Women in the Military: Myths and Misogyny

By Paula J. Caplan, PhD
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Women in greater numbers than ever before in American history are serving as soldiers exposed -- though often not assigned -- to combat or other serious dangers, such as from IEDs, improvised explosive devices.

Two years ago, nearly 209,000 women were serving on active duty in the U.S. military.

For these women, spending time at war brings special complexities and conflicts, because in war, expectations for hyper-masculine behavior are more extreme than at any other time. (This is true to some extent whether the soldier is serving in a provisions unit or as a mechanic.) Indeed, the association of the military with hyper-masculinity makes it harder for men as well as women to figure out what to do with their tenderness, vulnerability, moral conflicts and spirituality.

It is not possible to say whether it is harder for women to try to live up to the traditional standards of the other sex--because the expectation is that they cannot and perhaps that they should not --or for men to risk failing to meet the traditional standards for their own sex.

Although in some ways our society increasingly expands definitions of what can be considered "appropriate" behavior for men and "appropriate" behavior for women, in other ways the dichotomies have become more rigid.
What I am saying here, then, will not apply to everyone but is about the many people who remain influenced by traditional sex-role expectations. What is clear is that these expectations and assumptions create additional, somewhat similar and somewhat different problems for each.

Thus, some women in the military wonder, is it possible both to act in traditionally masculine, tough, unemotional ways in order to prove one deserves to serve in the military and also act in enough nurturing, expressive ways in order to maintain a traditionally feminine identity?

What are the consequences of trying to do both or, conversely, of trying to choose one behavioral style or the other, as a soldier and a vet?

**Woman v. Soldier**

For women, a typical conflict is between expectations about what a good woman feels and does and expectations about what a good (read: masculine) soldier feels and does. As a 23-year-old woman who is an Army Specialist said, "It's hard being a combat vet and a woman and figuring out where you fit in."

Some women struggle with trying to behave in traditionally feminine ways while having had to act (and perhaps to continue to act) in some traditionally masculine ones.

For instance, one woman was "trying to figure out how to be a wife by preparing meals, doing romantic things, and basically being a woman again instead of GI Jane." None of her female friends in Iraq wore makeup, and as a soldier she had been covered with dirt from "16-hour patrols and infrequent showers."

And physical injuries can make it hard to give or receive physical comfort and affection from a partner.

In her 2007 *New York Times Magazine* article, "The Women's War," Sara Corbett recounts the care that some servicewomen take to avoid friendships with other women while they are deployed, out of fear of being called lesbian. She quotes Abbie Pickett, a member of the Army National Guard, saying that in the military, "you are one of three things--a bitch, a whore, or a dyke." Pickett also describes the tension she feels because of constantly being in the minority as a woman.

**Mothers Face Special Problems**

A whole set of problems arises for women in the military who are mothers, and this includes a huge number of women. More than 100,000 soldiers who have served in the current wars are mothers, nearly half the number of women who have been deployed. The vast majority are primary caregivers, and one-third are single mothers. Twelve percent of the women and 4 percent of the men in the regular Army are single parents.

Kirstin Holmstedt describes many problems of these mothers in her book about women in the military. Those who come home physically injured or emotionally limited (detached, overwhelmed, angry) feel guilty and ashamed of being unable to carry out ordinary motherly tasks.

A 2006 *Washington Post* story carried the
report of the first woman combat amputee who is a mother and who could not do easily some of the things expected of a mother, such as cooking and helping a child to dress. And in 2009, a mother who had no one with whom to leave her two children was recalled to active duty (but was relieved to be discharged from the Army because of that).

The sheer variety of problems that mothers in the military encounter is mind-numbing. One woman reported desperately missing her 5-month-old baby and being put on antidepressants, her maternal feelings treated as psychiatric symptoms that needed to be suppressed.

Another "thought that when she was with Iraqi children, she would be able to relate to them as she did to her own children, but that wasn't the case. 'I don't look at those children and see my own at all... All I felt was anger and almost hatred...There were 12-year-old children threatening us with IEDs and RPGs.'"

In general, exposure to so much violence in the military can sap their patience, tenderness and resilience. Furthermore, for military women who had positions of power and authority when at war, to come home, where mothers' work is unpaid, often not respected, and often invisible, can make them feel "less consequential."

