in the chain of command than was formerly the case, but attorney Susan Burke says this modification is not really an improvement. Comments from two military commanders after a screening of “SERVICE: When Women Come Marching Home” at Harvard Kennedy School in September 2012, reflect ongoing problems. A male Army commander said that “[They] are mandatory reporters in the chain of command,” that MST is brought to their attention, and that they do not have the option of ignoring it. Although that particular individual might act responsibly, the statistics show that many do not. During the same discussion, a female Marine who has been a commander said she prefers that the report not go outside the chain of command, speculating that perhaps she feels this way because she is a woman, and she talks to the victims who come to her.<sup>8</sup> Talking with her can be helpful and healing for female victims, but the history of dismissive treatment (and worse) interpersonally/socially and frequent dismissal of reports is a systemic problem. One cannot rely on commanders to be compassionate and just, any more than one can rely on bosses in extra-military workplaces to be that way. Barriers to MST reports going forward in the military legal system must be removed.

According to Burke:

Why do you need a commander to open the door to justice? There is a functioning military judicial system. Why can't everybody just access it directly? In the civil system if you are raped, you go straight to that system rather than going through your supervisor at work. ... A commander can say, “I've got this person saying ‘He raped me,’

but he's a damned good soldier, and she's so-so," so the perpetrator is not prosecuted. It's the military readiness argument. (Burke 2012)

Burke has said "In order to eradicate rape and sexual assault, we have to go back to the basics of an operational judicial system that is fair to both the perpetrator and the victim" (Burke 2012). Because the military has not wanted "to cede any power that traditionally resides in the chain of command," she points out,

currently the commander has the power to open the spigot and let your allegation proceed into the military's judicial system or stop it. From our view, that's an inherent conflict of interest, because that person in the chain of command, usually they know the perpetrator and the victim, they've already formed views. ... Let's create a functioning judicial system that doesn't have that conflict of interest. That's not a radical notion. It's modernizing military justice. The United Kingdom, Canada has done it, Australia has done it. (Burke 2012)<sup>9</sup>

For cases that get into the military judicial system, the Service Women's Action Network advocates a DoD policy of discharging all convicted military sex offenders (Service Women's Action Network 2012).

## 2. Pass the equivalent of Title VII legislation for the military and create oversight.

Attorney Wendy Murphy has proposed requiring the military to meet the equivalent of Title VII, which in the civilian world prohibits sex discrimination in employment. She argues that the military's internal procedures for redress are unlikely

to be successful, because "independent oversight is sorely lacking" (Murphy 2011). She continues:

Some of the protective laws in the real world just don't apply in the military. ... We're talking about a highly gendered—in terms of disparity of power—environment in the military. Shouldn't there be an extra thumb on the scale, some version of ... Title VII in place in the military so that there is an institutionalized mechanism for redress that is uniquely designed to deal with what is truly a systemic and debilitating problem? The mere existence of such a system, of such a rule, of such a process, would help prevent sexual trauma by making it clear that sexual violence not only undermines good order, discipline, and combat readiness; it interferes with the fundamental civil rights of soldiers, especially women, to serve their country free from violations of personal autonomy, bodily integrity, and human dignity. (Murphy 2011)

Such change is increasingly important as women enter the military in far greater numbers than ever.

Protect Our Defenders advocates instead giving jurisdiction to "an impartial office staffed by military and civilian experts" (Protect Our Defenders 2012). Related to this idea, Murphy proposed a step involving less change: creating "a small degree of oversight and accountability" by ensuring enforcement of the military's existing rules about MST. She suggests that the military "submit themselves to an oversight entity roughly akin to a federal Office of Civil Rights (OCR) or the Equal Employment Opportunity Commission" (Murphy 2011). The panel would consist both of military and, at least a minority, of nonmilitary members, provide some over-

sight, and be a reporting entity with which complaints could be filed. This panel “at least would allow for the gathering of data in a central location.” It “could have some enforcement authority but would likely function in the way OCR does, with power to coerce changes rather than punish bad behavior” (Murphy 2011).

No doubt some in the military would resist having to meet external standards and be held accountable if such standards are not met, but radical action is essential when basic civil rights are violated, especially on a scale as grand as this one. As Murphy suggests, it is possible that this change would lead to a healthier kind of bonding among servicemembers, once they know MST will not be tolerated and the harassing dynamics that have no place in any work environment will be targeted for elimination. Such change is all the more important for work environments in which life itself is often at stake. During the second wave of the women’s movement, as women in large numbers spoke publicly about being abused, it became clear that simply hoping, or asking, men to cease being violent would not work. Steps such as charging and punishing perpetrators and implementing no-tolerance policies were essential to make clear that society would not tolerate or help cover up violence, no longer classify it as a family matter about which those (with the most power) could decide.

