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HEALING THE WOUNDS: EVALUATING MILITARY SEXUAL TRAUMA ISSUES

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

AND THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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HEALING THE WOUNDS: EVALUATING MILITARY SEXUAL TRAUMA ISSUES

THURSDAY, MAY 20, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE AND
MEMORIAL AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittees met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. John Hall [Chairman of the Subcommittee on Disability Assistance and Memorial Affairs] presiding.

Present from Subcommittee on Disability Assistance and Memorial Affairs: Representatives Hall, Donnelly, Rodriguez, Lamborn, and Miller.

Present from Subcommittee on Health: Representatives Michaud, Snyder, and Perriello.

OPENING STATEMENT OF CHAIRMAN HALL

Mr. HALL. Good morning, ladies and gentlemen. Welcome to the House Committee on Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs in a joint session with the Subcommittee on Health for a joint hearing on Healing the Wounds: Evaluating Military Sexual Trauma (MST) Issues.

Would you all please rise and join me in the Pledge of Allegiance.

[Pledge was taken.]

Mr. HALL. Thank you.

We will try to expedite this hearing because there is, at 11:00 a.m., a mandatory break for the address to the Joint Session of Congress by the President of Mexico, President Calderon.

I am grateful today to have the opportunity to conduct this hearing, Healing the Wounds: Evaluating Military Sexual Trauma Issues, with my colleagues, Ranking Member Lamborn; the Health Subcommittee Chair, Mr. Michaud; and Mr. Brown, the Ranking Member of the Health Subcommittee, and am especially enthusiastic to recognize the men and women veterans who are in this room today, and am looking forward to hearing about their experiences with MST.

The purpose of this hearing today is to evaluate ways in which the Veterans Benefits Administration (VBA), the Veterans Health Administration (VHA), and the U.S. Department of Defense (DoD) can better address veterans who are impacted by military sexual

trauma or MST and to identify and better prevent, treat, and properly compensate them.

MST refers to sexual harassment and sexual assault that occurs in military settings, often in a setting where the victim lives and works, which means that the victims must continue to live and work closely with the perpetrators.

MST can also disrupt the career goals of many victims as perpetrators are frequently peers or supervisors responsible for the decisions on work-related evaluations and promotions. This means the victims must choose between continuing their careers at the expense of frequent contact with their perpetrators or ending their careers in order to protect themselves.

Many victims shared that when they do report an incident, they are not believed or they are encouraged to keep silent because of the need to preserve organizational cohesion.

The National Center for Posttraumatic Stress Disorder (PTSD) of the U.S. Department of Veterans Affairs (VA) reports that in 1995, DoD conducted a large-scale study of sexual victimization among its active-duty population. This DoD study found that the rates of attempted or completed sexual assault were 6 percent for women and 1 percent for men.

Another study found that rates of sexual assault and verbal sexual harassment were higher during wartime than peacetime in their sample study population. This suggests that the stress of war may be associated with increases in rates of sexual harassment and assault.

The National Center for PTSD also reports that the rate of MST among the veteran population who use the VA health care system appears to be higher than that of the general military population.

One study found that 23 percent of female users of the VA health care system report having experienced sexual assault while in the military.

MST has been a concern among many veterans who have continually expressed frustration with the disability claims process, especially in trying to prove to the VA that the assault ever happened.

For many women and men, when their disability claims for PTSD are related to MST and are denied, they suffer a secondary injury, resulting in an exacerbation of PTSD symptoms and, thus, they are less likely to file an appeal.

We cannot allow these things to continue to happen to our Nation's veterans who have served so bravely and both VA and DoD need to ensure that the proper treatment is available.

Veterans should be able to access treatment facilities and qualified staff with care and benefits delivered by employees who are properly trained to be sensitive to MST-related issues. These veterans need to be treated with the dignity and respect that they deserve.

I look forward to hearing from our esteemed panels of witnesses today and now yield to Ranking Member Lamborn for his opening statement.

[The prepared statement of Chairman Hall appears on p. 23.]

OPENING STATEMENT OF HON. DOUG LAMBORN

Mr. LAMBORN. Thank you, Mr. Chairman.

And I, too, welcome our witnesses to this important hearing to discuss matters concerning military sexual trauma. Occurrences of sexual assault with the ranks of our military are totally and completely unacceptable. It distresses me to think that anyone who volunteers to protect our Nation through service in the Armed Forces would ever have to contemplate much less experience being harmed by a fellow servicemember.

But our military is a microcosm of society and crimes that occur in society unfortunately also occur in the military. So we must face reality and address the problems that arise.

First, it should be made clear through training at every level and to every servicemember that sexual offenses will not be tolerated and that perpetrators will be punished to the fullest extent under the Uniform Code of Military Justice.

Second, the military services should follow through and ensure that justice is rendered in cases involving sexual assault.

I would also add that the military must thoroughly investigate and prosecute false accusers of sexual assault who unfortunately detract from the plight of those who really are victims of sexual assault.

While it is important that we deliberate on the very serious topic of military sexual trauma, I want to also make very clear that this is not an indictment of our military as a whole. The vast majority of the men and women who volunteer for military service are honorable and patriotic individuals who courageously stand to defend our country and other countries from tyranny. They are some of our bravest citizens who abhor the type of individuals who would commit such a repugnant crime as sexual assault.

As far as this topic pertains to VA benefits, I believe the Department has appropriate rules in place for adjudicating and rating sexual trauma cases, but I will be listening for ways that we can possibly improve on the existing system.

I want to thank all of our witnesses for their participation and their testimony and I look forward to our discussion today.

Mr. Chairman, I yield back. Thank you.

[The prepared statement of Mr. Lamborn appears on p. 24.]

Mr. HALL. Thank you, Mr. Lamborn.

Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman.

Due to the President of Mexico addressing the joint session, I would ask unanimous consent that my opening remarks be submitted for the record so that we can begin hearing from the panels.

Mr. HALL. Without objection, so ordered.

Mr. MICHAUD. Thank you.

[The prepared statement of Chairman Michaud appears on p. 25.]

Mr. HALL. Other Members, would you agree to submit written opening statements so we can go to the witnesses? Thank you so much. So ordered.

I would also like to recognize Megan Williams from the Disability Assistance and Memorial Affairs staff who is leaving to go to grad-

uate school in Switzerland and to thank her for her work for the Subcommittee.

The first panel who I will now invite to join us at the witness table is Phyllis Greenberger, Chief Executive Officer (CEO) and President of the Society for Women's Health Research, and Helen Benedict, Professor of Journalism at Columbia University, and Author of the book, *The Lonely Soldier: The Private War of Women Serving in Iraq*.

Welcome, both of you, and your full written statements are entered in the record. You will have 5 minutes each to give oral testimony starting with Ms. Greenberger.

You are now recognized.

STATEMENTS OF PHYLLIS GREENBERGER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, SOCIETY FOR WOMEN'S HEALTH RESEARCH; AND HELEN BENEDICT, PROFESSOR OF JOURNALISM, COLUMBIA UNIVERSITY, NEW YORK, NY, AND AUTHOR, *THE LONELY SOLDIER: THE PRIVATE WAR OF WOMEN SERVING IN IRAQ*

STATEMENT OF PHYLLIS GREENBERGER

Ms. GREENBERGER. Thank you.

Mr. Chairman and Members of the Subcommittees, I want to thank you for calling this joint hearing on such an important and timely topic.

As said, I am Phyllis Greenberger, CEO of the Society for Women's Health Research, and we are a nonprofit patient advocacy organization dedicated to improving women's health through advocacy, education, and research of sex and gender differences.

The Society focus is on sex and gender differences and research needs to be done to explore conditions that affect women differently, disproportionately, or exclusively and to identify those differences and understand the implications for diagnosis and treatment.

The pressing issues that bring us here today are the risks and ramifications of military sexual trauma or MST. MST victims are disproportionately, as you know, and almost exclusively women.

A 2008 VA study reported that 15 percent of military women in Iraq and Afghanistan experience sexual assault or harassment and 59 percent of those were at higher risk for mental health problems. This is just among those cases reported. Many more, possibly more than half of all MST cases go undocumented each year.

The ramifications of MST for women persist long after the initial assault. While sexual assault in any setting is horrific, the combined insult of MST occurring while serving in a foreign setting, often in an active war zone, only exacerbates the effects.

By VA estimates, over 70 percent of women in the military have been exposed to combat. Further, with most MST assaults being orchestrated by military personnel against military personnel, the environment of trust among those serving is broken and a chain of command that fails to protect from and respond to MST further degrades unit cohesion.

Research in the area of MST and sexual assault has revealed some interesting sex-based differences. First, women are more like-

ly than men to contract a sexually transmitted infection or STI. STIs are more difficult to treat in women and can have emotional and mental impacts over a woman's life span. Sexual assault can result in an unplanned pregnancy or, conversely, leave a woman unable to bear children in the future.

The impacts of MST are not limited to reproduction. Infection with the human papillomavirus after a sexual assault can result in cancer decades later.

Second, sexual assault is a common trigger for post-traumatic stress disorders months and even years after the attack. Scientists are finding that women do not respond the same to some of the common medications prescribed for PTSD, often faring worse than men taking the same medication for the same diagnosis.

Third, multiple traumas can increase the likelihood of developing PTSD and the combined impacts of working in a war zone, multiple deployments, MST, and for a disproportionate share of female military members exposure to early life trauma all raise the risk for an eventual PTSD diagnosis.

Females in the military have twice the level of PTSD and depression as their male counterparts.

Fourth, research suggests that the ultimate impact of a traumatic event on a woman may depend on hormone levels and can vary based on where she is in her menstrual cycle and whether or not she uses medications that alter hormone levels such as birth control.

The role of cyclical hormonal variations, as well as studies finding that during pregnancy PTSD symptoms decrease, may offer insight into which women develop PTSD after MST and may further help discover more effective PTSD therapies for women, therapies that are responsive to sex-based hormonal differences.

More research is critical for moving forward and determining targeted treatments for women and men.

The VA in 2010 is in a unique position to better serve its female veterans at the same time becoming a leader in women's health and sex-based research. Changes in care can only come from sound research and investments in VA research often translate into new knowledge, methods, screenings, and treatment for women and men, military and civilian.

The VA system faces staffing, organizational, and infrastructure challenges when updating to meet the needs of the growing female veteran population. Reports as recent as March 2010 still found deficiencies in the availability of resources for female veterans.

From providing gender-specific care at all VA medical centers to including female subjects in the VA's health services research and development, the VA system with proper support and resources hopefully can transform what is needed today and what is needed for the future.

The VA needs to optimize its interactions with female veterans by offering women the option to participate in research projects. The health information technology capabilities that link all VA medical centers and each veteran's medical and personnel charts offers unmatched capabilities for research.

Further, increasing collaboration between the DoD and the VA would additionally offer an improved continuum of care as women

transition from active duty to veteran issues. Clearly there is a need for more investments in the VA and sex-based research and we hope that these recommendations will be acted upon quickly.

I encourage the VA and these Committees to consider the potential impact of appropriate research into women's health and the wide-reaching results that can improve sex-based research as well as mental and sexual health for all.

I want to thank you again for this opportunity to present to the Subcommittees and I would be pleased to answer any questions.

[The prepared statement of Ms. Greenberger appears on p. 25.]

Mr. HALL. Thank you, Ms. Greenberger.

And I would now recognize Professor Benedict.

STATEMENT OF HELEN BENEDICT

Ms. BENEDICT. Hello, Mr. Chairman. Thank you very much, Members of the Subcommittees, for honoring me with the chance to testify.

For 30 years, I have been writing about sexual assault culminating in my book, *The Lonely Soldier,* about military sexual assault.

First, I would like to commend the Caregivers and Veterans Act signed by President Obama just last month. It was an essential step toward helping female veterans. This Act addresses the horrendous problem of military sexual assault by requiring the VA to train mental health professionals to care for women with sexual trauma. This is progress. Yet, I am concerned that the training be done properly.

For my book, I interviewed more than 40 female veterans of our current wars and studied many other surveys. Too often they told me that when they tried to report an assault, the military and the VA treated them as liars and malingerers. A woman who reports a sexual assault should never be treated as a criminal.

They also told me that their sexual assault response coordinators assigned to help them by the military often treated them with such suspicion that they felt retraumatized and intimidated out of pursuing justice.

Indeed, the usual approach to a report of sexual assault within the military is to investigate the victim, not the perpetrator, and to dismiss the case altogether if alcohol is involved.

It is, therefore, essential that the counselors used by the military and the VA be trained in civilian rape crisis centers away from the military culture that habitually blames the victim and that is too often concerned with protecting the image of a platoon or commander by covering up wrongdoing.

These counselors and, indeed, anyone within the military charged with investigating sexual assault should be trained to understand the causes, effects, and costs of sexual abuse to both the victim and society.

Within the VA, reform is also needed. The process for evaluating disability caused by military sexual assault needs to be automatically upgraded and victims who were too intimidated to report an assault while on active duty should never be denied treatment once they come home as they so often are now.

The VA needs to recognize the fact that some 90 percent of victims, according to the DoD, never report assaults within the military because its culture is so hostile to them.

The VA must also recognize and address the fact that it can take years to recover from sexual assault.

In light of the new Caregivers Act, I also want to alert this Committee to the finding that many of our troops were sexually or physically abused long before they enlisted.

In two studies of Army and Marine recruits conducted in 1996 and 2005 respectively, it was found that half the women and about one-sixth of the men reported having been sexually abused as children, while half of both said they were physically abused.

This means that close to half our troops may be enlisting to escape violent homes. Thus, we need to provide counselors trained not only in military sexual assault but in childhood abuse and trauma. These counselors should be available to active-duty troops and veterans. They should be imbedded with the combat stress counseling teams already deployed.

This is necessary not only to help troops cope with multiple traumas of childhood and military sexual assault, as well as combat trauma, but to help prevent further sexual violence. Psychologists have long known that an abused boy can grow into an abusive man.

Finally, let us recognize that more effective than any rules or laws is the attitude of the commander on the ground. Studies have shown that commanders who treat their female soldiers with respect and insist that other soldiers do likewise reduce sexual persecution. Thus, we must reform the culture within officer academies which at the moment is rife with brutal hazing, abuse, and rape as the scandals at Tailhook, Aberdeen, and the Air Force Academy have too long demonstrated.

This violence drums women out of the service and trains men to enact and condone rape and torture.

All officer training schools for all military branches should teach their candidates to understand that rape is an act of anger, hatred, and power, not desire, and that sexual persecution destroys camaraderie and cohesion.

Officers should learn to take pride in ensuring their troops are safe from disrespect and violence from their comrades just as they take pride in bringing them home safely from war.

Thank you.

[The prepared statement of Ms. Benedict appears on p. 27.]