And the transition times between military service and home--where they are expected to immediately resume household responsibilities--can be excruciatingly difficult.

It is hard to imagine whether it is more disruptive to a woman and her family for her to be home for very brief periods of time in between deployments, so that not much readjustment is likely to be possible, or to be home longer periods, which might make readjustment more likely but render the next separation a more difficult rupture. This would also apply to men who take on significant household responsibilities.

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Paula J. Caplan, PhD, is a clinical and research psychologist, policy specialist, and activist. She is an Associate at the DuBois Research Institute, Hutchins Center, Harvard University and a past fellow in the Women and Public Policy Program of Harvard’s Kennedy School. She is the author of eleven books, including When Johnny and Jane Come Marching Home: How All of Us Can Help Veterans (MIT Press, 2011), which won three national awards, and They Say You’re Crazy: How the World’s Most Powerful Psychiatrists Decide Who’s Normal. She created Welcome Johnny and Jane Home listen2veterans.org, produced the award winning film "Is Anybody Listening?" isanybodylisteningmovie.org, and produced the award winning "Listen to a Veteran!" PSA series. Her play, SHADES, placed first in NYC's Pen & Brush Best New Play contest and will be produced in New York this fall. Dr. Caplan has received Lifetime Achievement Awards from the Institute on Violence, Abuse, and Trauma and from the Association for Women in Psychology.
Today, women make up 14.6% (or 214,098) of active duty personnel.

69 of the 976 generals and admirals are currently women.

Breakdown of enlisted females:
- 30% Medical
- 30% Administrative
- 16% Supply Units
- 14% Communications
- 10% Electronics Tech.

Further reading:
- womenmemorial.org/Education/timeline.html
- statisticbrain.com/women-in-the-military-statistics/
- history.org/history/teaching/enewsletter/volume7/images/nov/women_military_timeline.pdf
- nytimes.com/2013/01/24/us/pentagon-says-it-is-lifting-ban-on-women-in-combat.html
- history.org/history/teaching/enewsletter/volume7/images/nov/women_military_timeline.pdf
Sexual Trauma in the Military: Needed Changes in Policies and Procedures

By Paula J. Caplan, PhD
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 Service Member. 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 article, although much of the content also applies to male victims. The U.S. Department of Veterans Affairs (VA) uses the term military sexual trauma, defining it 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 the attacks 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 survivors against, among others, former Secretaries of Defense Donald Rumsfeld and Robert Gates and current Secretary of Defense Leon Panetta—saying that for military sexual assault victims, “the professional retaliation in their chosen career” is even worse than the assault. In the film, one female victim describes feeling “too humili-
ated 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 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 this 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 inaction 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). 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

Military 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 Service Members, they will be regarded with respect, it is painful to be blamed and mocked. Sexual assault in the military 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**

When 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 relevant facts. 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).
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 diagnosis 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. 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, 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 sexual assault—especially now that there is no note in the diagnostic manual that the characteristics listed therein for PTSD (such as hyper-vigilance, nightmares, flashbacks, 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 asks 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 an assault victim 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 Service Members 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 (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 the assault, 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 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 rejects 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 these 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 Court-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 quantifty.*

Once out of the military, the survivor encounters more problems in the VA system. In 2008–2010, the VA rejected two-thirds of survivors’ claims for services, 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 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, 2004). 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.”

**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 military sexual assault 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, these 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 the assault 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 she feels this way because she is a woman, and she talks to the victims who come to her. 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 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).

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 [system] 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

“A woman in the military is more likely to be raped by a fellow soldier than killed by enemy fire in Iraq.”

~ Jane Harman, Former Member of Congress (D-CA)
The New York Times
December 27, 2009
Commission” (Murphy 2011). The panel would consist both of military and, at least a minority, of nonmilitary members, provide some oversight, and be a reporting entity with which complaints could be led. 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 Service Members, once they know these assaults 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 these 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 intra-military immunity “where the injuries arise out of or are in the course of activity incident to service” 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 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 assaults 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 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 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 rounded 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 McClendon, 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 assault victims, 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: 


• 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; ¹¹

• 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 other organization that 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 sexual assault victims).¹²

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 Clendon (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 in 2013, 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 military sexual assault.
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.13

REFERENCES


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Endnotes

[1] POD is a human rights organization that supports sexual assault 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.


