An Invisible Issue

While most Americans are familiar with current issues surrounding the Federal deficit, or the debate circulating around marriage equality, not as many are familiar with a concern that plagues the US Department of Defense (DoD): MST. Sometimes referred to as the invisible issue (for until recently, it has received little to no media attention), military sexual trauma, or MST, is defined by United States’ Federal law as “psychological trauma, which in the judgment of a mental health professional employed by the Department [of Defense], 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” (38 U.S.C. 1720 D). For further clarification, the law also defines “sexual harassment” as “repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.” Among veterans who have chosen to seek healthcare benefits through the US Department of Veterans Affairs (VA), about 20% of female veterans and 1% of male veterans admit to suffering from MST, whether currently or in the past (Military Sexual Trauma). The effects MST has on the mental health of these service members can be devastating, even years after the initial incident, ranging in severity from acute cases of posttraumatic stress disorder (PTSD) to moderate or severe cases of depression and other mood disorders, as well as trouble sleeping and difficulty with attention, concentration, and memory (Military Sexual Trauma). One experience of unwanted sexual assault or harassment can change the life of an individual for years to come, and especially affects active-duty service members who are already under high amounts of stress. For this reason, one would presume that the VA, as well as the DoD, has taken measures to ensure that incidents of sexual assault among the ranks do not go unpunished, and that military veterans receive the mental health assistance they require if they fall victim to MST; however, this is not the case. All too often, sexual assault and harassment goes unreported, and specialized mental health assistance is not easily obtained by veterans. Within this paper, I argue that the avenues by which active-duty service members and veterans can report incidents of sexual assault, battery, and harassment among the ranks, as well as the avenues by which victims may obtain treatment for MST caused by these incidents, must be improved. In doing so, a safer, more supportive environment will be created for those who put their lives on the line to benefit the population.

The first issue that needs to be addressed is the lack of open lines of communication with regard to reporting incidents of sexual assault. According to the US Department Of Defense (DoD), 2,723 service members reported being sexually assaulted or harassed during the 2011 Fiscal Year (Department of Defense Annual Report on Sexual Assault in the Military). The DoD also estimates that during that time period “only 14 percent of the estimated incidents of unwanted sexual contact were reported” (2010 Workplace and Gender Relations Survey of Active Duty Members), meaning that the number of victims during FY 2011 may be as high as 19,450. This gap in the number of reported incidents and the number of estimated victims could be attributed, in some instances, to the hierarchy of power within the ranks and the stigma that is attached to reporting a fellow service member for a committing a sexual crime. In fact, in many cases, service members that report an incident of sexual assault to their commanding officer or other higher-up are often ignored, then discharged shortly after their claims are made as they are deemed “psychologically unfit to serve” (Martin).

An article published by CNN examines this phenomenon, as it describes the experiences of four different women, each employed by different branches of the armed forces, as they testify that they “received a psychiatric diagnosis and military discharge after reporting a sexual assault” (Martin). Anna Moore, one of the women interviewed, had a particularly compelling personal testimony. She was alone in her barracks when she was sexually assaulted by an officer of another battery, and when she filed a report with her commanding officer, he told her to “forget it, it never happened” and subsequently ripped up the paperwork (Martin). Moore was then referred to a DoD commissioned counselor by that same commanding officer, who diagnosed her with a borderline multiple personality disorder and ordered for her discharge from the armed forces.