Mr. HALL. Thank you, Professor.

And to both of our witnesses, thank you. Your complete written statements are a part of the record.

Chairman Michaud and I spoke about the time situation before and if there is no objection from Members of the Subcommittees, we would like to submit our questions in writing and for the record and move on to the second panel so that we can try to hear as many witnesses as possible.

Is there objection to that? Without hearing any, thank you to our witnesses on the first panel. And we will submit questions to you in writing and you are now excused.

And we will move to our second panel, Scott Berkowitz, President and Founder of the RAINN, Rape, Abuse, Incest National Network; Joy J. Ilem, Deputy National Legislative Director of the Disabled American Veterans (DAV); Jennifer Hunt, Project Coordinator, Iraq and Afghanistan Veterans of America (IAVA); and Anuradha K. Bhagwati, Executive Director, the Service Women's Action Network (SWAN).

Welcome, all of you, again. As you know, your full written statements are made a part of the record, so you each have 5 minutes starting with Mr. Berkowitz.

STATEMENTS OF SCOTT BERKOWITZ, PRESIDENT AND FOUNDER, RAINN—RAPE, ABUSE, AND INCEST NATIONAL NETWORK; JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; SERGEANT JENNIFER HUNT, USAR, PROJECT COORDINATOR, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; AND ANURADHA K. BHAGWATI, EXECUTIVE DIRECTOR, SERVICE WOMEN'S ACTION NETWORK

STATEMENT OF SCOTT BERKOWITZ

Mr. BERKOWITZ. Mr. Chairman, thank you for inviting me today.

My name is Scott Berkowitz. I am the President of RAINN which is the Nation's largest anti-sexual violence organization. We run the National Sexual Assault Hotline, which is a partnership of about 1,100 local rape crisis centers across the country. We also run an online hotline and do public education.

When I first testified to Congress on this issue about 6 years ago, a DoD task force had just published an exhaustive study. Unfortunately, at the time, that was a fairly common occurrence and about a dozen commission reports that preceded it had had very little impact.

But this report had a different ending. It helped lead DoD to step up its efforts and I think it has resulted in some tangible progress. That is certainly not to say that the problem has been solved—in fact, we are a long way from that, as reporting and prosecution rates remain too low and too few victims reach out for help. But, at last, we are headed in the right direction.

To put the problem in some context: in one sense, the military is not at all unique. About 80 percent of all rape victims are under age 30 and so the problems faced by the military are very similar to those faced by large universities, as both have disproportionately young populations.

Rape is the most violent and traumatic crime that a victim lives to remember. The long-term mental health effects can be devastating, leaving victims at higher risk for PTSD, depression, substance abuse, and many other issues. Embarrassment and shame are almost universal among victims.

In the civilian world, these reactions help explain why victims are so reluctant to report their attack to police, or even to their own friends and family. While the civilian reporting rate is going up, still about six out of every 10 victims do not report to police.

Now, add to this mix that in the military, filing an unrestricted report, the kind that can actually lead to a prosecution, will mean

that everyone on base knows. Add in the fear of being ostracized, and the impact it might have on your career, and it is clear why so many victims remain reluctant to report.

Of course, there is no single, simple solution. But there are a few lessons from the civilian world. One is that much research has shown that victims who receive prompt care and crisis intervention return to full strength much more quickly and, very importantly, they are ultimately much more likely to report their attack to law enforcement and to follow through with prosecution.

Of course, more reports to law enforcement means many more prosecutions and more prosecutions leads directly to fewer assaults. Rapists are serial criminals. We are talking about a relatively small group who are committing a large number of crimes. And so every time we can convince just one more victim to come forward, leading to just one more successful prosecution, we are potentially preventing dozens of rapes.

So how do we get more victims to come forward? The guarantee of confidentiality is one big piece. I think DoD has made some good progress on this score, with the introduction of restricted reporting, which has already encouraged more than 3,000 victims to come forward, about 15 percent of whom later decided to pursue prosecution.

Still, the safety of a restricted report is incomplete. For example, DoD has determined that some State mandatory reporting laws for medical personnel in California, for example, supersede the protections victims enjoy under restricted reporting. And I think that is an issue that needs some Congressional study.

Also, victims to date have not had the guarantee of privileged communications with military victim advocates, as is the case in most States, though I understand that DoD is in the process of implementing that change.

Another vital part of the solution is to make use of the extensive civilian services available, such as the National Sexual Assault Hotline and local rape crisis centers. These services offer the confidentiality that victims desire and deserve while still advancing the military's goal of encouraging more victims to report their attack to law enforcement. They are by no means a replacement for military-based services, but they are, I think, a bridge to such services.

While time constraints limit the recommendations I can share today, I do want to touch on issues of leadership and prevention.

Without sincere buy-in from leadership, evidence that zero tolerance means zero tolerance, any prevention efforts will absolutely fail. And so DoD leadership needs to continue to find ways to ensure that the commanders who take this seriously are recognized and rewarded, and that recalcitrant commanders are identified and reformed by training when possible, by the threat of poor performance ratings when necessary.

In this process, we need to ensure that commanders do not fear that an increase in rape reports on their base will be held against them. In fact, such an increase will most likely be a sign that what they are doing is working, that a higher percentage of victims are coming forward and reporting, which is good news. And so that should be reflected in their evaluations.

I would like to add just one quick point about internal DoD management. I have heard reports that DoD is considering moving its sexual assault programs to be under its domestic violence programs. While that might seem efficient on paper, I think doing so has the potential to de-emphasize sexual violence and seriously hamper prevention and victim service efforts.

Now that we have started to make real progress fighting sexual violence in the military, I think it would really be the wrong time to backtrack by conflating two very different issues.

Thank you.

[The prepared statement of Mr. Berkowitz appears on p. 28.]

Mr. HALL. Thank you, Mr. Berkowitz.

Ms. Ilem, you are now recognized.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you.

Chairman Hall, Chairman Michaud, and Members of the Subcommittees, thank you for inviting DAV to testify at this joint hearing focused on improving treatment and disability compensation policies for veterans with conditions related to military sexual trauma or MST.

This hearing takes on a topic that is very personal and sensitive to many servicemembers, veterans, and the respective departments that are responsible for the safety and well-being of their members.

In most cases, MST profoundly changes the lives of those affected. For these reasons, all VHA patients are screened for history of sexual trauma and treatment is available for MST-related conditions at VA medical facilities.

We acknowledge VHA for providing clear and concise information about MST on its Web site and in its written materials and, most importantly, information on how and where veterans can get help.

It is clearly noted in these materials that service-connection is not required for eligibility for this treatment. However, if a sexual assault is not officially reported during military service, establishing service-connection for a related condition can be extremely difficult.

An area of special concern for DAV relates to collaboration between DoD's Sexual Assault Prevention and Response Office or SAPRO and VHA. Current DoD policy allows servicemembers to file restricted or unrestricted reports of sexual assault.

In the case of a restricted report, the servicemember opts to forgo an investigation but does have the right to have an official record of the incident created, receive a forensic medical examination, and access to medical and mental health treatment as necessary.

Obviously these records are critical to substantiating a disability compensation claim through VBA. For this reason, DAV is concerned that VBA policy manuals appear to lack any reference to SAPRO in obtaining documentation from restricted DoD MST reports.

In reviewing VA's testimony from this morning, it appears that their collaboration with SAPRO has been focused more on the VHA side of the house and related more to health care providers and treatment issues.

It is my understanding that VBA and SAPRO officials have spoken about the issue, but we are not aware that an official policy, process, or Memorandum of Understanding is currently in place or being developed to secure restricted MST reports.

Once a claim is filed, VBA has a number of standard sources that it examines for records to support these types of claims. It does not appear, however, that these reports are archived in the individual's military personnel or medical records for purposes of confidentiality. And we have been unable to confirm if VBA unofficially searches for restricted reports as an alternative evidence source for information to substantiate a veteran's claim.

We also have questions with respect to where the forensic sexual assault examination form and subsequent mental health treatment records related to a restricted MST report are archived by each military branch and for how long.

We ask that VBA provide the Subcommittees with any information it has in reference to materials for claims developers and raters that reflect collaboration with SAPRO and guidance on how to obtain supporting MST documentation from each military service branch including any differences in records retention, security, or disposal policies.

Establishing service-connection for related MST is important including financial stability, increased access to VA health care, but most meaningful for most MST survivors, being rated service-connected for disabilities attributed to the trauma represents validation that the event occurred, expresses gratitude for their service to their country, and recognizes the tribulations they endured while serving.

One of DAV's central purposes is to aid veterans in obtaining fair and equitable compensation for their service-related disability. In this particular area, however, many of our national service officers report they are deeply frustrated at the routine occurrence of MST claims being denied for lack of evidentiary documentation.

It seems to DAV that the agencies responsible for preventing, monitoring, and reporting on MST and providing related benefits and health care services should work in concert to lower the burden associated with the claims process for these veterans and ensure that both servicemembers and veterans are fully assisted by the government in securing the benefits they deserve and have earned.

If VBA does not have a policy in place to secure restricted MST reports and related medical records, we believe this issue can be resolved internally by the respective agencies through an MOU or some other mechanism if they simply agree to work together to address the issue.

Again, we appreciate the Subcommittees' interest in this area and efforts to identify ways to improve access to benefits and health services related to military sexual trauma. And we thank you for the opportunity to testify.

[The prepared statement of Ms. Ilem appears on p. 31.]

Mr. HALL. Thank you, Ms. Ilem.

Ms. Hunt, you are recognized now for 5 minutes.

STATEMENT OF SERGEANT JENNIFER HUNT, USAR

Sergeant HUNT. Good morning.

Chairmen, Ranking Members, and Members of the Subcommittees, on behalf of IAVA's 180,000 members and supporters, I would like to thank you for giving us the opportunity to testify.

Healing the Wounds: Evaluating Military Sexual Trauma is a critically important topic. The issue of sexual assault has deeply affected IAVA membership, the military and veterans community as a whole, and me personally.

I would like to point out that my testimony today is on behalf of IAVA and does not reflect the views and opinions of the United States Army.

My name is Jennifer Hunt and I am a Sergeant in the Army Reserves. I have served two tours in Iraq and Afghanistan. In Iraq, I earned a Purple Heart when my Humvee was struck by a roadside bomb causing shrapnel injuries to my face, arms, and back.

I also serve as my unit's designated victim advocate as part of the Army's Sexual Assault Prevention and Response Program. While I am proud to serve in this position, I sincerely hope that my duties as a victim advocate are ones I will never have to perform, but I am ready should the need arise to provide any support necessary to the victim. I know firsthand how frustrating that the healing process can be having experienced sexual assault as a civilian myself.

Unfortunately, the reality is that servicemembers have been coping with significant and under-reported sexual assault and harassment in the military for years. Even in a war zone, troops cannot escape the threat of sexual assault. While sexual assault disproportionately affects female troops, large numbers of male servicemembers have been victimized as well.

While the number of reported assaults are alarming, they grossly underestimate the severity of the issue. According to the military, only 20 percent of all unwanted sexual contact is reported to a military authority. We must find ways to encourage more victims to report sexual assault and harassment. More importantly, we must make it so that there are no more victims of military sexual trauma.

Despite the urgency of this issue, it has taken decades for the military and the VA to finally respond. In recent years, both Departments have taken commendable steps. The military has introduced a restricted reporting option that can encourage more victims to seek care. It also completed its long-awaited review of the issue by the Defense Department Task Force on Sexual Assault in the Military Services.

For its part, the VA began universally screening all veterans seeking care at the VA for MST in 1999 and every VA facility has a designated MST coordinator who serves as a point person for these issues. The VA provides free treatment to any veteran experiencing health conditions related to MST. However, as is the case with other VA health care, not all veterans have access to the care that they deserve.

These steps are an improvement over the years of inaction, but more must be done. Victims deserve the very best treatment and support that we can provide.

In the interest of time, I would like to concentrate on our top recommendations for how the Subcommittees can best address this important issue. You can also find our recommendations in our written testimony that was submitted to the Subcommittees and our IAVA issue report on women warriors available at our Web site.

First, the VA must do a better job of advertising its MST programs. According to one IAVA member, she did not know until 3 years after returning from a deployment that the VA provided sexual trauma counseling. In her words, it is well hid and not talked about at the VA.

Even the U.S. Government Accountability Office (GAO) had problems locating information about the VA's MST program. According to the GAO, the VA's Web site did not provide a complete list of facilities that have MST-related treatment programs.

IAVA believes that no victim should have to chase after their own care.

Second, the VA must expand availability of its specialized sexual trauma treatment in inpatient settings. Less than 10 percent of all VA medical centers offer inpatient mental health treatment for veterans that have experienced MST or other traumas. This is simply unacceptable.

IAVA recommends that every Veterans Integrated Service Network (VISN) should offer at least one inpatient setting specializing in care for MST victims.

Finally, the VA must ensure that these victims have access to preferred treatment settings and providers. Victims should not have to settle for mixed-gender treatment options because there are no facilities with separate programs for males and females in their area.

According to the GAO, only nine of 153 medical centers nationally have residential treatment programs specifically for women suffering from mental health injuries.

This problem is also evident in outpatient treatment programs. According to another IAVA member being treated for MST-related conditions, it is difficult to go to appointments when you have a full-time job and there are not enough VA counselors to care for all of us returning veterans on consistent basis.

These recommendations are urgent and IAVA encourages you to work with the rest of your colleagues in Congress to help make them happen. Sexual assault is a violation of military values, values that I hold dear. It undermines the professionalism, the morale, the unit cohesion, and the effectiveness of our men and women in uniform.

Sexual assault is also a crime, a crime that has gone on for far too long with too little done to stop it. These victims need justice. They need our support and they need the proper care for their trauma.

I am here today on behalf of them all to issue you a call to service in their support. Again, I thank you for the time that you have given me to testify in front of this Committee today and I look forward to any questions that you might have.

[The prepared statement of Sergeant Hunt appears on p. 37.]

Mr. HALL. Thank you, Ms. Hunt, and thank you for your service to our country and to our veterans.

Ms. Bhagwati, you are now recognized.

STATEMENT OF ANURADHA K. BHAGWATI

Ms. BHAGWATI. Good morning, Mr. Chairman and Members of the Subcommittees. My name is Anuradha Bhagwati and I am a former Marine Corps Captain and Executive Director of Servicewomen's Action Network or SWAN.

SWAN's policy work this year focuses largely on reforming DoD and VA's sexual assault and harassment policies and educating the public about the epidemic known as MST.

SWAN's testimony is based on the collective input of over 120 MST survivors, MST crisis intervention works and VA health providers. My own experience filing an equal opportunity investigation for sexual harassment and discrimination in the Marine Corps, and experiences with both VHA and VBA corroborate the input of my colleagues and fellow veterans below.