[3] The inaccuracy of these notions is addressed at length by Caplan 2011a and Whitaker 2010.


[8] For full discussion, see http://www.youtube.com/watch?v=Exln7oQfI5Q&feature=youtu.be


[10] 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.


[12] 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.

Military Recruitment Needs Sex Assault Warning

How many women would take the job if they knew they faced a 1-in-3 chance of sexual assault and a high probability of retaliation for reporting it? As a recent Pentagon survey confirms, changes in our system of military justice are long overdue.

By Paula J Caplan, PhD
Imagine this: Three women apply for jobs in a particular workplace because they need the money, will get to travel, or believe they will be treated with respect and as equals to the men in that workplace. In the job interview, the employer says, "We'll hire you. Just sign here on the dotted line. Welcome to our workplace. Oh, by the way, did I mention that one of you will be sexually assaulted here? And that if you are one of the tiny number who are brave enough to report the assault, you will be punished, but the perpetrator will not? In fact, your life will be ruined and the perpetrator will get off with a hand-slap and might even be promoted."

How many women would take that job? How many men would take it if told the same thing except that one in 100 of them would be sexually assaulted? But those are the probabilities for the American military, and after decades of the victims bravely speaking out in Congressional hearings, in films such as "The Invisible War" and "SERVICE: When Women Come Marching Home," on news programs, in books, and at rallies, as well as becoming plaintiffs in lawsuits, the rates of assault remain essentially the same, two-thirds of victims who report the assaults are subjected to retaliation, perpetrators are almost never brought to trial and those brought to trial are rarely punished in any substantial way.

On Dec. 8 the nonprofit organization Protect Our Defenders announced a national campaign asking President Obama to "declare that after 20 years of 'zero tolerance,' a year filled with news of retaliation against victims, and survey estimates showing no progress, it's time to change the military justice system."

Photographs and stories of 12 survivors of sexual abuse in the military are attached to the campaign, which Protect Our Defenders' Co-Chair and CEO Nancy Parrish describes as necessary because many Americans wrongly assume that victims "have access to a fair system of justice" in the military.

They point out that this is not true, because "in the military, the rapist's commander has the power to decide if the case goes to trial and, what the charges will be and can hand-pick the jury. The current military justice system is not fair and it is not impartial." Protect Our Defenders asks Americans to sign the letter it plans to send to President Obama, to ensure "that rape is not 'an occupational hazard' for Americans serving in the military."

Frightening Facts

The frightening facts are these: Each year, at least 26,000 service members report being sexually assaulted, but only a tiny fraction of the perpetrators are ever disciplined, and almost never is one discharged from the military because of committing an assault.

The military, which has made some strides toward reducing sexism in its ranks in other respects, has largely failed over the decades in making significant changes to decrease the frequency of sexual assaults and increase the frequency of appropriate punishment of those who commit them. Instead, too many--though not all--officials in the chain of command try to silence the victims in order to protect the reputation of their unit, protect
their buddies who committed the assaults (and sometimes the officials are themselves the perpetrators), or both. One sexual assault victim who understandably continues to feel devastated many years after being attacked described the horror of not only seeing the perpetrator escape all discipline but actually be named the most valuable member of their unit.

One of the most common mechanisms used to silence victims and render them powerless is psychiatric diagnosis.

A woman—or man—who is sexually assaulted and experiencing the natural, intense upset that results from such assaults understandably seeks help and support from a military therapist. Often, the victim's upset is used to "prove" that she is mentally ill. I would say this happens usually or nearly always, but the absence of data about diagnoses makes it impossible to quantify the harm.

It's so easy to label victims with a mental disorder, because the deeply human effects of being a victim of violence reside in the official handbooks of mental illness under the title "Post-traumatic Stress Disorder."

Having served on two committees that wrote the diagnostic handbook in which PTSD first appeared, I can attest that there is absolutely no justification for calling such upset a mental illness. Doing so causes harm of which most Americans are totally unaware.