According to the Diagnostic and Statistical Manual of Mental Disorders, published by the America Psychiatric Association, the general criteria for a personality disorder is “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individuals culture…and its onset can be traced back at least to adolescence or early adulthood” (CITE THIS). If Moore had truly suffered from the borderline multiple personality disorder she was diagnosed with, she would have displayed symptoms of it before joining the Army. Since this was not that case, Moore attributed her referral to a counselor and her subsequent discharge as a result of the sexual assault incident report she filed with her commanding officer, exemplifying several issues with the lines of communication regarding reporting sexual crimes within the ranks. Moore was brave enough to report her attacker to a trusted officer, yet that officer ignored the information Moore produced and decided to remove her from the setting entirely, costing Moore her job and any mental health benefits she may have received to treat her lingering MST (for VA health benefits do not apply to the category of preexisting conditions, which personality disorders fall under), rather than deal with the actual issue. In doing so, the hierarchy perpetuated the culture of fear that surrounds the victims when reporting sexual assault within the military: fear of losing their jobs, and fear of being labeled as “crazy” or “weak,” and fear of not being taken seriously. Victims of sexual crimes should not be afraid to report the attack to their superiors, and their superiors should not get away with ignoring the issue and perpetuating that fear. If the United States is going to properly address the issue of MST, some aspects of the lines of communication between higher and lower ranking members of the military must change.

To improve these lines of communication, the government must extensively train superiors to handle a sexual assault incident report in a way that does not prosecute the victim, as it did in Moore’s case. This requires more than a single information session or the distribution of a pamphlet; I propose the utilization of a two week intensive course, taught by a licensed professional who specializes in MST, required for all members of the armed forces who are currently in a position to oversee incident reports. This course would provide statistical data regarding the estimated number of sexual crimes among the ranks, as well as information about MST and its consequences if not properly treated. The course would also require participants to recognize the symptoms of MST, and seek a professional evaluation for those who display those symptoms. Finally, the course would require participants to partake in 5-7 mock incident report sessions to ensure that ranking officials are trained how to do with the issue properly and with great sensitivity. By requiring this course, the DoD would be able to ensure that the officials with the authority to oversee incident reports know how to do so without perpetuating the previously mentioned culture of fear, thereby increasing the rate at which incidents are reported, attackers are punished in court, and victims of MST receive the treatment necessary to live comfortably.

In addition to this policy alteration, something must be done to make obtaining treatment for MST easier for victims. After an incident occurs, it can be difficult for those veterans who are suffering from MST to obtain the mental health assistance they need to treat their condition. Less than 10 percent of all VA centers are equipped with inpatient treatment options for MST (Hunnicutt), and when visiting the VA’s website concerning MST, a comprehensive list of those centers that do offer those options is not provided. The website states that veterans seeking treatment for MST may do so at any VA facility, however it lists the VA’s general services for PTSD, depression, anxiety, and substance abuse as “important resources for MST survivors” (VA Programs and Services). Anuradha Bhagwati, Marine Corps. Veteran and executive director of the Service Women's Action Network, labels this integration of treatment programs as a “disturbing trend,” and also acknowledges the lack of gender-specific programs as detrimental, for “MST patients are not guaranteed privacy or safety from other patients of the opposite sex” (Hunnicutt). The circumstances by which patients receive treatment for MST should be as easily accessible, effective, and comfortable as possible, and by lumping in the treatment of those who suffer from MST with those who suffer from PTSD and depression as well as ignoring the importance of gender-specific programs, the VA leaves veterans with an unclear picture of how they should go about their treatment.

In order to improve the level of treatment victims suffering from MST receive, specialized, gender-specific MST programs need to be offered at every VA center, rather than an assortment of integrated programs that cater to a general audience. Changes in the state of the mental health or stability of an individual is shaped by unique experiences, and by lumping treatment options for MST in with treatment options for PTSD, depression, anxiety, and substance abuse, those unique experiences are ignored and real progress becomes harder for to patients to make. Gender-specific program options are as equally important, for it typically increases the level of comfort among participants who have been sexually assaulted or harassed by a member of the opposite sex. I propose that every VA center across that nation hire and train a licensed psychologist or psychiatrist in the area of MST and its consequences, and allow them to hold bi-weekly group, gender-specific meetings free-of-charge for veterans. I also propose that those who so desire should be able to sign up for one-on-one meetings with that same psychologist, to be held at different intervals on a case-by-case basis. In doing so, veterans would be able to better deal with their MST, and be able to build support systems among the participants in the group sessions that would also be beneficial to their treatment.