Unlike the civilian world, MST survivors do not have the option of quitting their jobs. They are often stuck working with, nearby, or under the supervision of their perpetrators. There is simply no guarantee that the chain of command will support survivors if they come forward.

Commanders have consistently ignored equal opportunity and sexual assault policies in order to maintain their personnel at full capacity. Additionally, commanders have very little incentive to prosecute perpetrators as documented incidents in their units reflect poorly on their leadership performance and reputations.

MST survivors who report an incident are likely to face isolation, retribution, or accusations of lying, irresponsibility, or impropriety. There is no guarantee of anonymity from the chain of command or victims' advocates and survivors are likely to face the horror of retribution from perpetrators and the anguish of being a target of public ridicule, scorn, and further harassment in their respective units.

We cannot honestly expect people to come forward to report and it is irresponsible for us or for DoD to suggest that survivors do so without guaranteeing their protection first. DoD's failure to protect our servicemembers ought to be the subject for a separate set of hearings as there is far too much to say here.

Suffice it to say that without third-party civilian oversight of sexual assault and harassment cases, survivors will continue to be punished, taunted, isolated, or intimidated by their commands for speaking out and perpetrators will in most cases go unpunished.

MST survivors universally describe the horrors of using VA medical centers nationwide. Triggers of one's assault or harassment are everywhere from the prospect of running into your perpetrator, to being surrounded by male patients who routinely engage in sexual harassment of female patients, to being improperly treated by staff members who have no knowledge about the unique experience of sexual trauma in a military setting.

One survivor said to SWAN, I do not want to be fending off advances when I am raw from dealing with my issues in therapy.

Survivors universally say that if they had health insurance, they would definitely use private health care instead of the VA.

Many veterans are ignored, isolated, or misunderstood at VA facilities because their PTSD is not combat related. The veterans community still primarily considers PTSD to be a combat-related condition to the great detriment of MST survivors.

Survivors who have used the VA routinely say they are fed up with being given endless prescription medication. One Iraq veteran described the experience of her MST treatment as nothing but pills and pep talks. Many survivors wish they had access to yoga, massage therapy, acupuncture, and gender-specific MST support groups.

I strongly recommend that the Committee give MST survivors the option of fee-based care for all treatment, not just MST treatment. At the same time, VHA cannot be let off the hook. VA medical centers ought to have separate facilities for women patients generally and easy, safe, and direct access to MST treatment areas for both male and female MST survivors.

With respect to MST residential treatment programs, it appears that most MST patients and even many VA providers do not know that these programs even exist. Among patients who have attended, several have experienced sexual harassment by staff or fellow patients.

Also, several programs are collocated with mixed-gender veterans' programs in which MST patients are not guaranteed privacy or safety from other patients of the opposite sex. VA needs to invest in separate facilities for MST programs and guarantee the safety and welfare of all participants.

Filing for disability compensation for MST is universally considered a traumatic, agonizing, and cruel experience. Many survivors describe the process of rewriting one's personal narrative for a VA claim and being rejected by VBA as just as traumatic as the original rape or harassment.

VA claims officers nationwide have proven themselves entirely inept when dealing with MST claims. Claims are routinely rejected even with sufficient evidence of a stressor and a corroborating diagnosis from a VA health provider. Many survivors' claims are rejected outright because of VBA's lack of knowledge about sexual violence in general.

This Committee needs to understand that until it is safe to report sexual assault or harassment in the military, the majority of incidents will not be reported. This bears directly on the unrealistic and biased nature of VA claims against veterans living with MST. VA must make up for DoD's failure to protect its own by awarding just compensation to survivors.

Another equal protection issue features prominently in MST issues. The do not ask, do not tell policy has allowed perpetrators to routinely abuse gays and lesbians who would otherwise report harassment or assault. Society has yet to measure the mental health impact of this insidious policy on our Nation's lesbian, gay, bisexual, and transgender veterans. We must guarantee access to quality health care for all veterans regardless of sexual orientation or gender identity.

I must add a special note for our older MST survivors, our mothers, fathers, and grandparents who suffered at the hands of fellow servicemen decades ago. Much of their trauma continues to be unrecognized by VA or society.

One Vietnam era veteran who described MST to us told us please help me feel validated before I die. Please honor and validate her service and her life by fixing this broken system now.

Thank you.

[The prepared statement of Ms. Bhagwati appears on p. 39.]

Mr. HALL. Thank you, Captain, for your testimony and for your service to our country and to our veterans.

We will, as with the prior panel, submit questions to you. If you would be so kind as to answer them in writing, and you are excused with our heartfelt thanks for your testimony, which we will be working seriously to address. So this panel is excused.

And we would like to call our third panel including Kaye Whitley, the Director for Sexual Assault Prevention and Response Office (SAPRO), the Office of the Under Secretary for Personnel and Readiness, U.S. Department of Defense, accompanied by Clarence Johnson, Acting Deputy Under Secretary for Plans, Office of the Under Secretary for Personnel and Readiness, DoD; Bradley G. Mayes, Director of Compensation and Pension Service, Veterans Benefits; Susan McCutcheon, R.N. and Ed.D., Director of Family Health and Women's Mental Health and Military Sexual Trauma Services, Veterans Health Administration, U.S. Department of VA, accompanied by Rachel Kimerling, Ph.D., Director, Monitoring Division of the National Military Sexual Trauma Support Team of the Veterans Health Administration at the VA; Patty Hayes, Ph.D., Chief Consultant, Women Veterans Health Strategic Health Care Group of the Veterans Health Administration, U.S. Department of Veterans Affairs.

Welcome, all of you, and your complete statements are made a part of the record.

Dr. Whitley, you are now recognized for 5 minutes.

STATEMENTS OF KAYE WHITLEY, ED.D., DIRECTOR, SEXUAL ASSAULT PREVENTION AND RESPONSE OFFICE, OFFICE OF THE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY CLARENCE JOHNSON, ACTING DEPUTY UNDER SECRETARY OF DEFENSE FOR PLANS, OFFICE OF THE UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS, U.S. DEPARTMENT OF DEFENSE; BRADLEY G. MAYES, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND SUSAN MCCUTCHEON, R.N., ED.D., DIRECTOR, FAMILY SERVICES, WOMEN'S MENTAL HEALTH AND MILITARY SEXUAL TRAUMA, OFFICE OF MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RACHEL KIMERLING, PH.D., DIRECTOR, MONITORING DIVISION, NATIONAL MILITARY SEXUAL TRAUMA SUPPORT TEAM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND PATTY HAYES, PH.D., CHIEF CONSULTANT, WOMEN VETERANS HEALTH STRATEGIC HEALTH CARE GROUP, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF KAYE WHITLEY, ED.D.

Ms. WHITLEY. Thank you.

Chairman Michaud and Chairman Hall, Ranking Members Brown and Lamborn, and Members of the Subcommittees, thank you for inviting me today to discuss the progress the Department of Defense has made in recent years on caring for victims of sexual assault.

The reason for our commitment is clear. Sexual assault levies a tremendous human toll, disrupts lives, and destroys the human spirit. In the military, it destroys unit cohesion and affects military readiness.

And as I say at each hearing, we always try to keep in mind that behind all of the statistics that you hear, there is always an individual, a victim whose life has changed forever.

I would like to start by mentioning a few issues to ensure that my role is clear. The term military sexual trauma was created by Congress for the Department of Veterans Affairs to address the physical and mental problems stemming from both sexual assault and sexual harassment.

The office I represent is tasked with policy related to the crime of sexual assault. Our policy was signed just in 2005. So while all reports of sexual assault are of great concern to us, we are especially focused on incidents that have occurred after 2005 so that we can identify any necessary changes for our policy.

In my written testimony, I provided a detailed account of our program and our collaboration with civilian and Federal partners. And given the scope of the issues faced by your two Subcommittees, I want to take this opportunity to highlight our collaboration with the Department of Veterans Affairs.

One of the key areas of collaboration relates to documentation. In 2007, we contacted the staff of the Veterans Benefits Adminis-

tration to brief them on our victim preference reporting form known as DD–2910. This is the form servicemembers use to indicate if they would like to file an unrestricted report, which leads to commander notification and can initiate an investigation or a servicemember may use this form to indicate a preference to file a confidential report which allows them access to care without an investigation and command notification.

Based on our discussions with the VBA, servicemembers can now use this form as evidence of reporting of sexual assault. This is another reason we work tirelessly to reduce the stigma of reporting. We want victims to come forward and report so that they can get the care as well as have documentation they may need later.

While treatment for sexual assault in a VA facility does not require this document, disability evaluations require some kind of evidence in the military record. Our form is not typically part of the military record provided to the VA for disability evaluation. However, it can be submitted by victims as part of their paperwork for a disability evaluation process.

Just as the DD–214 is the main basis for proof of military service, we would like the DD–2910 to be universally accepted of proof that a victim made a report of sexual assault.

There is more our two Departments can do together to assist victims of sexual assault, but we need assistance in removing at least one barrier to collaboration and that is State mandatory reporting laws.

Servicemembers in the State of California do not have the option of restricted reporting. We would welcome the opportunity to discuss this further with your staff and the VA. This is a challenge we need help in resolving.

I would like to share one last thought. Each day, our servicemembers dedicate their lives to protecting our country and they deserve no less than the very best care and support in return. And that is why it is so important that we work together to make this program the best it can be.

Again, thank you for your time and opportunity to testify today.

[The prepared statement of Dr. Whitley appears on p. 41.]

Mr. HALL. Thank you, Dr. Whitley.

Mr. Mayes, you are now recognized.

STATEMENT OF BRADLEY G. MAYES

Mr. MAYES. Chairman Hall, Chairman Michaud, Members of the Subcommittees, thank you for providing me the opportunity to speak today about how the Department of Veterans Affairs assists veterans who have been subjected to military sexual trauma while serving their Nation in uniform.

Dr. Susan McCutcheon, who is sitting to my left, will also provide brief oral remarks on this subject. We are accompanied by Dr. Rachel Kimerling, Director of the Monitoring Division of the National Military Sexual Trauma Support Team in the Veterans Health Administration, and Dr. Patty Hayes, Chief Consultant for the Women Veterans Health Strategic Health Care Group.

In both civilian and military settings, women and men can experience a range of unwanted sexual behaviors. Within the VA, these sorts of experiences are described as military sexual trauma, the

overarching term used to refer to experiences of sexual assault or repeated threatening acts of sexual harassment.

It is important to remember that MST is an experience, not a diagnosis or a mental health condition in and of itself. Given the range of distressing sexually-related experiences and crimes that veterans report, it is not surprising that there are a wide range of emotional reactions that veterans have in response to these events.

Among users of VA health care, medical record data indicate that diagnoses of post-traumatic stress disorder, depression, and other mood disorders, psychotic disorders, and substance use disorders are most frequently associated with MST.

Fortunately, people can recover from experiences of trauma and VA has services to help veterans do this. Dr. McCutcheon will discuss these services in greater detail in her remarks.

Additionally, VA provides compensation payments for service-connected disabilities that are related to MST while serving in the military. As previously stated, MST may result in a number of disabling physical and mental conditions, but with respect to benefit claims most often manifest itself as PTSD.

In order to better assist those veterans with PTSD claims based on military sexual trauma, VA promulgated special regulations at 38 CFR Section 3.304(f)(4) in 2002. This rule change emphasized that if a PTSD claim is based on in-service personal assault which includes military sexual trauma, evidence from sources other than a veteran's service, treatment, and personnel records may corroborate the in-service traumatic event.

The change effectively lowered the evidentiary burden for veterans of either sex to prove their PTSD claim based on military sexual trauma. This change was made in recognition of the fact that oftentimes there is little or no evidence specially describing an MST encounter or encounters in the military.

Therefore, we accept markers or indicators that support the veteran's contentions. Such evidence may include but is not limited to records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals or physicians, pregnancy tests or tests for sexually transmitted diseases, and statements from family members, roommates, fellow servicemembers, or clergy.

In addition, evidence of behavior changes following the claimed assault constitutes another source of relevant evidence. Examples of such behavior changes include but are not limited to a request for a transfer to another military duty assignment, deterioration in work performance, substance abuse, episodes of depression, panic attacks, or anxiety without an identifiable cause, or unexplained economic or social behavior changes.

The regulation prohibits the denial of claims for service-connection for PTSD based on in-service personal assault without first advising the veteran that information from sources other than the veteran's service records or evidence of behavior changes may constitute credible evidence of the stressor and allowing the veteran an opportunity to furnish this type of evidence or advise VA of potential sources of such evidence.

The regulation also provides that VA may submit any evidence it receives to an appropriate medical or mental health professional

for an opinion as to whether it indicates that a personal assault may have occurred.

VBA field personnel who adjudicate PTSD claims based on MST were provided with detailed information on proper claims processing methods in a training letter issued in November 2005. Additionally, all VBA Regional Offices have a woman veterans' coordinator who is well versed in MST issues and can provide assistance to veterans as necessary.

These procedural steps taken by VA assure that veterans filing claims for their PTSD based on military sexual trauma will receive fair and thorough consideration of their claims.

We recognize the damage that MST can inflict on its victims and we have developed policies in response that do make it easier to establish entitlement to benefits based on disability as a result of MST.

I believe that there is room for us to make improvements, but we have taken steps.

Mr. Chairman, thank you again for the opportunity to appear before you today. And at this time, I will turn to my colleague from the Veterans Health Administration who can elaborate on their efforts to assist veterans suffering from MST-related conditions.

Mr. HALL. Dr. McCutcheon?

STATEMENT OF SUSAN MCCUTCHEON, R.N., ED.D.

Dr. MCCUTCHEON. Good morning.

Chairman Hall, Chairman Michaud, Ranking Members Lamborn, Brown, and Members of the Subcommittees, thank you for the opportunity to appear to discuss VA's work in identifying and treating veterans for conditions related to military sexual trauma or MST.

Addressing the needs of survivors of sexual assault and harassment in the military is a priority for the VA. It is a tragic fact that many veterans suffered sexual trauma while serving on active military duty.

Some are still struggling with fear, anxiety, shame, or profound anger as a result of these experiences. A number of individuals have never discussed their experiences or their feelings with anyone and they are understandably reluctant to talk about them now.

MST includes any sexual activity where someone is involved against his or her will. He or she may have been pressured into sexual activities, may have been unable to consent to sexual activities, or may have been physically forced into sexual activities.

Other experiences that fall into the category of MST include repeated, unsolicited verbal or physical conduct of a sexual nature that is threatening in character.

If these horrific experiences occurred while an individual was on active duty or active duty for training, they are considered to be MST.