Harmful Labeling

To receive such a label—rather than being described accurately and non–pathologically as experiencing trauma or betrayal trauma (after all, you were assaulted by someone who was supposed to have your back, even in life-and-death situations in combat zones)—often leads the labeled person to lose custody of a child, lose a job or fail to get one, lose or fail to get security clearance, lose the right to make decisions about their medical or legal affairs, or be discharged from the military because of allegedly being mentally ill.

Importantly, when it comes to reporting sexual assault, once the victim is labeled mentally ill, she loses credibility as a witness. In this way, the effects of the assault—being terrified, sleepless, or numb, feeling powerless and betrayed—are recast as the causes of allegedly false or exaggerated accusations when she tells the truth.

As Parrish points out, "Last year, President Obama said that he had victims' backs. He gave the Department of Defense one year to show progress. But recently, the Pentagon released a report showing that estimates of sexual assaults are at the same level they were four years ago. And the rate of retaliation against victims, 62 percent, is the same it was last year. The news over the past 12 months has been filled with one scandal after another involving retaliation against those who report sexual assaults."

Many service members have intensely positive experiences in the military in a wide array of other ways, but they have the right to be forewarned about the major risks related to sexual assault in they enlist, in the same way that people going to work in an environment with high rates of exposure to toxic chemicals should be
forewarned. The practice of forewarning them should immediately be made a standard part of recruitment interviews in all branches of the military.

The Pentagon issues official statistics about sexual assault, but that is woefully inadequate, given the military's vigorous advertising campaigns that focus only on positive images of the armed forces.

In a strong editorial, the New York Times calls attention to a part of the Pentagon's Dec. 4 survey showing that two-thirds of those who reported being victims of military sexual assault were subjected to retaliation. The paper put its weight behind the legislation that Sen. Kirsten Gillibrand (D-NY) proposed, which would end the requirement for victims wishing to report such attacks to do so to people above them within their chain of command.
Mothers bear different, often more onerous or at least more complex burdens than do fathers in relation to the military. This includes mothers who are active duty military or veterans and mothers whose offspring, partners, or parents have been emotionally, physically, or morally wounded because of military service. Both Canada and the United States are war-illiterate nations in which only a tiny percentage of citizens have ever served in the military, never mind having gone to war or served in so-called peacekeeping missions, and thus few civilians know much about war’s realities. This lack of knowledge, when combined with the terrible consequences of prevalent—and often unacknowledged—myths about mothers, leads too often to serious isolation of mothers who are Service Members, veterans, and/or caretakers or partners of either.

In both countries, there are steps that every citizen can take to become both war-literate (knowledgeable about the emotional, physical, and moral effects of war) and literate about the nature and harm caused by myths about mothers. These steps will pave the way for other steps that every citizen can take to reduce harm done to mothers who are variously connected to the military. The steps include wider distribution of the responsibilities of caring for both mothers in the military and mothers otherwise connected to the military and to veterans, as well as dramatically shifting the focus of “treatment” for war trauma away from often-ineffective psychothera-
py and often harmful (and multiple) psychiatric drugs, and instead toward the vast array of alternative approaches that do not involve pathologizing every war traumatized person as “mentally ill” but do involve providing effective, low-risk help for their suffering.

The Problem of Invisibility

It is hard to think about the world of the military and of war. Since North Americans don’t much want to think about it, to many civilians the suffering of Service Members and veterans is invisible. I wrote that statement in my book about war veterans (Caplan 2011), but I was troubled to see that observation borne out as starkly as it has appeared. In March of 2011, I began to write a blog for Psychology Today and have posted about 70 essays there, about a dozen of which have been about veterans and Service Members; the rest have been about a very wide array of subjects, including various women’s issues, psychiatric diagnosis, and the courts (Caplan 2011-12). With only one exception, every time I have written about veterans, the essays have received 1-30 percent the number of views of anything else about which I have written.