One could argue that my solutions to improving the lines of communication regarding reporting incidents of sexual assault and improving the level of treatment victims suffering from MST are illogical due to the fact that they have a high monetary cost. I acknowledge the fact that in order to fund these endeavors, the United States government would have to cut spending in other areas; however, these cuts are a necessary sacrifice to benefit those who already sacrifice so much – our veterans. If the United States cannot protect active-duty service members from sexual exploitation by their peers, as well as help them on the road to recovery when such horrors do occur, it only increases the amount of stress that weighs on their shoulders. Our active-duty service members and veterans protect(ed) our freedom, it is only right that the United States protect their mental stability by all means possible.

Though not terribly obvious, a large amount of veterans are affected by MST. The struggle these victims experience is real, and largely manifested by incidents that occur on the DoD’s watch, though the DoD and their VA branch are not currently trying their hardest to do right by these victims. Ranking officials denounce sexual assault incident reports and persecute the victims who file them, when they should be taking the matter more seriously and punishing the attackers in military court. VA centers do not offer adequate treatment options for those suffering from MST, when they should be prioritizing the issue that affects a large number of veterans each year. These concerns can be resolved by requiring all officials to participate in an intensive two week course that educates them on the severity of the causes and consequences of MST, as well as being able to recognize its symptoms and the ability to properly file an incident report. In addition, VA centers must be equipped with at least one licensed psychologist who specializes in the treatment of MST, and that professional must hold gender-specific group meetings, as well as one-on-one sessions, free of charge.

Works Cited

38 U.S.C. 1720 D - Counseling and Treatment for Sexual Trauma, § 17-1720 D (2011). Print.

"Better Treatment Options Are Needed for Victims of Military Sexual Trauma." *Do Veterans Receive Adequate Health Care?* Ed. Susan C. Hunnicutt. Detroit: Greenhaven Press, 2012. At Issue. Rpt. from "Lack of Research and Treatment Programs Burdens Survivors of Military Sexual Trauma." *U.S. Medicine* (July 2010). *Opposing Viewpoints In Context*. Web. 23 Mar. 2013.

"DSM-IV and DSM-5 Criteria for the Personality Disorders." *DSM 5 Development*. American Psychiatric Association, Apr. 2012. Web. 23 Mar. 2013. <http://www.dsm5.org/Documents/Personality%20Disorders/DSM-IV%20and%20DSM-5%20Criteria%20for%20the%20Personality%20Disorders%205-1-12.pdf>.

Martin, David S., Jonathan Binder, and Sean O'Key. "Rape Victims Say Military Labels Them 'Crazy.'" *CNN Health*. Cable News Network, 14 Apr. 2012. Web. 23 Mar. 2013.

"Military Sexual Trauma." *Mental Health*. United States Department of Veterans Affairs, Aug. 2012. Web. 23 Mar. 2013. <http://www.mentalhealth.va.gov/docs/mst\_general\_factsheet.pdf>.

United States. Department of Defense. Office of the Under Secretary of Defense for Personnel and Readiness. “Department of Defense Annual Report on Sexual Assault in the Military.” *Sexual Assault Prevention and Response*. Comp. Lindsay Rock and Rachel Lipari. By Natalie Namrow. Department of Defense, Mar. 2011. Web. 23 Mar. 2013. <http://www.sapr.mil/media/pdf/research/DMDC\_2010\_WGRA\_Overview\_Report\_of\_Sexual\_Assault.pdf>.

United States. Department of Defense. “2010 Workplace and Gender Relations Survey of Active Duty Members.” *Sexual Assault Prevention and Response*. Department of Defense, Apr. 2012. Web. 23 Mar. 2013. <http://www.sapr.mil/media/pdf/reports/Department\_of\_Defense\_Fiscal\_Year\_2011\_Annual\_Report\_on\_Sexual\_Assault\_in\_the\_Military.pdf>.

"VA Programs and Services." *Mental Health*. United States Department of Veterans Affairs, 28 Nov. 2012. Web. 23 Mar. 2013. <http://www.mentalhealth.va.gov/msthome.asp>.