It is important to remember that MST is an experience, not a diagnosis or a mental health condition in and of itself. Among users of VA health care, medical record data indicate that diagnoses of post-traumatic stress disorder, depression and other mood disorders, psychotic disorders, and substance use disorders are most frequently associated with MST.

Even after severely distressing experiences, there is no one way that everyone will respond. For some veterans, experiences of MST may continue to affect their mental and physical health even many years later.

Fortunately, people can recover from experiences of trauma and VA has services to help veterans do this. All veterans seen at a VA facility are asked two questions, one to assess sexual harassment and the other to assess sexual assault that occurred during their military service.

Veterans who respond yes to either question are asked if they are interested in learning about MST-related services that are available. Not every veteran who responds yes needs or is necessarily interested in treatment.

The VA MST screening rates only reveal how many men and women that seek VA health care report MST, not the actual incidence of sexual trauma among those serving in the military.

VA data indicates that approximately one in five women and one in a hundred men seen in VHA respond yes when screened for military sexual trauma.

Although rates of MST are higher among women, because of the disproportionate ratio of men to women in the military, there are actually only slightly fewer men seen in VA who have experienced MST than women.

Since 1992, VA has been developing programs to monitor MST screening and treatment, providing staff with training on MST-related issues, and engaging in outreach to veterans who have experienced MST.

VA established a national level MST support team in fiscal year 2007 to achieve these objectives and promote best practices in care.

Currently all veterans seen in VA are screened for MST. Every VA facility has a designated MST coordinator and has providers knowledgeable about treatment for MST. And VA offers both inpatient, residential, and outpatient services as needed.

VA also collaborates with others including the Department of Defense Sexual Assault Prevention and Response Office or SAPRO to discuss treatment approaches for individual veterans and servicemembers.

At the local level, many VA facilities have established partnerships with the local military installations to provide additional support and to improve outreach and awareness of MST.

Thank you again for the opportunity to appear. We are now prepared to answer any questions you may have.

[The prepared statement of Mr. Mayes and Dr. McCutcheon appears on p. 47.]

Mr. HALL. Thank you, Ms. McCutcheon.

Unfortunately, we will have to have you answer those in writing because the Joint Session is convening across the street.

Mr. Michaud, you are now recognized.

Mr. MICHAUD. Thank you, Mr. Chairman.

And I, too, want to thank the three panels for your testimony this morning. It has been very enlightening. I appreciate your coming forward.

And I want to thank the Chairman as well.

Unfortunately, because the President of Mexico is here, we are not able to ask questions today, but we will be submitting for the record several questions for the witnesses. My question will be more for DoD since that is where the problem usually starts, before veterans end up in the VA system. I am very curious about what have been some of the repercussions of what the predators have done, whether all they have received is a slap on the wrist or whether they have been honorably discharged or lose their retirement or another punishment.

I want to thank all of you for coming today and look forward to your response to our questions in writing. And thank you for your services to those who have served. And thank you to the audience as well, for those who decided to come here today. Thank you for your service.

This is a very serious issue and I know the Chairman and I will be taking it very seriously and be looking forward to your input as we move forward with legislation to address this serious problem. Once again, thank you.

And I yield back, Mr. Chairman.

Mr. HALL. Thank you, Chairman Michaud.

Thank you again to our third panel and all of our panels today. I regret that we have to have this hasty process. And please do not think that it means that we do not care as deeply about this issue as you do.

I want to acknowledge that we are submitting a statement for the record from Denise Williams, the Assistant Director of the Veterans Affairs and Rehabilitation Commission of the American Legion, and a statement by Dr. Beth Kosiak of the American Urological Association for the record of this hearing as well all Members having 5 days to revise and extend their remarks.

And we will submit questions for you and look forward to receiving your answers in writing.

So, on behalf of the Subcommittees, thank you for your insight and your recommendations.

And this hearing stands adjourned.

[Whereupon, at 11:08 a.m., the Subcommittees were adjourned.]

APPENDIX

Prepared Statement of Hon. John J. Hall, Chairman, Subcomittee on Disability Assistance and Memorial Affairs

Good Morning Ladies and Gentleman:

Would everyone please rise for the Pledge of Allegiance? Flags are located at the front and back of the room.

I am grateful for the opportunity to be here today for a joint hearing entitled, *Healing the Wounds: Evaluating Military Sexual Trauma Issues,* with my colleagues, Health Subcommittee Chairman Michaud, and our Ranking Members, Mr. Lamborn and Mr. Brown. But, I am particularly enthusiastic to recognize the men and women veterans who are in this room today and to hear about their experiences with the Department of Veterans Affairs and DoD as it relates to Military Sexual Trauma Issues (MST).

The purpose of this hearing today is to evaluate ways in which the Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and the Department of Defense (DoD) can better address the needs of veterans impacted by Military Sexual Trauma (MST) and identify ways to better prevent, treat and properly compensate them.

MST refers to sexual harassment and sexual assault that occurs in military settings. MST often occurs in a setting where the victim lives and works, which means that the victims must continue to live and work closely with their perpetrators. MST can also disrupt the career goals of many of its victims, as perpetrators are frequently peers or supervisors responsible for the decisions on work-related evaluations and promotions. This means that victims must choose between continuing their military careers at the expense of frequent contact with their perpetrators or ending their careers in order to protect themselves. Many victims share that when they do report the incident, they are not believed or are encouraged to keep silent because of the need to preserve organizational cohesion.

The National Center for PTSD of the Department of Veterans Affairs (VA) reports that in 1995, the Department of Defense (DoD) conducted a large scale study of sexual victimization among its active duty population. This DoD study found that the rates of attempted or completed *sexual assault* were 6 percent for women and 1 percent for men. Another study found that rates of sexual assault and verbal sexual harassment were higher during wartime than peacetime in their sample study population. This suggests that the stress of war may be associated with increases in rates of sexual harassment and assault. The National Center for PTSD also reports that the rates of MST among the veteran population who use the VA health care system appear to be even higher than that of the general military population. One study found that 23 percent of female users of the VA health care system reported having experienced sexual assault while in the military.

MST has been a concern among many veterans who have continually expressed frustration with the disability claims process, especially in trying to prove to the VA that the actual assault ever happened. For many women and men, when their disability claims for PTSD related to MST are denied, they suffer a secondary injury, which results in an exacerbation of PTSD symptoms. Thus, they are less likely to file an appeal.

There also has been frustration with the lack of appropriate health care providers to treat veterans who have experience working with MST.

We cannot allow this to happen to this Nation's veterans who have served her. VA and DoD need to ensure that the proper treatment is available. Veterans should be able to have access to treatment facilities and qualified staff with care and benefits delivered by employees who are properly trained to be sensitive to MST related issues. These veterans need to be treated with the dignity and respect that they deserve.

I look forward to hearing from the esteemed panels of witnesses assembled today as we attempt to heal the wounds of these veterans and get them the proper treatment and benefits without unnecessary delay.

Prepared Statement of Hon. Doug Lamborn, Ranking Republican Member, Subcommittee on Disability Assistance and Memorial Affairs

Thank you Mr. Chairman,

I welcome our witnesses to this important hearing to discuss matters concerning military sexual trauma.

Occurrences of sexual assault within the ranks of our military are completely unacceptable.

It saddens me to think that anyone who volunteers to protect our Nation through service in the armed forces would ever have to contemplate being harmed by a fellow servicemember.

But our military is a microcosm of society—and crimes that occur in society unfortunately also occur in the military—so we must face reality and address the problems that arise.

First, it should be made clear through training at every level and to every servicemember that sexual offenses will not be tolerated and that perpetrators will be punished to the fullest extent under the Uniform Code of Military Justice.

Second, the military services should follow through and ensure that justice is rendered in cases involving sexual assault.

And I would also add that the military must thoroughly investigate and prosecute false accusers of sexual assault who work to the detriment of those individuals who really are victims of sexual assault.

While it is important that we deliberate on the very serious topic of military sexual trauma, I want to also make very clear that this is not an indictment of our military as a whole.

There are those with anti-military views who would try to use incidences involving sexual assault to depict our entire military as a bunch of violent misogynists.

Doing so would be a vulgar smear against the heroes this committee serves.

I'm sure the families of the young men who died in Afghanistan this past week during the attack on Bagram (bah-GRAHM') Air Field would find such a generalization offensive, and I share their perspective.

The vast majority of the men and women who volunteer for military service are honorable and patriotic individuals who courageously stand to defend our country and other countries from tyranny.

They are some of our bravest citizens who abhor bullies and the type of individuals who would commit such a repugnant crime as sexual assault.

As far as this topic pertains to VA benefits, I believe the Department has the proper rules in place for adjudicating and rating sexual trauma cases.

Title 38 United States Code section 1154 provides VA the authority to give proper consideration to the time, place and circumstances, of service when determining eligibility to compensation.

This means that VA must consider non-specific, but corroborating pieces of evidence when considering claims based on sexual assault.

As some of our witnesses point out—this does not always occur and VA should address this shortcoming through training to ensure proper consideration is afforded to every claim.

I appreciate the DAV's point that VA should be able to access the *restricted* DoD records documenting reports of sexual trauma.

I look forward to learning whether such a policy is in place or being established to secure such records.

I want to thank all of our witnesses for their participation and their testimony, and I look forward to our discussion today.

Mr. Chairman, I yield back.

Prepared Statement of Hon. Michael H. Michaud, Chairman Subcommittee on Health

Good morning. I would like to thank everyone for attending today's hearing on military sexual trauma.

I am happy to join my colleagues, DAMA Subcommittee Chairman Hall and our Ranking Members Mr. Brown and Mr. Lamborn, in holding this joint hearing.

Servicemembers who experience military sexual trauma and are brave enough to speak out about their experiences are often marginalized and for many, it means the end of their military career while their offenders often times remain unscathed. We must do better by the women and men who experience military sexual trauma.

Last May, the House Committee on Veterans' Affairs held a roundtable discussion with women veterans representing veteran service organizations and their auxiliary organizations. During the roundtable discussion, military sexual trauma was a commonly cited concern and the participants expressed their frustration with the shortage of appropriate health care providers to treat veterans with military sexual trauma.

I am proud to say that just last month, S. 1963, the Caregivers and Veterans Omnibus Health Services Act, was enacted as Public Law 111–163. This landmark legislation included important provisions from H.R. 1211, the Women Veterans Health Care Improvement Act, which was introduced by Ms. Stephanie Herseth Sandlin. Among the key provisions, VA would be required to provide training and certification for VA mental health care providers on caring for veterans suffering from sexual trauma and PTSD.

As we build a VA for the 21st century, we must ensure that it embraces the growing and unique needs of our women veterans. I am pleased to join my colleagues in the DAMA Subcommittee to explore ways that we can better support veterans with military sexual trauma.

I look forward to hearing the testimonies of our witnesses today.

Prepared Statement of Phyllis Greenberger, President and Chief Executive Officer, Society for Women's Health Research

Mr. Chairman and Members of the Committees:

I would like to begin by thanking you for calling this joint hearing on Military Sexual Trauma. I appreciate the opportunity to address both committees on this important and timely topic. I am Phyllis Greenberger, the President and CEO of the Society for Women's Health Research. SWHR is a non-profit patient advocacy organization dedicated to improving women's health through advocacy, education, and research of sex and gender differences.

SWHR's focus since 1995 has been to clearly demonstrate that sex and gender differences exist, and research needs to be done to explore conditions that affect women differently, disproportionately, or exclusively—to identify these differences and to understand the implications for diagnosis and treatment.

Research into this area comes at a time of great need within the Department of Veterans Affairs (VA), as today over 10 percent of the military presence in Iraq and Afghanistan is female. As the Department of Defense (DoD) continues to work to integrate an ever-larger female presence among active military, the VA sees a comparable rise in numbers of female veterans seeking care *after* their time of service, for both service-related and non-service-related care. Women are the fastest growing sector of VA patients. Over 450,000 women have enrolled with VA medical centers for care, and that number is projected to rise by 30 percent in the next 5 years.

The pressing issues that bring us here today are the **risks and ramifications** of military sexual trauma, or MST.

The statistics on **risk** are well known. MST victims are disproportionately and almost exclusively women. A 2008 VA study reported that 15 percent of military women in Iraq and Afghanistan experienced sexual assault or harassment, and 59 percent of those were at higher risk for mental health problems. This is just among those cases reported. Many more, possibly more than half, of all MST cases go undocumented each year.

The **ramifications** of MST for women persist long after the initial assault. While sexual assault in any setting is horrific, the combined insult of MST occurring while serving in a foreign setting, often in an active war zone, only exacerbates the effects. By VA estimates, over 70 percent of women in the military have been exposed to combat. Further, with most MST assaults being orchestrated by military personnel against military personnel, the environment of trust among those serving is broken,

and a chain of command that fails to protect from and respond to MST further degrades unit cohesion.

Research in the area of MST and sexual assault has revealed some interesting sex-based differences:

First, women are more likely then men to contract a sexually transmitted infection, or STI. STIs are often more difficult to treat in women and can have emotional and mental impacts over a woman's lifespan. Sexual assault can result in an unplanned pregnancy or conversely leave a woman unable to bear children in the future. The impacts of MST are not limited to reproduction. Infection with HPV after a sexual assault can result in cancer decades later in life. Scientists studying HIV in women found the virus enters and infects the cells of the vaginal wall in a way different from how the virus is introduced into male cells.

Second, sexual assault is a common trigger for post-traumatic stress disorder, months and even years after the attack. Scientists are finding that women do not respond the same to some of the common medications prescribed for PTSD, often fairing worse than men taking the same medication for the same diagnosis.

Third, multiple traumas can increase the likelihood of developing PTSD, and the combined impacts of working in a war zone, multiple deployments, MST, and for a disproportionate share of female military members, exposure to early life trauma, all raise the risk for an eventual PTSD diagnosis. Females in the military have twice the levels of PTSD and depression as their male counterparts.

Fourth, research suggests that the ultimate impact of a traumatic event on a woman may depend on hormone levels, and can vary based on where she is in her menstrual cycle and whether or not she uses medications that alter hormone levels, such as birth control. The role of cyclical hormonal variations, as well as studies finding that during pregnancy PTSD symptoms decrease, may offer insight into which women develop PTSD after MST, and may further help discover more effective PTSD therapies for women—therapies that are responsive to sex-based hormonal differences. More research is critical for moving forward and determining targeted treatments for women and men.

The VA in 2010 is in a unique position to better serve its female veterans, at the same time becoming a leader in women's health and sex based research. Changes in care can only come from sound research, and investments in VA research often translate into new knowledge, methods, screenings, and treatments for women *and* men, military *and* civilian. As discussed before this Committee 1 year ago today, the VA system faces staffing, organizational, and infrastructure challenges when updating to meet the needs of the growing female veteran population. The VA still has a long way to go. Reports as recent as March 2010 are still finding deficiencies in the availability of resources for female veterans. From providing gender-specific care at all VA Medical Centers to including female subjects in the VA's Health Services Research and Development, the VA with proper support and resources can transform to what is needed today and what is needed for the future.