War and the military are associated with violence and loss, and since most North Americans don’t have to think about them, are not related to anyone involved, often they simply do not do so. In Canada, this is perhaps especially the case. Canada has primarily said it does not fight in wars but only sends its Service Members on “peacekeeping” missions, so nonmilitary citizens are even less likely even to notice the military and to realize that they have problems that cry out to be addressed. But as L. (Tex) Leugner cd, Warrant Officer (Ret’d), Canadian Army has reported,

*What is called United Nations Peacekeeping often in fact requires soldiers to stand by helplessly, watching the commission of horrific acts of violence against women, children, or others who cannot defend themselves. The helplessness is all the more infuriating and frustrating because United Nation Peacekeeping rules of engagement will not permit the direct interference by Peacekeepers with local military authorities, armed militias, or savage gangs bent on revenge killings, rapes, or other atrocities, unless Peacekeepers themselves are directly attacked.*

(Leugner)

Also largely invisible is much of the work of mothering (Caplan 2000), so it is not surprising that little attention has been paid to the suffering and struggles of mothers whose lives intersect with the military in various ways, in their capacities as Service Members, veterans, or caretakers or partners of either.

The Problems of Pathologizing

Furthermore, now that North America is intensely psychiatrized, the citizenry and certainly most mental health professionals are quick to call the emotional and moral suffering experienced by members of the military and veterans “mental disorders,” most commonly Post-traumatic Stress Disorder. People who are not therapists have often told me that, since they have no mental health training, they believe there is nothing they can do to help Service Members or veterans, given
that they are “probably mentally ill” (Caplan 2011). Often, these civilians are afraid of saying or doing the wrong thing, thereby somehow damaging these “mentally disordered” people or provoking them to violence. Some therapists have, of course, been helpful to Service Members or veterans, but therapists’ guilds have created the impression that professionals—and only professionals—know how to deal with the emotional suffering and moral anguish with which the former often live. As a result, in North America and the United States, the serious needs of Service Members and veterans are too often left to those who medicalize them, “treat” them primarily with psychiatric drugs that sometimes help but are more likely to damage or kill them than to help them (Whitaker), and intensify their isolation from the communities in which they live, where they are seen as “other,” as sick and dangerous (Caplan 2011).

Research has long shown that women are more likely than men to be classified as mentally ill (Caplan and Cosgrove), and my own research and that of others has shown that that is even more true of women who are mothers (Caplan 2000, 2005). This contributes even further to the jeopardy in which mothers who intersect in any way with the military are placed, because any form of strain, suffering, or conflict can be pathologized. And thus, any of these mothers can be made to feel that they should somehow be managing better than they are.

Imagine a mother who is sent to war, leaving behind her young child, and finding unbearable both her longing for the child and her belief that she is a bad mother to have left. Some mothers who have sought help from military therapists have reported being given psychiatric labels for those completely understandable feelings and being prescribed psychiatric drugs to “manage” them (Caplan 2011) and keep them functioning in their military roles. The psychiatric labels can impede their careers, prevent them from getting or cause them to lose security clearance, undermine their self-confidence and trust in their own judgment, and have a health of damaging consequences once they are out of the military (Caplan 1995).

A mother serving in the military who is told that her normal reactions to missing her child, to war, and/or to being sexually assaulted are actually proof that she is mentally ill will struggle with the added burden of believing that she should have managed her feelings in some better way, that she should have “gotten over it,” that she is broken and may never be fixed. A mother whose offspring or spouse is labeled as, or assumed to be, mentally ill when in fact they are “normally” suffering the despair, terror, shame, guilt, loss of innocence, and moral anguish that any human being would experience because of having been to war, faces the daunting prospect of believing she needs to know how to deal with someone who is mentally ill. Her life is made much harder by the widespread but mistaken belief that drugs and therapies that require extensive training and knowledge are more effective than love, support, and understanding (Caplan 2011). And if she urges the Service Member or veteran to seek help from the traditional mental health system, what guilt she feels when—as happens so of-
ten—the therapy is inadequate or strongly directed, or the medications fail to help and actually cause harm (Caplan 2011).

The Problems of Stereotypes and Myths

Nearly every mother is affected by the pervasiveness of two sets of motherhood myths: The Perfect Mother myths involve standards of behavior so high that no human being could ever meet them (e.g., being 100 percent nurturing 100 percent of the time), and the Bad Mother myths involve interpreting virtually anything a mother might do, including something neutral or even good, as evidence that she is deficient or harmful (Caplan 2000). These myths alone are sufficient to rouse fear and shame in any mother who attempts the impossible task of finding ways to act that do not activate the myths and therefore make her look bad in her own eyes and the eyes of others, and this applies to mothers who intersect with the military by being Service Members or by being caretakers or partners of Service Members or veterans.