Given the record of military courts’ handling of MST cases, a Title VII equivalent, or transferring cases out of the military system altogether or creating an OCR-equivalent seem especially important, because the suggestion to initiate reports directly to the military judicial system might prove insufficient. As Rachel Natelson shows, the 1950 decision in *Feres v. United States* affirming intramilitary immunity “where the injuries arise out of or are in the course of activity incident to ser-

vice” has held sway for far too long (2009). It is imperative for this trend to end.

### **3. Make major changes in the way the VA deals with MST victims.**

If measures 1 and 2 were well enough executed, that would pave the way for changes within the VA system, because victims’ stories would be validated and perpetrators held accountable far more often. Reducing or eliminating the sexist tendency to diagnose women who report MST as mentally ill is crucial. When women reach the VA, they would be less likely to be burdened with labels of mental illness, and the physical consequences of having been assaulted would be harder to explain away as the imaginings of a psychiatrically ill person.

The VA should in any case move immediately to address MST survivors’ needs, including to reduce its own psychopathologizing of them and, accordingly, treatments based on assumptions of pathology; hire people trained to deal sensitively with victims; and both within the VA and in close partnership with the wider local community, help MST survivors heal in non-pathologizing, low-risk ways such as those described earlier. That the VA has resisted demands for major change, as when it appealed the Ninth Circuit Court’s ruling that its mental health system needed a complete overhaul (the ruling was reversed on appeal), is no reason to refrain from recognizing the importance of doing what is needed (Caplan 2011a).

### **4. Implement the regulation and oversight of creation and use of psychiatric diagnosis.**

Currently, the creation (often, invention) of psychiatric categories and labels is completely unregulated. The two major handbooks used for applying psychiatric diagnoses are the Diagnostic

and Statistical Manual of Mental Disorders-IV-TR (DSM), published by the American Psychiatric Association (APA 2000), and the 2011 International Classification of Diseases (ICD), published by the World Health Organization (WHO) (American Psychiatric Association 2000; World Health Organization 2011). The APA, a lobby group, portrays its manual as scientifically grounded and clinically helpful and fails to warn adequately of the risks that receiving a psychiatric diagnosis can carry. The APA has earned more than \$100 million in profit from the manual's current edition, and the next is slated for publication this year. No requirements are imposed externally on how the APA's money is spent, but there is no evidence that any has been spent to warn of harm or to redress harm that DSM labels have caused. There is no evidence that the APA has made any attempt even to gather information about the kinds or extent of harm. In fact, some of its most prominent leaders have publicly claimed that it does not cause harm (Caplan 1995). Nine ethics complaints to the APA's Ethics Department, including one by veteran Jenny McCleendon, about harm from DSM labels were summarily dismissed without attention to their merits (Caplan 2012a).

The ICD includes diagnoses for both psychiatric and physical problems (cancer, broken bones, etc.), but both its creators and the APA have repeatedly made clear that they ensure that the ICD's psychiatric section hews closely to the DSM or vice versa.

Absence of oversight or regulation of psychiatric diagnosis (even less than the minimal regulation of major U.S. financial institutions) allows psychiatric labels to be applied as though they are scientific, helpful, and not harmful. Within the enterprise of scientific diagnosis, the absence of high-quality science leaves a void into which every conceivable kind of bias and

subjectivity can rush, and that includes sex bias, which characterizes not only the labels discussed earlier but also many other diagnoses in the manuals (Caplan and Cosgrove 2004). As discussed, psychiatric diagnosis is regularly and powerfully used to silence and pathologize victims of MST, casting them as the problem and helping perpetrators escape punishment, even accountability.

A variety of steps to reveal the truth about and reduce the harm from psychiatric diagnosis are essential. It is insufficient that people harmed by diagnosis can file complaints with state licensing boards about individual practitioners who assigned specific psychiatric labels to them. The APA and WHO are the "first cause" of harm, similar to an automobile manufacturer who knowingly sends out dangerous vehicles and claims they are safe. Useful steps could include:<sup>10</sup>

- Requiring the military and VA to stop using psychiatric labels or at least to disclose fully to everyone whom they label the facts that the label is not scientifically grounded, is unlikely to reduce survivors' suffering, and carries risks of harm, and to take measures to reduce the chances of harm;<sup>11</sup>
- Congressional hearings about psychiatric diagnoses;
- Legislation requiring black-box warnings on the DSM, an American-produced book sold globally, to alert people to the lack of scientific grounding, failure to improve outcome, and risks of harm. The manual's use in interstate commerce makes this a federal matter in the United States;
- Legislation requiring the APA and any organization that or individual

who might market a psychiatric diagnostic system to seek, collect, and rapidly publish data on harm it causes (as the FDA requires of drug companies);