SWHR would like to encourage the VA to optimize its interactions with female veterans, by offering women the option to participate in research projects—receiving a high quality of care while gathering information to help other female veterans. The health information technology capabilities that link all VA medical centers, and each veteran's medical and personnel charts, offers unmatched capabilities for research. The VA is to be praised for its electronic medical records system, and encouraged to utilize it to its full capacity. Further, increasing collaboration between the DoD and the VA would additionally offer an improved continuum of care, as women transition from active duty to veteran status. A victim of MST during her time of service needs streamlined care after she returns, as well as a VA system that is equipped to meet her sex and gender specific needs. For the female veterans who choose to seek care outside of the VA setting, private clinicians also depend on the research and clinical guidance only the VA can provide—capturing the nuances specific to military service, combat exposure, and MST faced by female veterans. The VA alone can pull together these details and offer direction to help all clinicians make sound choices for their female veteran patients, and all women.

While I hope that I have made clear the need for more investments in the VA and sex based research, SWHR further hopes that these recommendations will be acted upon quickly. I encourage the VA and these committees to consider the potential impact of appropriate research into women's health and the wide reaching results that could improve sex-based research as well as mental and sexual health for all. The VA today has a unique opportunity to champion the cause of women's health research—not only for veterans, but for all patients.

I want to again thank you for this opportunity to present to the Committee. I would be pleased to answer any questions.

Prepared Statement of Helen Benedict, Professor of Journalism, Columbia University, New York, NY, and Author, *The Lonely Soldier: The Private War of Women Serving in Iraq*

Thank you for holding this hearing and honoring me with an invitation to testify.

First, I would like to commend the Caregivers and Veterans Omnibus Health Services Act, signed by President Obama just this month, as an essential step toward helping female veterans and the families of wounded warriors.

This Act takes an important step toward addressing the horrendous problem of military sexual assault by requiring the VA to train mental health professionals to care for women with sexual trauma.

This is progress. Yet I am concerned that the training be done properly. For my book, *The Lonely Soldier,* I interviewed more than 40 female veterans of our current wars. Too often they told me that when they tried to report an assault, the military and VA treated them as liars and malingerers.

They also told me that their Sexual Assault Response Coordinators, assigned to them by the military, often treated them with such suspicion that they felt re-traumatized and intimidated out of pursuing justice. Indeed, the usual approach to a report of sexual assault within the military is to investigate the victim, not the perpetrator, and to dismiss the case altogether if alcohol is involved. Counselors have told me of seeing case after case where a battered and abused victim has been told, "It's your word against his."

It is therefore essential that the counselors used by the military and the VA be trained in *civilian* rape crisis centers, away from a military culture that habitually blames the victim, and that is too often concerned with protecting the image of a platoon or commander by covering up wrongdoing. These counselors, and indeed anyone within the military charged with investigating sexual assault, should be trained to understand the causes, effects and costs of sexual abuse to both the victim and to society.

Within the VA, reform is also needed. The process for evaluating disability caused by military sexual assault needs to be automatically upgraded. And victims who were too intimidated to report an assault while on active duty should never be denied treatment once they come home, as they so often are now. The VA needs to recognize the fact that some 90 percent of victims never report assaults within the military because its culture is so hostile to them. The VA must also recognize and address the fact that it can take years to recover from sexual assault, and that untreated trauma caused by sexual assault can result in depression, homelessness, self-destructive behavior, and suicide. No victim of military sexual assault should ever be denied benefits and help.

In the light of the new Caregiver's Act, I also want to alert this committee to the finding that many of our troops were sexually or physically abused long before they enlisted.

In two studies of army and marine recruits, conducted in 1996 and 2005 respectively, it was found that half the women and about one-sixth of the men reported having been sexually abused as children, while half of both said they were physically abused.[i]

The picture may have shifted lately with the recession driving more people into the military. Nonetheless, it looks as if close to half our troops are enlisting to escape violent homes.

Thus we need to provide counselors trained not only in military sexual assault but in childhood abuse and trauma. These counselors should be available to active duty troops and veterans. They should embedded with the combat stress counseling teams already deployed.

[i] L.N. Rosen and L. Martin, "The measurement of childhood trauma among male and female soldiers in the U.S. Army," *Military Medicine* 161 (1996): 6, 342–345.

This is necessary not only to help troops cope with trauma, but to help prevent further sexual violence. Psychologists have long known that an abused boy can grow into an abusive man.[ii]

I emphasize this because too often the focus when addressing military sexual trauma is on women alone, ignoring the fact that men cause the problem, and that they, too, are sexually assaulted in the military.[iii]

Violence is endemic to the military, and little can be done about that. But our troops are not supposed to be enacting this violence on one another. The last chapter of my book offers a list of suggestions for how to at least decrease military sexual violence. These are too numerous to list here, but I include some essential examples:

- Promote more women. With more recognition and authority, women will help to increase respect for female troops, and respect is the single most important weapon against harassment and rape.
- Distribute women more evenly. No women should serve alone with all-male platoons, as they sometimes do now, for it leaves them isolated and vulnerable to assault.
- Strike the "Don't Ask, Don't Tell" policy, which encourages persecution of men and women, gay or not.
- Reject recruits with records of domestic or sexual violence.
- Hold commanders accountable for assaults that occur in their units.
- And reward commanders and officers who pursue justice in cases of sexual assault.

Finally, let us recognize that more effective than any rules or laws is the attitude of the commander on the ground. Studies have shown that commanders who treat their female soldiers with respect and insist that other soldiers do likewise significantly reduce sexual persecution.[iv] Thus we must reform the culture within officer academies, which at the moment is rife with brutal hazing, abuse, and rape, as the Tailhook, Aberdeen and Air Force Academy scandals have too often demonstrated.[v] This violence drums women out of the service and trains men to enact and condone rape and torture.

All officer training schools for all military branches should teach their candidates to understand that rape is an act of anger, hatred, and power, not desire, and that sexual persecution destroys camaraderie and cohesion. Officers should learn to take pride in ensuring their troops are safe from disrespect and violence from their comrades, just as they take pride in bringing them home safely from war.

Thank you.

Prepared Statement of Scott Berkowitz, President and Founder, RAINN—Rape, Abuse, and Incest National Network

Good afternoon Chairmen Hall and Michaud, Ranking Members Lamborn and Brown, and distinguished Members of the Subcommittee on Disability Assistance and Memorial Affairs and the Subcommittee on Health. Thank you for the invitation to participate in today's hearing on military sexual trauma.

My name is Scott Berkowitz and I am the founder and president of the Rape, Abuse & Incest National Network, or RAINN. RAINN, the Nation's largest anti-sexual violence organization, founded and operates the National Sexual Assault Hotline. The hotline is a partnership of 1,100 local rape crisis centers across the U.S., and has provided free, confidential counseling and support to more than 1.4 million victims of sexual violence. We also run the National Sexual Assault Online Hotline, a web-based service that provides help to the generation of victims who are more

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[ii] A. Nicholas Groth and H. Jean Birnbaum, Men Who Rape: The Psychology of the Offender (New York: Plenum Press, 1979).

Jessica Wolfe, Kiban Turner, et al. "Gender and Trauma as Predictors of Military Attrition: A Study of Marine Corps Recruits," *Military Medicine* 170(2005): 12, 1037.

[iii] According to a 2008 DoD report, some 27 percent of men in the reserves and national guard reported sexual trauma in the military. Department of Veterans Affairs, "Military Sexual Trauma Among The Reserve Components Of The Armed Forces."

[iv] Sadler, et al. "Factors Associated With Women's Risk of Rape in the Military Environment." (2003).

[v] "Conduct Unbecoming" by Cathy Booth Thomas, Time magazine, *http://www.time.com/time/magazine/article/0,9171,428045,00.html.*

"Military Sex Scandals From Tailhook to the Present: The Cure Can be Worse Than the Disease." By Kingsley R. Browne, Duke Journal of Gender Law & Policy, Volume 14:749 2007.

comfortable typing than talking. RAINN also educates more than 120 million Americans each year about sexual assault prevention, prosecution and recovery.

When I first testified to Congress on this issue, about 6 years ago, a DoD task force had just published an exhaustive study of the problem. Unfortunately, that wasn't an uncommon occurrence, as one of your colleagues vividly demonstrated when she lined up the reports from more than a dozen DoD task forces from the preceding two decades.

Most of these task force reports had shown an understanding of the issue and proposed a number of reforms that would help address the problem. And all had been shelved soon afterwards, left undisturbed until the next commission was created and its staff started searching through the archives. While there were many smart, committed people within the military services who had worked for years to address the sexual assault problem, they lacked the institutional support, leadership commitment and resources to fix it.

So while we were hopeful about the 2004 report, optimistic that this time would be different, the odds weren't on our side.

The good news is: it looks like this time we may have a chance to beat the odds. That's not to say that the problem has been solved—in fact, we're a long, long way from that. But over the last 6 years, I have been pleased to observe that the Pentagon, led by SAPRO and the services, has taken the problem seriously and made some tangible progress.

The Problem in Context

To understand the remaining challenges, we need to understand the problem in context. In one sense, the military isn't unique. Nationally, about 80 percent of all rape victims are under age 30. So the problems faced by the military are, in fact, quite similar to those faced by large colleges and universities. It is unfortunate, but, for the moment, true:

Where there are many thousands of young people, there are surely a large number of rape victims. While there's no question military culture is unique—and presents unusual challenges to providing services for victims—that unique culture itself is certainly not the cause of the sexual assault problem.

Much research, and our own experience serving rape victims, has shown us that they respond to their crime quite differently from victims of other crimes. Mental health professionals widely agree that rape is the most traumatic violent crime. The FBI ranks it as the second most violent crime, trailing only murder. In other words, it is the most violent and traumatic crime a victim lives to remember.

And remembering comes naturally to victims of rape. Sexual assault can be devastating to victims, causing post-traumatic stress disorder, depression, eating disorders, sleeplessness and other mental health issues. Victims, particularly those who do not get help, are many times more likely to become addicted to drugs or alcohol or even to attempt suicide. Embarrassment and shame are near universal.

In the civilian world, these reactions help explain why most rape victims are so reluctant to report their attack to police, or even to their own friends and family.

While the percentage of civilian rates that are reported to police has increased by one-third in the last 15 years, the majority of victims—about six out of 10—still do not report.

Now, add to this mix the fact that in the military, filing an unrestricted report, the kind of report that could lead to prosecution, will mean that everyone knows—and I do mean everyone, from your superiors to your bunkmates. And add in the fear of retaliation or ostracization, and the fear of the impact it might have on your career, which only serve to amplify the resistance to reporting. If most civilian victims are unwilling to report even without all those extra concerns, without the fear of sabotaging their career, it's going to remain difficult to get military victims to report.

Lessons from the Civilian World

Of course, there's no single, simple solution to this problem. But we can start by applying a few key lessons we have learned in the civilian world.

- Number One: Victims who receive prompt, quality, confidential crisis intervention return to full strength more quickly, and are ultimately more likely to report their attack to law enforcement officials.
- Number Two: More reports to law enforcement leads to more prosecutions.
- Three: The result of more prosecutions is fewer sexual assaults. Increasingly, the data are clear: Rapists are serial criminals. There aren't an enormous number of rapists in our midst, inside the military or out. There are a relatively small number of rapists, collectively committing an enormous number of rapes. So every time we can convince just one more victim to come forward, leading

to a successful prosecution and serious punishment, we may be preventing dozens of rapes down the line.

Victim Services & Confidentiality

So how do we get more victims to come forward for help? Former Congresswoman Tillie Fowler, who chaired the investigation into the Air Force Academy, told me at the time that every victim they interviewed—every single one—told the panel that *they would never access help without the guarantee of confidentiality.* This response matches RAINN's own research. In the course of developing the National Sexual Assault Online Hotline, the consistent message from victims was that the service must guarantee confidentiality, even anonymity. This led us to go to great lengths to create a safe technology that victims would trust.

DoD has made some progress on this score, with the introduction of restricted reporting, which allows the victim to access services without an official report that engages the chain of command. Those we have spoken to within the services believe restricted reporting has been a qualified success. It has encouraged more than 3,000 victims to come forward and get help, about 15 percent of whom later decided to make an unrestricted report and pursue prosecution.

Still, the safety of a restricted report is incomplete. Victims' communications with military victim advocates do not enjoy the rape crisis counselor privilege that is found in most state laws, leaving open the possibility that the victims advocate could later be forced to testify against the victim in court. That possibility is sure to discourage some victims from coming forward, which is the reason most states have passed some kind of rape crisis privilege law. I understand that DoD recently submitted this change to OMS for the president's approval, and I hope the administration acts swiftly to approve and implement the change.

At the same time, DoD has determined that mandatory reporting laws for medical personnel, in California for example, supersede the protections victims enjoy under restricted reporting. The result is that victims in those states are forced to forego the medical care they urgently need—even treatment for major injuries, and testing for STls and HIV—unless they're willing to sacrifice the confidentiality promised by restricted reporting. If they do choose medical care—and, by the way, RAINN strongly recommends that all victims receive a medical exam as soon as possible following the crime—they may trigger a chain of events that ends in civilian law enforcement informing military law enforcement, resulting in the very chain-of-command report that restricted reporting was meant to avoid. We encourage Congress to investigate this issue and determine whether a federal solution is feasible.

Fortunately, there are steps Congress can take to address these remaining barriers to victims receiving confidential help.

Another part of the solution is to make good use of the extensive civilian services offered by the National Sexual Assault Hotline, the Online Hotline, and local rape treatment centers across the Nation. By functioning outside the chain-of-command, civilian services can offer the confidentiality and security victims desire and deserve, while simultaneously advancing the military's goal of encouraging more victims to report their attack to military law enforcement. They are by no means a replacement for military-based victim services. Rather, they are a bridge to such services, and an alternative for those victims who are unwilling to ask for help through official channels.

Leadership & Prevention

While time constraints limit the recommendations I can share regarding prevention programs, I do want to mention the most important kind of prevention program. The most effective prevention—the one without which all other efforts are sure to fail—is discipline and leadership.

To be effective, any prevention program must be able to credibly communicate leadership's personal commitment to zero tolerance of sexual assault and to the punishment of all who commit such crimes. Our soldiers are smart enough to know the difference between orders they need to obey and lectures they must endure and then are free to ignore.

Without sincere buy-in from leadership, without real evidence that zero tolerance means *zero* tolerance, any prevention efforts will fail.