Those mothers who serve in the military, like all military women, are also torn when traditional expectations for women crash up against expectations for soldiers: Features of traditional socialization of women such as passivity, fragility, and dependency conflict with expectations for Service Members to be active, strong, independent, and emotionally tough (Caplan 2011). Yet women in the military need to prove that they deserve as much as men to be in the military, even while the vast majority are told they are either dykes or sluts, and at least one-third are sexually assaulted while in service, with, for instance, an estimate of 19,000 such assaults last year in the U.S. military (Caplan 2011; Department of Defense). And military women confront such impossible tasks as trying to act in adult, autonomous ways despite learning through experience to avoid all liquid intake after late afternoon, because if they must venture out to the latrine after dark—especially if they go alone—they are at high risk for being raped (Caplan 2011).

Those Servicewomen who are mothers and experience war trauma and/or who are sexually harassed or assaulted while in the military often find when they return home that they are too distracted, upset, or debilitated to do what they feel that good mothers are supposed to do, and the pervasiveness of the myths about mothers only intensifies their anguish about what they regard as failures. Often, they are so ashamed that they cannot bring themselves to talk to anyone, professional or otherwise, about what they are going through, and trying all the harder to be good mothers, they do not feel they ought to take time and energy away from their children in order to seek any kind of help or even respite for themselves.

Mothers whose offspring or life partners have served in the military and been emotionally traumatized or physically harmed are expected, as are mothers across the board, to be able to do endless caretaking and to provide single-handedly the cures for loved ones’ grief, despair, terror, shame, and guilt and solutions for their moral conflicts and religious, spiritual, or existential crises (Caplan 2000). When they are unable to
meet these impossible Perfect Mother standards, or even when they are just exhausted from making the attempt, their upset puts them at risk for being diagnosed as mentally ill.

Plaguing all mothers is the expectation that mothers are not supposed to need or want anything for themselves, and the various burdens that mothers connected to the military carry makes it even harder to avoid longing or asking for help, support, or even notice of what they are trying to do. For those who have served in the military, due to the culture shock caused by the rapid move from a military—even combat—setting back to their home, they struggle with having been profoundly changed, when those back at home often expect them to be the same as they were before. These mothers tend to assume that no one outside those with whom they served has any conception of what they experienced and how it has changed them. They often fear that to speak of what they have seen would be to burden a cared-for listener something no woman and certainly no mother is supposed to do—and/or reveal a chasm between herself and others that cannot be bridged. Many struggle with ongoing guilt for having been away from their children and with the torment of figuring out how, having been trained to be constantly vigilant, constantly on guard, having been scared to death, having witnessed or even committed acts of violence, they can go back to being a serene, loving, nurturing mother who focuses totally on her children while her memories of war haunt her day and night. Imagine how she struggles between the Scylla and Charybdis of the Perfect Mother myth and the Bad Mother myths.

Those mothers whose offspring or partners suffer emotionally, physically, or both often struggle with the fear or knowledge that they can never be the perfect nurturers, that nothing they can give will ever be all their adult child or partner needs, that they can never make all the loved one’s suffering go away. Many deal in addition with the Service Member’s or veteran’s anger about their own suffering, limitations, or losses, which—given that mother-blame is rampant in North America (Caplan 2000)—is often taken out on the mother or woman spouse. When these mothers and the military mothers feel drained, unappreciated, even—heaven forbid—angry, they know they are failing to meet the Perfect Mother standards, and a mother who is flawed or inadequate is often immediately categorized as a Bad Mother (Caplan 2000).

The Problem of Politics

Much of the foregoing is political in various senses, but let us look at some matters that involve politics in the most usual sense. For a number of different reasons, any of the mothers whose lives intersect with the military may wrestle with the question of how they can be involved in the military in any capacity, given that military traditions and war are so strongly associated with much that conflicts with traditional views of women in general and with mothers in particular.