- Requiring the Office of Civil Rights of the U.S. Department of Health and Human Services to make known findings of discrimination on the basis of disability and sex and action on the part of the Federal Trade Commission to make known violation of trade regulations in marketing the manual;
- Assigning oversight of the creation and use of psychiatric diagnoses to the U.S. Department of Health and Human Services;
- Bringing lawsuits against the producers of the manuals for false advertising and failure to warn of harm; and
- Appealing to national and international organizations that support the Convention on the Rights of Persons with Disabilities, since discrimination occurs when people who are not (mentally) disabled have been treated as though they are (as with MST victims).<sup>12</sup>

It appears useless, in the absence of all the above, to try to convince the APA to take steps to prevent or redress harm, especially in light of its dismissal of the nine complaints from and refusal to meet with survivor Jenny McClendon (Caplan 2012a).

Implementing any of these changes would make a significant difference to women in the military, but all should be implemented. As Wendy Murphy said, this is nothing less than a matter of human rights.

## ADDENDUM

As this article was going to press, the U.S. Congress passed the National Defense Authorization Act, which included:

1. Mandatory separation from the military of convicted sex offenders from military service;
2. Special Victims Units created to investigate, prosecute, and provide support to the victim;
3. An independent review panel with both civilian and military members to monitor the investigation, prosecution, and adjudication of MST; and
4. Some language to allow better oversight and tracking of how past sexual assault provisions have been implemented.

On behalf of Protect Our Defenders, President Nancy Parrish says that the new legislation contains a number of promising steps but warns that implementing them properly is essential. She points out, for instance, that requiring mandatory separation of convicted sex offenders from the military is important but that plea bargains resulting in charges with lesser offenses are common. She adds that what will make all the difference will be the ways in which Special Victims Units and the independent review panel actually operate, and how “better oversight and tracking” are actually carried out. “What is needed to end the crisis of unpunished rape and sexual assault within our military,” she says, “is transformational reform to fix the broken military justice system. This would require the standing up of an independent special victims unit completely outside the unit chain of command, under civilian oversight.”<sup>13</sup>

## Special Features

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#### ENDNOTES

<sup>1</sup> POD is a human rights organization that supports MST survivors and fixes military training, investigation, and adjudication systems to prevent re-victimization of survivors and achieve prosecution of perpetrators. See <http://www.protectourdefenders.com/> for more information.

<sup>2</sup> See Caplan (2012a) for the story of Jenny McClendon and see the video of her telling her story at <http://www.youtube.com/watch?v=6vj4JzOBb88>.

<sup>3</sup> The inaccuracy of these notions is addressed at length by Caplan (2011b) and Whitaker (2010).

<sup>4</sup> See <http://www.youtube.com/playlist?list=PL51E99E866B9D735E> for twenty-eight brief videos of different non-pathologizing, low-risk approaches to healing, from "A Better Welcome Home" conference at the Ash Center for Democratic Governance and Innovation, John F. Kennedy School of Government at Harvard University.

<sup>5</sup> See Caplan 2011b, especially chapter 3, for a detailed description of the limitations of psychotherapy and drugs for veterans.

<sup>6</sup> Burke, Susan. Personal communication to author. November 29, 2012.

<sup>7</sup> Stotter, Patricia Lee. Personal communication to author. 2012.8 For full discussion, see <http://www>.

[youtube.com/watch?v=Exln7oQfI5Q&feature=youtu.be](http://youtube.com/watch?v=Exln7oQfI5Q&feature=youtu.be).

<sup>9</sup> See also <http://www.protectourdefenders.com/the-facts/>.

<sup>10</sup> The ICD is not addressed in this list because so far it has not been possible to determine the inner workings of ICD production and marketing, what is done with the profits from its sales, or whether there is a procedure for filing ethics complaints against the WHO. In light of the WHO's international status, it is possible that human rights complaints could be brought to the United Nations.

<sup>11</sup> See the introduction in Caplan and Cosgrove (2004) for some such measures.

<sup>12</sup> Attorney and human rights activist Tina Minkowitz's October 23, 2012, letter to the National Council on Disability in the U.S. included discussion of the harm from psychiatric diagnosis and the fact that this is a matter of human rights. Personal communication to the author.

<sup>13</sup> Parrish, Nancy. Personal communication to author. January 8, 2013.