As you would expect in an institution as large as the U.S. military, there are plenty of examples of leadership both good and bad. DoD leadership needs to continue to find ways to ensure that the commanders who take this seriously are recognized and rewarded.

And recalcitrant commanders need to be identified and reformed, by training when possible; by the threat of poor performance ratings and limited upward mobility when necessary.

If DoD leadership makes it clear that sexual assault is a force readiness issue that deserves the time and effort of those in command, that attitude will filter down through the commanding officer of a unit to the soldiers he or she oversees. Commanders who are vocal about and maintain a focus on their commitment to preventing sexual assault will positively influence their units.

This point is highlighted in the DTFSAMS report, which noted that commanders themselves identified this as an issue that needed to be addressed. According to the report, interviews with commanders concluded that they "need better training on sexual assault prevention and response."

As continued improvements in prevention programs and victim services show results, we all have a duty to ensure that the public and the media understand that a higher number of reported rapes in the military is almost certainly a sign of *success,* not of increased danger in the ranks. Such an increase is most likely evidence that we're successfully increasing the percentage of victims who pursue justice. That's also an important point when assessing commander performance. Commanders must not fear that an increase in rape reports on their base will be held against them. Rather, they should be accountable for instituting an effective program that encourages increased reporting.

I'd like to add one point about process. There have been news reports recently about DoD's plan to restructure its personnel office. I defer to DoD as to whether that's a good idea. But I am concerned about one idea I've heard floating around—the idea of putting DoD's sexual assault programs under its domestic violence programs. While on the surface it sounds plausible to combine sexual assault with domestic violence, or even sexual harassment, the effect of that could be to set back efforts to prevent sexual assault and help victims.

Sexual assault is a very different issue than domestic violence. The relationship between attacker and victim is different; the factors that influence the decision to get help or report to law enforcement are different; the entire nature and cause of the two crimes are different. Equating the two issues might seem like an efficiency move on paper, but doing so has the potential to de-emphasize sexual violence and hamper prevention and victim-service efforts. Now that we've started to make progress, it's the wrong time to backtrack like that.

In summary, the problem of sexual assault is not unique to the military, nor is the reluctance of victims to report the crime. To successfully combat this problem, we must continue to improve services on base. We must provide Servicemembers with alternative, confidential services off base. We must implement effective prevention and education programs on every base. And all this must be backed up by personal commitment by base commanders and Pentagon leadership to zero tolerance and routine prosecutions. The result will be fewer sexual assaults, healthier and safer soldiers, and an improved public image of the greatest military the world has ever seen.

Prepared Statement of Joy J. Ilem, Deputy National Legislative Director, Disabled American Veterans

Messrs. Chairmen and Members of the Subcommittees:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this joint oversight hearing focused on collaboration between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to better address military sexual trauma (MST) and to identify better ways to treat and properly compensate veterans for conditions related to MST. We also continue to express a fervent hope that DoD is effectively addressing methods to prevent and in fact eliminate the incidence of sexual assaults and harassment within all branches of the military services.

This hearing takes on a topic that is extremely personal and sensitive to many servicemembers, veterans and the respective Departments that are responsible for the safety and well-being of their members. Sexual trauma is not a "sex crime." It is a violent personal crime perpetrated against an innocent and unwilling person, and attended by both physical and mental legacy wounds. In that sense, the title of today's hearing, "Healing the Wounds," is most appropriate. When a servicemember is wounded by enemy rifle fire or mortar shrapnel on the field of battle, as a society we are shocked and dismayed by the sacrifice and loss of our wounded military personnel, but when someone is wounded by sexual violence, society responds in a very different way. We hope this hearing can begin to heal these deep wounds that are often invisible but have profoundly changed the lives of those affected.

MILITARY SEXUAL TRAUMA: AN UPHILL BATTLE FOR VA DISABILITY COMPENSATION

An area of concern for DAV relates to veterans' compensation claims for disabilities resulting from MST. The prevalence of sexual assault in the military is alarming and has been the object of numerous military reports, media coverage, and Congressional hearings over the past decade and before. Servicemembers who have suffered MST often do not report these assaults during their military service, but many do experience lingering physical, emotional and psychological scars and symptoms following these incidents. Unfortunately, many men and women who experience these types of trauma do not disclose them to anyone until years after the fact.

According to VA, during fiscal year (FY) 2009, 21.9 percent of women and 1.1 percent of men screened by the Veterans Health Administration (VHA) reported MST. We note, however, that the size of each VA clinical population gender cohort (women to men) who reported military sexual trauma within VA treatment programs is almost equal: 53,295 women and 46,800 men, respectively.[1]

Another VA study found that of 125,000 veterans screened, about 15 percent of Operations Enduring and Iraqi Freedom (OEF/OIF) women veterans who use VA health care, reported experiencing sexual assault or harassment during their military service.[2] VA research also indicates that men and women who report sexual assault or harassment during military service were more likely to be diagnosed with a mental health condition. According to VA, women with MST had a 59 percent higher risk for mental health problems, with the risk among men slightly lower, at 40 percent.[3] The most common conditions linked to MST were depression, post-traumatic stress disorder (PTSD), anxiety and adjustment disorders and substance-use disorders.

Unfortunately, if an assault is not reported by the victim during his or her military service, establishing service connection later on for disabling conditions related to MST can be daunting. These claims are frequently denied by the Veterans Benefits Administration (VBA) due to lack of required documentary evidence to support the occurrence of a personal assault stressor. Although VHA provides comprehensive treatment for nearly 100,000 MST victims, many would be eligible for compensation benefits but are unable to support their claims with documented evidence of the stressor incidents. According to an Institute of Medicine (IOM) National Research Council report on PTSD compensation, significant barriers prevent women from being able to independently substantiate their experiences of MST, especially in combat arenas.[4] The IOM report concluded that little research exists on the subject of PTSD compensation and women veterans specifically. The Committee noted that available information suggests that women veterans are less likely to receive service connection for PTSD and that this is related to being unable to substantiate non-combat traumatic stressors such as MST. The Committee further noted that VA administrative procedures and rules for adjudicating and rating these types of cases address MST related PTSD claims but that little attention is paid to the unique challenges of obtaining documentation of an in-service stressor.

In 2005, the DoD established the Sexual Assault Prevention and Response Office (SAPRO). This organization is responsible for all DoD sexual assault policy and provides oversight to ensure that each military service branch complies with DoD policy. SAPRO serves as a single point of accountability and oversight for sexual assault policy, provides guidance to the DoD components, and facilitates the resolution of issues common to all military services and joint commands. The objectives of DoD's SAPRO policy are to specifically enhance and improve: 1) prevention through training and education programs; 2) treatment and support of victims; and 3) system accountability.

Under DoD's MST confidentiality policy, active duty victims of sexual assault have two reporting options-*restricted reporting* and *unrestricted reporting*. Restricted reporting allows a sexual assault victim to confidentially disclose the details of his or her assault to specified individuals and to receive medical treatment and counseling, *without triggering any official criminal or civil investigative process.* Servicemembers who are sexually assaulted and desire to file a restricted report under this

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[1] Amy Street, PhD., Dept of Veterans Affairs, National Military Sexual Trauma Support Team; *DVA Response to MST,"* PowerPoint presentation for the DCOE Webinar Series, April 22, 2010.

[2] Dept of Veterans Affairs; *VA Research Currents.* Nov-Dec 2008. *http://www.research.va.gov/resources/pubs/docs/va_research_currents_nov-dec_08.pdf*

[3] Ibid.

[4] Institute of Medicine and National Research Council of the National Academies, Committee on Veterans' Compensation for PTSD, Board on Military and Veterans Health, Board on Behavioral, Cognitive, and Sensory Sciences; *PTSD Compensation and Military Service,* 2007.

policy may only report the assault to the Sexual Assault Response Coordinator (SARC), Victim Advocate or an appropriate health care personnel member. According to SAPRO, health care personnel will initiate the appropriate care and treatment, and report the sexual assault to the SARC in lieu of reporting the assault to law enforcement or to the victim's unit commander. Upon notification of a reported sexual assault, the SARC will assign a Victim Advocate to the victim. The assigned Victim Advocate will provide information on the process of restricted versus unrestricted reporting. At the victim's discretion, appropriately trained health care personnel will conduct a sexual assault forensic examination (SAFE), which may include documentation of the injuries and collection of physical evidence. According to SAPRO, in the absence of a DoD provider, the servicemember can be referred to an appropriate civilian facility for the SAFE [examination].

According to DoD, unrestricted reporting is recommended for victims of sexual assault who request *an official investigation of the crime* in addition to treatment and counseling. When selecting unrestricted reporting, these victims permit current reporting channels to be used, e.g. notifying the chain of command, military police or civilian law enforcement, reporting the incident to SARC, or requesting health care personnel to notify law enforcement. Upon notification of a reported sexual assault, the SARC assigns a Victim Advocate. At the victim's discretion, health care personnel may conduct a SAFE examination, with similar collection of information and potential physical evidence. According to SAPRO policy, personnel access to details regarding the incident are limited to those who have a legitimate need to know.

In FY 2009, DoD reported an 11 percent increase from the prior year in all categories of sexual assault reporting. There were a total of 3,320 reports to DoD in FY 2009, with 2,516 unrestricted and 714 restricted reports. These reports represent the largest annual increase DoD has seen since yearly data collection began. The rise is attributed to DoD's release of its MST social marketing campaign last year, and SAPRO officials have stated they believe their message appealing for more reporting of MST within the ranks of the active force is achieving breakthrough and generating this recent jump in reporting. Since June of 2005, when the Department implemented the new restricted reporting option for victims of MST, SAPRO has documented 3,486 restricted reports having been filed.[5]

While DoD reports that it prefers complete (meaning, unrestricted) reporting of sexual assaults to activate both victims' services and law enforcement actions, it recognizes that some victims desire only health care and support services, without command or law enforcement involvement. The Department states its first priority is for victims to be protected, treated with dignity and respect, and receive the best possible medical treatment, counseling and care. DAV acknowledges that DoD policy, but we also want to protect MST victims' rights and benefits when they transition to veteran status.

DAV's primary concern is that VA be able to access the *restricted* DoD records documenting reports of MST for an indeterminate period. On several occasions over the past 2 years, DAV has contacted VBA and SAPRO staff to try to verify that the organizations are collaborating to ensure access to these records, if authorized by the veteran, in support of a VA benefits claim for conditions related to MST. It is my understanding that they have spoken but that to date there is not an official policy, process or Memorandum of Understanding (MOU) in place to secure such records. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Once a claim is filed VA has a number of standard sources it examines for records to support a claim for a condition secondary to personal trauma or MST. However, we do not see SAPRO-related reports listed in any of VA's training and reference materials/manuals for developing claims for service connection for PTSD based on MST. At this juncture we are unable to confirm if VBA unofficially searches for "restricted" reports as an alternative evidence source for information to substantiate the veteran's claim. VA does list medical reports from civilian physicians or caregivers who treated the veteran immediately after the trauma as alternative evidence to seek out in these cases; however, we do not know if VBA staff developing these claims are aware of DoD SAPRO policies and would contact the veteran to see if a restricted report was in fact filed, a physical examination conducted and if follow-up medical or mental health treatment records exist.

To maintain confidentiality in the case of restricted reporting, DoD policy prevents release of MST-related records, with limited exceptions. Also, VA is not specifically identified as an "exception" for release of records in DoD's policy, and it is

[5] Dr. Kaye Whitley, Director, Office of the Sec. of Defense, Sexual Assault Prevention and Response Office; *Sexual Assault in the Military,* PowerPoint presentation for the DCOE Webinar Series, April 22, 2010.

unclear if VA could gain access to these records even with permission of the veteran. Nevertheless, DoD does list VA as an advisor to the DoD Sexual Assault Advisory Council or (SAAC), a council that coordinates policy and review of the Department's sexual assault prevention and response policies and programs. We also have questions with respect to where and how physical assessment records that are completed following the assault and subsequent mental health treatment records related to the restricted MST reports are kept and for how long. It does not appear that these reports, whether restricted or unrestricted, are archived in the individual's official military personnel record, even subsequent to discharge from active duty. We are concerned that VBA adjudication staff may not be aware or attempt to gain access to these records that for privacy reasons are being kept separate from victimized servicemembers' medical treatment and personnel records. Additionally, we are not clear on how each military service branch maintains these records. According to DoD policy, *physical* evidence collected associated with a restricted report of the event is destroyed after 1 year if the servicemember or veteran does not wish to pursue civil or criminal sanctions against the perpetrator. However, we are not aware of the policies for maintaining DD Form 2911 (Forensic Medical Report Sexual Assault Examination form) completed by the examining clinician following the reported assault. The information on this form would in many cases validate the stressor associated with subsequent PTSD or other mental health consequences of MST.

We hope to confirm with the Subcommittee's oversight that VA is indeed fully collaborating with DoD to ensure veterans who have suffered MST and have filed claims for benefits for related conditions gain VA's full assistance in accessing these important records in support of their claims for disability. Additionally, we concur with the recommendation made in the 2008 report of the VA Advisory Committee on Women Veterans that suggested VBA identify and track claims related to personal assault/MST to determine the number of claims submitted annually, grant rates, denial rates, and types of conditions most frequently associated with these claims. The Committee stated that development of tracking systems could further guide studies on research on all aspects of MST. Finally, we ask that VBA provide the Subcommittees any information it has in its reference materials for claims developers/raters that reflect its collaboration with DoD/SAPRO and guidance to MST-related claims developers on how to access supporting documentation from each military service in the case of both restricted and unrestricted reporting options, including any differences in records retention, security and disposal policies.

VBA REQUIREMENTS FOR MST–RELATED CLAIMS

Establishing a veteran's service connection for PTSD requires: (1) medical evidence diagnosing PTSD; (2) credible supporting evidence that the claimed in-service stressor actually occurred; and (3) medical evidence of a link between current symptoms and the claimed in-service stressor.

However, if the claimant did not engage in combat with the enemy, or the claimed stressors are not related to combat, then the claimant's testimony alone is not sufficient to establish occurrence of the claimed stressors, and his or her testimony must be corroborated by credible supporting evidence. If a PTSD claim is based on in-service personal assault, evidence from sources other than a veteran's service records may corroborate a veteran's account of the stressor incident. Examples of such evidence include, but are not limited to: records from law enforcement authorities, rape crisis center, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow servicemembers, or clergy. Additionally, evidence of behavioral changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavioral changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavioral changes (title 38 CFR § 3.304(f)(4).)

Unfortunately, in many cases, even when the veteran has been diagnosed with PTSD based in part on claimed in-service sexual trauma, his or her claim is denied because there is no independent evidence (credible supporting evidence) to corroborate their statements as to the occurrence of any claimed in-service stressor. Even in cases where a VA physician indicates that a veteran was being followed for symptoms of military related sexual trauma, these lay and medical statements do not constitute credible supporting evidence. For more information, see *Moreau* v. *Brown*,

9 Vet. App 389, 396, (1996), wherein the court concluded that corroboration of an in-service stressor cannot consist solely of after-the-fact medical nexus evidence.