For mothers in any of the three groups described here, what are the consequences if they are opposed to war or to the particular war that directly affected them? Mothers who have served in the
military, some of whom joined because their recruiters misleadingly told them they would not see combat and would not be deployed overseas, many of whom joined because they needed the money or were promised higher education or skilled job training, dealing with the traumatic effects of war is hard enough without having to answer questions from people who challenge them about why they joined the military. Mothers who support those wars in which they have served are not infrequently told that one cannot be a good mother if one supports war.

Mothers whose children go off to war and mothers whose spouses are Service Members have much to do to help themselves and others in the family cope with the terror they feel, knowing their loved one may be seriously injured or killed, while the military and much of the country expects them all to keep their chins up, claim that they are sure their loved one will return and that all will be well, and say they are proud that the loved one is defending their country, liberating other countries, etc. What about those mothers who opposed the loved one’s decision to join the military and/or who oppose the particular war or wars across the board? Do they tell the beloved Service Members how they feel, or do they keep their politics to themselves? Imagine what anguish and distance both speaking up and keeping silent may cause between them. What to do if they hate a war because of what it has done to their loved one, but that loved one who has been in the military fiercely supports that war? What if the suffering adult child or spouse is proud of their military service, but the mother wishes the sufferer had never joined? Will they feel that being a good mother/spouse means remaining silent if they cannot agree with what their suffering child or partner feels about the war that has hurt them? Is silence the only way to be a good woman, a motherly woman?

The Needs of Mothers Connected to the Military

All three groups of mothers whose lives intersect with the military need the rest of us to do our part to reduce the invisibility of the realities of Service Members, veterans, and mothers. As is evident from what has been described here, the expectations placed on all of these mothers are impossible to fulfill. Yet in nations whose populations do not want to think about war, the work of helping Service Members and veterans to heal is hardly ever shared by the community beyond the immediate family or an all-veterans group of friends. In the war-illiterate nations of Canada and the United States, every civilian should be urged at least to take some responsibility for listening—just listening, with respect and without judgment—to the stories of suffering Service Members and veterans, whether or not they are mothers, so that all is not left to their mothers and other loved ones (Caplan 2011). And then we can offer to listen to the stories of their mothers and the other family members. All of these people need a chance to speak the truth about how war has affected them and what they need. In a study Heather Milkiewicz and I conducted at Harvard Kennedy School (Caplan and Milkiewicz), we found that having civilians not trained in interviewing but simply instructed to listen with respect and
without judgment had a tremendously positive impact on veterans who had not been given the chance to tell their stories. This reminds us that in many cultures and countries, the community understands that trauma changes a person, isolates a person, and that the community must help them heal, must reach out, let these Service Members, their mothers, and their partners—all of whom have been traumatized in various ways—know they are understood, and listen to what they need in order to break down the terrible isolation, fear, shame, moral anguish, and loss of innocence that torment them, that they suffer far too often in silence and that are the mostly hidden, bitter fruits of war (Caplan 2000).

For all three groups of mothers whose lives intersect with the military, a great deal of respite care is needed. Mothers back from their military service need that support as they make the transition through that culture shock, especially given that the expectations placed on mothers are impossible to meet at the best of times, so how much more help should be given for those who have been traumatized and are now suddenly supposed to be perfect caretakers. Mothers whose offspring or spouses have come back from war need and deserve respite care so that they can have time to sleep, to relax, to play, to study, in fact to do whatever helps reduce the often intolerable strains of trying to provide nonstop care for those who are emotionally and/or physically traumatized by war.

Also essential are far more places where all of these mothers can speak the truth about the impossibility of feeling like a good mother, given the power and pervasiveness of the Perfect Mother Myths and the Bad Mother Myths. For all military-related mothers, all of whom live in a culture in which the myths about mothers only make their lives more difficult, it is helpful to draw their attention purposefully and specifically to the myths about mothers and to point out how the system of myths and the pathologizing of mothers everywhere make their mothering work even more daunting and anxiety-producing than it would otherwise be. Most mothers know at some level about at least some of the myths and about the tendency to blame mothers for anything that goes wrong, but for them to hear someone put this in words and say that it is wrong can provide much-needed support and perspective. Everyone can help by explicitly addressing—with everyone, often, including in classes and in social settings—the myths and the realities of mothers in general and especially of mothers whose lives intersect with the military. We can talk about them every chance we get, thereby transforming our cultures not only from war-illiterate to war-literate ones but also from ones in which mother myths and the pathologizing of mothers are powerful because they are so often unacknowledged to ones in which these forces lose some of their destructive power.

Author’s Note: This article is heavily based not only on the books cited in the text but also on the author’s listening sessions and discussions with hundreds of mothers who have served in the military or have had offspring or partners who served and/or have been veterans. In just one article it is impossible to address more than some of the most common problems they have encountered, and the focus here is primarily on those that solely or disproportionately affect mothers; but many more than those mentioned here affect not only mothers but also women in general whose lives intersect in various ways with the military.

1See Caplan (2011) for an extensive critique of the classification of war trauma as “Post-traumatic Stress Disorder” or other kinds of psychopathology.
3See Caplan (2000) for a list and description of the dozen or so major myths.

REFERENCES
Department of Defense. DoD News Briefing with Secretary Panetta from the Pentagon. 2012.
“The first time I found out about the Semper Fi Fund was actually in 2014, when I finally decided I needed to get help mentally and physically,” says 31 year old Sgt Daniel E., who fulfilled a lifelong dream when he enlisted in the Marine Corps in 2008. He deployed three times to Afghanistan—halfway around the globe from Everett, Washington, where he was born and raised.

“I was starting to get rocky again,” Daniel continued, referring to his struggles with PTSD. “I have very bad insomnia. I got a referral for an Alpha-Stim machine.”

An Alpha-Stim machine is a device that uses low-level electrical current to safely and effectively treat anxiety, depression and insomnia. The Semper Fi Fund works with service members suffering from PTSD to provide Alpha-Stim machines in appropriate situations.

“I tried it, and I thought it was pretty interesting,” Daniel said, “but there was no way I could afford it. Then I was told about the Semper Fi Fund, and I got referred to a Case Manager. The Fund bought me the Alpha-Stim. That was huge. Finally, there was something that could help me without medication.”

Daniel’s struggles with PTSD started during his first deployment, which began October 2009 and continued through May 2010. “I was a vehicle gunner,” he explains. “The gunner in the turret has the best vision. It’s an important role. We encountered a lot of IEDs [improvised explosive devices].”

Daniel’s second deployment, which began April 2011, ended abruptly on June 2 of that year when he took a bullet to his left shoulder. “I fractured my scapula,” he explains. “The round ricocheted off a wall and went through the back of my shoulder, punctured my scapula, and stuck in there. It’s still in my body—it’s actually potentially more dangerous to take it out.”

After recovering from his wound and returning home to his wife (they had been married just five months earlier), Daniel began a program of physical therapy—and also began what he calls “a whole new type of depression. Being home, knowing what the guys have gone through—I told my physical therapist that I needed to get back to Afghanistan.”
In March 2013, Daniel returned to Afghanistan with the 3rd Battalion, 4th Marines, the same unit he served with on his first two deployments. His third deployment lasted through October of that year.

“I don’t think I’ve been through the worst thing,” Daniel acknowledges, “but I’ve had some tough times, and the Semper Fi Fund really helped me pull through. I will always donate to the Fund because of what they’ve done for me, and I want them to be able to do it for other people. The program is just amazing.”

In addition to the Alpha-Stim machine, the Semper Fi Fund has helped Daniel in a variety of ways, including providing him with a guitar – “five days after I made my request to the Fund, the guitar was on my doorstep; the music therapy classes have been huge in my recovery.” “No matter how much you think there’s nothing that can help you, or how deep you get into a hole, there’s always someone there that wants to help you,” he says.

Assistance from the Fund has also included providing support so he can care for his wife, who is on dialysis three times a week. “She’s been on that since May of last year,” Daniel explains. “She is currently on a kidney transplant list. She has medullary cystic kidney disease—when she was 10, she got a kidney from her dad. It lasted about 17 years before it started failing.”

Medically retired on February 27, 2015, Daniel recently began full-time classes at Cedarville University, majoring in Biblical studies. He notes that his Chaplain in the service had a big impact in his life, and he’d love to return to the service as a Marine Chaplain.

“I’m not a religious person but I’m a Christian man,” Daniel says, “and my experience has helped me realize who I am and where I am in my faith.”
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