As noted above, to receive disability compensation from an MST-related condition, as noted above, the standard of evidence is stricter than for combat injuries, or even for military occupational injuries. Service connection for a condition related to MST is important on a number of levels. Specifically, veterans with service connection have improved access to VA health care—for veterans with VA disability ratings of 50 percent or more disabling—access to VA health care for any condition. Disability compensation can also make a tremendous difference in a disabled veteran's financial status. Finally—and most importantly for many MST survivors—being rated service connected for mental and physical disabilities attributed to MST represents validation, connotes gratitude for their service to their country and recognizes the tribulations they endured while serving.

COUNSELING AFTER MST: AN OPEN DOOR FOR VA TREATMENT

In accordance with section 101 of Public Law 103–452, the Veterans Health Programs Extension Act of 1994, any veteran self-reporting a history of in-service sexual trauma is eligible for VA health care for conditions related to that trauma. In compliance with this mandate, all patients are screened for MST, and treatment is available for MST-related conditions at all VA health care facilities. Service connection or disability compensation *is not* required for eligibility for this treatment, and veterans in these MST programs are exempt from co-payments for care provided.[6]

We congratulate VHA for making available on its Web site, http://www.mentalhealth.va.gov/msthome.asp, clear and concise information related to definition, screening and treatment for MST. VHA notes that both men and women have experienced MST during their military service, and that *all* veterans seen in the VA health care system are screened and asked about experiences of sexual trauma. VA provides a fact sheet to answer commonly asked questions including the commonality of MST and ways MST can affect veterans. VA also includes a list of possible signs and symptoms survivors of MST may experience, and most importantly, the Web site provides information on how and where veterans who experienced MST can get help from VA. Information is provided regarding the Women Veterans Program Managers, the MST Coordinators and VA's general benefit information hotline. VHA's Web site, outreach posters and brochures clearly indicate that VA provides confidential counseling and treatment for mental health and physical health conditions related to experiences of MST, all without copayment. VA also holds that service connection or disability compensation is *not* required to receive VA MST treatment, and that a veteran need not have reported the incident, nor have documented that it occurred, to obtain these services. In some cases a veteran may be able to receive VA MST treatment even if he or she is not otherwise eligible for VA care.

We are pleased that VHA makes a point to convey that recovery from personal trauma is possible; and that VA has the resources and services to help veterans through this extremely difficult challenge. We acknowledge the many experts, specialized research conducted and programs that have been established through the VA's National Center for PTSD, many of which are focused on MST and its consequences in mental health of victims. Nationwide, VA offers specialized MST inpatient and outpatient services, and evidence-based treatments and counseling by specially trained sexual trauma counselors in its Vet Center community-based facilities. Veterans can also request a same-sex provider if it makes them feel more comfortable in their counseling sessions.

In testimony before the Health Subcommittee on March 9, 2009, VA testified that it had established an MST support team in VA Central Office to monitor MST screening and treatment, oversee MST-related education and training, and promote best practices for screening and treatment.

Despite this progress, VHA staff across the nationwide system needs to be more sensitive and knowledgeable and recognize the importance of environment of care delivery when evaluating these veterans for their physical and mental health conditions. For years we have encouraged VHA to develop a MST provider certification program, guarantee at least 50 percent protected time for MST coordinators to devote to position responsibilities, provide separate and secure women's subunits for inpatient mental health and residential services, ensure privacy and safety, and improve coordination with the DoD in transition of veterans, especially those with

[6] Dept of Veterans Affairs, Office of the Inspector General; *Health Care Inspection, Review of Inappropriate Copayment Billing for Treatment Related to Military Sexual Trauma,* February 4, 2010. *http://www4.va.gov/oig/54/reports/VAOIG-09-01110-81.pdf.*

complex behavioral health needs related to MST. The Government Accountability Office (GAO) released a GAO "Watchdog Report #12" on April 7, 2010, in which GAO's Director of Federal Health Care stated: "One challenge is a [VA] difficulty in hiring primary care providers with specific training and experience in women's health. For example, officials at many VA facilities we visited noted they had difficulty attracting mental health care providers with experience in treating post-traumatic stress disorder and military sexual trauma, which are prevalent [among] women veterans." Based on the continuing reports we have received from our National Service Officer (NSO) corps and veterans themselves, DAV strongly endorses GAO's observation.

We are pleased that Public Law 111–163, the Caregivers and Veterans Omnibus Health Services Act of 2010, recently approved by the President, includes a provision to mandate graduate education, training and certification for VA mental health providers delivering counseling, care and services for MST-related conditions, to ensure veterans have access to mental health clinicians with specialized expertise in this unique area. DAV urges VA to promptly begin implementation of the MST Congressional mandate in Public Law 111–163, to begin to address some of these unmet needs.

In 2007, VA's National Center for PTSD published the first-ever randomized controlled trial to assess PTSD treatment for active duty women and women veterans. In the study, the women who received prolonged exposure therapy had greater remissions of PTSD symptoms than women who received present-centered therapy. Additionally, the prolonged exposure group was more likely than the present-centered therapy group to no longer meet the criteria for a diagnosis of PTSD and achieve total remission. However, mental health experts report that these case-intensive treatments *are not* universally available at VA medical centers (VAMCs) nationwide. This study documented the importance of spreading this evidence-based practice throughout VA's system. DAV is pleased that VA has developed a program to train its mental health providers to provide the most effective treatment for PTSD due to sexual trauma and combat trauma and is examining how best to address complex combat and MST issues.[7] However, further expansion of these training programs is still needed.

HOMELESS WOMEN VETERANS AND MST—A SPECIAL CONCERN

Finally, we note another area in relationship to MST that warrants the Subcommittees' attention. VA has excellent programs for homeless veterans but women veterans present some unique challenges for VA within those programs. Frequently women are reluctant to take advantage of VA's stellar programs such as transitional housing, substance-use disorder programs and residential rehabilitation and treatment programs, due to *personal safety concerns* and because often they are the sole or primary caretakers of minor children. In some facilities VA has struggled to maintain a welcoming, *secure and safe treatment setting* especially for women who have serious mental illness and/or have been victims of MST.

According to VA, the overall number of homeless veterans has been declining (now approximately 131,000 on any given night), but the number of homeless women veterans has nearly doubled to 6,500 over the last decade, about 5 percent of the total homeless veteran population. In a recent newspaper report, VA was cited as reporting that overall, female veterans are now between two and four times more likely to end up homeless than their civilian counterparts.[8] This alarming jump is coupled with the report that 1 in 10 homeless veterans under the age of 45 are women, and as more veterans return from deployments in Iraq and Afghanistan, these numbers are expected to rise. Combat-related stress and MST are both risk factors for homelessness. These women present unique challenges to the VA system, designed for use primarily by men, and very few VA facilities have homeless programs designed specifically for women, and none are able to accommodate children. It is also noted that about 75 percent of these female veterans have been victims of sexual abuse and many have substance-use and mental health problems that require specialized care. Programs and treatment services for mental health, MST, substance-use disorders, and maintaining independent housing and gainful employment are all essential to this vulnerable population. Therefore, we must ensure that VA programs are

[7] Dept of Veterans Affairs News Release; *Health Care Report Card Gives VA High Marks,* June 13, 2008.

[8] Bryan Bender, The Boston Globe; *More Female Veterans Are Winding Up Homeless,* July 6, 2009. *http://www.boston.com/news/nation/washington/articles/2009/07/06/more_female_veterans_are_winding_up_homeless/.*

properly adjusted to meet the unique and growing needs of women veterans and ensure that women have equal access to these specialized services.

SUMMARY

In summary, DAV recommends the Subcommittees provide oversight to ensure VA, DoD and SAPRO work collaboratively to develop a joint policy directive and system for each military service branch to maintain and share with VA when needed critical medical records related to MST cases; provide servicemembers information on how and where to access these records and information about VA benefits and services should they decide in the future to file claims for disability compensation with VA for conditions related to MST. We also ask that VBA provide the Subcommittees any information it possesses in its reference materials or guidance for claims developers and raters that reflect VBA's collaboration with SAPRO, as well as any guidance to claims developers working on MST-related claims on how to access supporting documentation from each military service branch in cases of both restricted and unrestricted reporting options, including acknowledgements of differences in records retention across branches, and security and records disposal policies within the DoD service branches.

Unfortunately, we continue to see increasing numbers of servicemembers and veterans who report MST and seek care from VA as well as file claims for disability compensation through our NSO corps. One of DAV's central purposes is to aid veterans in obtaining fair and equitable VA compensation for their service-related disabilities. We believe our NSO corps provides a premier service to help veterans rebuild their lives, and we have aided millions of veterans since the founding of our organization. In this one particular area, however, our NSOs are deeply frustrated at the routine occurrence of MST claims being denied for lack of evidentiary documentation. For these reasons and more, it seems to DAV that the agencies that are responsible for monitoring and reporting on MST, and providing benefits and services to victims of MST, as well as preventing the problem at its source, to work in concert to lower the burden of this claims process and ensure servicemembers and veterans are fully assisted by the government and their advocates in securing the benefits they deserve and have earned. We believe this issue can be resolved internally by the respective agencies involved through a memorandum of understanding agreed to by both parties, or through some other mechanism short of a new statutory mandate, if they simply agree to work in a cooperative spirit on a seemingly very solvable problem.

Finally, we recommend the Subcommittee on Health request VHA provide a report to the Subcommittee on its safeguards and efforts to ensure all women veterans and especially women veterans with combat-related stress and/or MST histories have access to secure and safe treatment settings in all VA facilities and programs. As indicated above, MST is not a "women's issue" in VA; however, VA is still primarily populated with men and male oriented. As such women's safety, security and comfort must remain a special concern.

Messrs. Chairmen, again we thank you for the opportunity to share our views at this important hearing focused on healing the wounds of military sexual trauma—and your efforts to identify ways to improve treatment and properly compensate veterans for conditions related to MST. We appreciate the attention to these issues and hope the Subcommittees will consider the issues of concern and recommendations we have brought forward in our statement. Thank you once again for the opportunity to provide testimony at this hearing. I would be pleased to address your questions, or those of other Subcommittee members.

Prepared Statement of Sergeant Jennifer Hunt, USAR, Project Coordinator, Iraq and Afghanistan Veterans of America

Chairmen, Ranking Members, and Members of the Subcommittees on Disability Assistance and Memorial Affairs and Health, on behalf of Iraq and Afghanistan Veterans of America's one hundred and eighty thousand members and supporters, I would like to thank you for inviting us to testify today. "Healing the Wounds: Evaluating Military Sexual Trauma" is a critically important topic. The issue of sexual assault has deeply affected IAVA membership, the military and veterans' community as a whole, and me personally. I would like to point out that my testimony today is on behalf of IAVA and does not reflect the views and opinions of the United States Army.

My name is Jennifer Hunt, and I am a Sergeant in the U.S. Army Reserves. I grew up in Shelton, CT and enlisted in the Army Reserves shortly after September 11th. I've served combat tours in Iraq and Afghanistan as a Civil Affairs Specialist and, in Iraq, I earned a Purple Heart when my Humvee was struck by a roadside bomb, causing shrapnel injuries to my face, arms and back.

Whether deployed or drilling stateside, I also serve as my unit's designated Victim Advocate, as part of the Army's Sexual Assault Prevention and Response program. I sincerely hope that my duties as Victim Advocate are ones that I will never have to perform.

But if I was called upon to serve as a Victim Advocate my official responsibilities would include: acting as the first point of contact for the victim; counseling them on what their options are for reporting the attack; notifying the installation's Sexual Assault Response Coordinator; and accompanying victims to medical appointments or related meetings. And I am ready, should the need arise, to provide personal support to the victim. I know first-hand how difficult and frustrating the healing process can be, because I was a victim of sexual assault as a civilian.

Unfortunately, the reality is that servicemembers have been coping with significant and underreported sexual assault and harassment in the military for decades. While sexual assault disproportionately affects female troops, male servicemembers are impacted too. And they may face even greater stigma when deciding whether to report it or seek care. In FY 2009, there were more than 3,200 reports of sexual assault involving servicemembers. Even in the warzone, troops cannot escape the threat of sexual assault; there were 279 reported sexual assaults in combat areas last year. While these numbers are alarming, they grossly underestimate the severity of the issue. According to the Defense Department, only 20 percent of all unwanted sexual contact is reported to a military authority. This must change—and the time is now.

But despite the urgency of the issue, it has taken several congressional hearings, extensive media attention, and the increasing number of victims coming forward to share their trauma publicly for the military and the Department of Veteran Affairs to finally respond to the staggering number of incidents. In recent years, both departments have taken commendable steps. The military introduced a "restricted reporting option" to encourage more victims to seek care and counseling and completed its long awaited review of the issue by the Defense Department Task Force on Sexual Assault in the Military Services.

MST can lead to the development of major health problems, such as depression, eating disorders, miscarriages, and hypertension. Victims may also be eligible for disability compensation from the VA. Consequently, the VA began universally screening all veterans seeking care at the VA for Military Sexual Trauma in 1999 and the VA provides care to any veteran who has experienced MST. However, as is the case with other VA health care, treatment is inconsistent and not all veterans receive the care they deserve. IAVA was extremely concerned to learn that the VA's Inspector General had to review the billing practices of VA health facilities and clinics after it was revealed that patients at one Texas clinic were being improperly charged copays for MST-related care. VA hospitals need to be trained in the proper treatment of and benefits for MST victims.

These steps are an improvement over the years of inaction, but much more must be done to adequately prevent and respond to Military Sexual Trauma. Our women warriors deserve the best treatment and support on the planet. Therefore, IAVA recommends the following steps to "Help Heal the Wounds":

For the Department of Defense——

- Adequately fund the Department of Defense's Sexual Assault Prevention and Response Program (SAPR) to achieve its mission of prevention, response, training and accountability. As recommended by the DoD's Task Force on Sexual Assault, the Secretary should include the SAPR Program in its Program Objective Memorandum budgeting process ensuring a separate line of funding is allocated to the services.
- Conduct a study to identify a more comprehensive system that will accurately measure the incidence of sexual assault within the military—not just reported assaults. DoD should also conduct its gender relations survey bi-annually to more accurately assess the rate of sexual harassment.
- Require the Secretary of Defense to review sexual assault prevention and response efforts in the Reserve Components—which is not happening now.
- Require all military installations to have a Sexual Assault Response Coordinator (SARC) and deployable SARC on base. SARCs must be full-time military or DoD civilian personnel.

- Ensure all servicemembers have access to a restricted reporting option, and improve avenues for restricted reporting by allowing victims to reserve their right to a restricted report even after disclosing an assault to a third party, with the exception of chain of command or law enforcement. Additionally, a hotline should be established to allow victims to report sexual assault and harassment even when in-theatre. And that hotline must be connected with a local Sexual Assault Response Coordinator.
- Guarantee that all military personnel have access to qualified medical personnel to conduct evidence collection in sexual assault cases in a safe, timely, confidential, and gender—unbiased manner, even in deployed and remote locations.

For the Department of Veterans Affairs—

- Expand availability of specialized sexual trauma treatment inpatient and residential settings.
- Ensure that victims have access to preferred treatment settings and providers. For example, victims should not have to settle for mixed-gender treatment facilities because there are no facilities with separate programs for males and females in their area.
- Conduct a fully independent review of VA medical facilities to assess whether or not they are adequately complying with VA standards for safety and privacy for MST victims.
- Ensure the use and implementation of a method specifically designated to track MST-related care at all VHA medical facilities, so that MST treatment data are readily accessible across the VA system, as recommended by the VA's Office of Inspector General.
- Identify, track and report to Congress the outcomes of disability claims that involve MST. This will better measure the number of MST-related claims submitted annually, length of processing times, denial rates, and the types of disabilities that are associated with MST.

These recommendations are urgent. And IAVA encourages you to enlist the support of the President and the first lady to help make them happen.

Sexual Assault is a violation of military values and professionalism. It undermines unit cohesion, morale and effectiveness. The majority of assailants are older and of higher rank than their victims. They abuse not only their authority, but the trust of those they are responsible for protecting.

Sexual assault, whether it occurs in the military or in the civilian world, is also a crime. It is a crime that threatens the individual victim and the strength of the United States military.

Sexual assault is a crime that has gone on for too long, with too little done to stop it. While not all of IAVA's recommendations fall in the jurisdiction of these Subcommittees, we look forward to working with you to fully address the issue of Military Sexual Trauma. Our women warriors have served nobly. And I am here today on behalf them all, to issue to you a call to service. We have done our part. Now it's time for you to do yours.

Thank you.

Prepared Statement of Anuradha K. Bhagwati, Executive Director, Service Women's Action Network

Good morning, Mr. Chairman, and Members of the Committee. My name is Anuradha Bhagwati. I am a former Marine Corps Captain and Executive Director of Service Women's Action Network (SWAN), an advocacy and direct services organization for servicewomen and women veterans.

SWAN's policy work this year focuses largely on reforming DoD and VA Sexual Assault and Harassment policy and educating the public about the epidemic known as Military Sexual Trauma (MST).

MST is an intensely personal issue for us and for the veterans we represent. This testimony is based on the collective input of over 120 MST survivors, MST crisis intervention caseworkers and VA health providers. My own experience filing an Equal Opportunity investigation for sexual harassment and discrimination in the military and the unfortunate follow-on experiences I've had with both VHA and VBA regarding treatment and benefits corroborate the experiences of my colleagues and fellow veterans below.

I. Department of Defense (DoD):

Sexual trauma in a military setting is unique and must be recognized as such before suggesting appropriate policy remedies. We must first understand why a servicemember would choose to stay silent after being sexually assaulted or harassed.

DoD puts MST survivors in an awful predicament in which they are likely to be further traumatized if they come forward. Unlike the civilian world, MST survivors don't have the option of quitting their job; they are often stuck working with, nearby, or under the supervision of their perpetrators. There is simply no guarantee that the chain of command will support survivors if they come forward. Commanders consistently ignore equal opportunity and sexual assault policy in order to maintain the personnel in their unit at full capacity. Additionally, commanders have little incentive to prosecute perpetrators, as documented incidents reflect poorly on their leadership performance and reputation.

MST survivors who report an incident are likely to face isolation, retribution, or accusations of lying, irresponsibility or impropriety; there is no guarantee of anonymity from the chain of command or Victim Advocates, and survivors are likely to face the horror of retribution from perpetrators and the anguish of being a target of public ridicule, scorn and further harassment in their respective units. We cannot honestly expect people to come forward to report—it is irresponsible for DoD to suggest that survivors do so, without guaranteeing protection.

Despite overtures by DoD in recent years to prevent sexual assault and harassment, nothing on the ground has changed for women and men in uniform. DoD's failure to protect our servicemembers ought to be the subject for a separate set of hearings, as there is far too much to say here. Suffice it to say that without third party oversight of sexual assault and harassment cases, a culture of impunity and hatred of women within the military makes it almost certain that survivors will be punished, taunted, isolated, or intimidated by their commands for speaking out, and that perpetrators will in most cases go unpunished.

II. Veterans' Health Administration (VHA):

MST survivors universally describe the horror of using VA Medical Centers nationwide. The climate at VA hospitals is still largely unwelcoming to women, but for MST survivors, the experience of going to an appointment can be life-threatening—triggers of one's assault or harassment are everywhere, from the prospect of running into your perpetrator, to being surrounded by male patients who routinely engage in sexual harassment of female patients, to being improperly treated by staff members who have no knowledge about the unique experience of sexual trauma in a military setting.

One survivor said to SWAN, "I don't want to be fending off advances when I'm raw from dealing with my issues in therapy" while another said, "I have no [private] health care. I have to use the VA. Therefore I have to go through all the embarrassment." Survivors universally say that if they had health insurance, they would definitely use private health care instead of the VA.

Many veterans are ignored, isolated, or misunderstood at VA facilities because their PTSD is not combat-related. The veterans' community still primarily considers PTSD to be a combat-related condition, to the great detriment of MST survivors.

Survivors who have used the VA routinely say they are fed up with being given endless prescription medication—one Iraq veteran described the experience of her VA MST treatment as nothing but "pills and pep talks." Many survivors wish they had access to yoga, massage therapy, acupuncture, and gender-specific MST support groups.

Lots of MST patients echo the comments of other veterans generally—that a lack of privacy, child care and availability of evening or weekend appointments prevents them from accessing care at VA Medical Centers.

I strongly recommend that the Committee give MST survivors the option of fee-based care for all treatment. At the same time, VHA cannot be let off the hook. VA Medical Centers ought to have separate facilities for women patients, and easy, safe, and direct access to MST treatment areas for both male and female MST survivors.

I'd like to say a few words about MST Residential Treatment programs. It appears that most MST patients do not know that these programs exist, and it's apparent that many VA providers also don't know about them. Survivors have mixed reactions to these treatment programs. Most describe agonizing wait lists for the programs, along with a shortage of VA funding to travel to the program. Among those patients who have attended, several have experienced sexual harassment by staff or fellow patients. Another disturbing trend is VA's integration of residential programs with other mixed-gender veterans' programs, in which MST patients are not guaranteed privacy or safety from other patients of the opposite sex. VA needs

to invest in separate facilities for MST programs, and guarantee the safety and welfare of all participants.

III. Veterans' Benefits Administration (VBA):

Filing for disability compensation for MST is universally considered a traumatic, agonizing, and cruel experience. Many survivors describe the process of re-writing one's personal narrative for a VA claim as just as traumatic as the original rape or harassment.

VBA claims officers nationwide have proven themselves entirely inept when dealing with MST claims. Claims are routinely rejected, even with sufficient evidence of a stressor and a corroborating diagnosis from a VA health provider. Many survivors' claims are rejected because of VBA's lack of knowledge about sexual violence. For example, many servicemembers have been denied VBA compensation because their job performance did not decline after the assault or harassment—which in the sexual violence community is a perfectly normal survival reaction to a life-threatening situation. Countless more survivors failed to report through official channels, or cannot fathom the agony of attempting to file a claim when military culture and the VA are so rigged against women.

Current VBA policy is forcing women and men with insufficient evidence of their assault and harassment to suffer in silence and shame, to numb their pain through use of substances, and to take or attempt to take their own lives. This Committee needs to understand that until it is safe to report sexual assault or harassment in the military, the majority of incidents will not be reported. You cannot continue to punish veterans with MST twice. VA must take responsibility for DoD's failure to protect its own by awarding just compensation to survivors.

Another equal protection issue features prominently in the work we do on MST. The "Don't Ask, Don't Tell" policy has allowed gay and lesbian servicemembers, as well as those who are perceived to be gay, to be systematically sexually harassed and assaulted in uniform. Perpetrators have routinely abused gays and lesbians who would otherwise report harassment or assault. Society has yet to measure the mental health impact of this insidious policy on our Nation's LGBT veterans. We must guarantee access to quality health care for all veterans, regardless of sexual orientation or gender identity.

I must add a special note for our older MST survivors, our mothers and grandmothers whose sacrifice years ago both on the battlefield and in the barracks forged the way for women like us to join the military—we must not forget them. Many of them suffered at the hands of fellow servicemen decades ago, and their trauma continues to be unrecognized. One Vietnam-era veteran who survived MST told us, "Please help me feel validated before I die." Honor and validate her service and her life by fixing this broken system now.

Thank you.

Prepared Statement of Kaye Whitley, Ed.D., Director, Sexual Assault Prevention and Response Office, Office of the Under Secretary of Defense for Personnel and Readiness, U.S. Department of Defense

Chairmen Michaud and Hall, Ranking Members Brown and Lamborn, and Members of the Subcommittees, thank you for inviting me today to discuss the progress the Department of Defense has made in recent years on caring for victims of sexual assault. I would like to focus on the efforts of my office, the Sexual Assault Prevention and Response Office (SAPRO), working in partnership with the Military Services. As a team, we are making great headway to standardize, professionalize, and institutionalize our programs. Once we achieve all three, we hope to realize our vision: A culture free of sexual assault. Until that time, ensuring an effective response for victims is one of our highest priorities.

At the beginning of my testimony, it is important to clarify a few issues.

- The Department of Veterans Affairs is tasked by Congress to address the physical and mental problems of veterans stemming from physical assault or sexual assault or sexual harassment that occurred while the verteran was serving on active duty or active duty for training. VA utilizes the umbrella term "military sexual trauma" to refer to these experiences.
- In the Department of Defense, the office that I represent is tasked with policy relating to the prevention and response of sexual assault. Sexual harassment is addressed by the Equal Opportunity Program. Reported incidents of sexual harassment are not included in my statistics.

- Finally, I would like to remind everyone that our DoD-wide sexual assault policy has been in place since 2005. All reports of sexual assault are of concern to us, and we are especially concerned with reports of incidents that occurred after 2005 in that we want to examine them to determine if there are any necessary changes in our policy.

Sexual Assault: An Underreported Crime

One of the challenges facing the Departments of Defense and Veterans Affairs is the fact that sexual assault is one of the most underreported crimes in our society. National studies indicate that most sexual assaults go unreported in the civilian sector—largely because victims are fearful of the life-changing events, public scrutiny, and loss of privacy that often come with a public allegation. The potential medical and psychological costs and consequences of sexual assault are extremely high.

Unfortunately, the military is not immune to the problems faced by the rest of American society—and sexual assault is no exception. Sexual assault in the military has similar costs and consequences for victims—but there are other factors that complicate a victim's experience in the military and interfere with reporting. First, sexual assault can occur where a victim works and lives. Victims are not always able to escape painful reminders that keep them from putting the incident behind them. Second, when the perpetrator resides in the same unit as the victim, sexual assault sets up a potentially destructive dynamic that can rip units apart. Third, recent research has found that a history of sexual assault doubles the risk of posttraumatic stress when the victim is exposed to combat.[1]

Some victims may not want to come forward to report for many of the same reasons cited by their civilian counterparts: DoD studies indicate that about eight of ten sexual assaults in the military go unreported.[2] Victims are concerned about losing their privacy, fearful about being judged, fearful of retaliation, and afraid that people will view them differently. In addition, female and male military victims alike mistakenly believe that reporting their victimization somehow makes them weak and less of a warrior. They worry that their career advancement will be disrupted and their security clearances revoked.

Bringing Sexual Assault Victims into Care

In order to bring more victims forward, the Department offers two reporting options: Restricted and Unrestricted Reporting. The addition of Restricted Reporting as an option was critical to our program. Restricted Reporting allows victims to confidentially access medical care and advocacy services. Although Restricted Reporting does not trigger the investigative process, commanders are provided with non-identifying personal information that allows them to provide enhanced force protection. Also, victims who initially make a Restricted Report may change their minds and participate in an official investigation at any time.

Restricted Reporting is having the desired effect. At the end of FY 2009, the Department had received 3,486 Restricted Reports since the option was made available in 2005. We believe that number represents 3,486 victims who would not have otherwise come forward to access care had it not been for the Restricted Reporting option. In addition, 15 percent of those victims who made a Restricted Report converted to Unrestricted Reports, allowing us to take action to hold those offenders accountable.

Bringing as many victims forward to report the crime of sexual assault is one of our strategic goals. During the past 3 years, reports of sexual assault have been increasing by about 10 percent annually. While our goal is to decrease sexual assaults, we do want to increase the numbers of victims coming forward and are engaging in a variety of activities that encourage victims to report. For example, in 2008, the Secretary of Defense identified reducing the stigma of reporting sexual assault as one of his priorities. Since then, each of the Services has taken steps to educate their members that reporting the crime and seeking help are a sign of strength, not weakness. In 2009, the Department issued a memorandum underscoring that being the victim of a crime like sexual assault is not grounds for losing one's security clearance. The memo further encouraged all members of the Department of Defense, military and civilian alike, to engage care services as soon as possible following traumatic events.

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[1] Smith, et al., (2008). Prior Assault and Posttraumatic Stress Disorder After Combat Deployment, *Epidemiology, 19,* 505–512.

[2] U.S. Department of Defense (2008). *2006 Workplace and Gender Relations Survey of Active Duty Members.* Washington, DC: Defense Manpower Data Center. Retrieved from *http://www.sapr.mil/contents/references/WGRA_OverviewReport.pdf.*

Military Sexual Assault Response

When we created our policy in 2005, we established the framework for a coordinated, multidisciplinary response system modeled after the best practices in the civilian community. Victim care begins immediately upon an initial report of a sexual assault. At the heart of our sexual response system are the Sexual Assault Response Coordinator (SARC) and Victim Advocates. Servicemembers worldwide have access to a 24/7 response. Every military installation in the world—both in garrison and deployed—has a SARC and Victim Advocates who provide the human element to our response. Our SARCs and Victim Advocates will:

- Work with victims to identify and address issues related to their physical safety and needs as well as concerns about their commander and the alleged perpetrator;
- Listen to victims' needs and then connect them with appropriate and necessary resources, including medical care, mental health care, and legal and spiritual resources; and
- Connect victims to off-base resources when necessary.

SARCs and Victim Advocates also work with victims to help them decide whether to make a Restricted or Unrestricted Report. In order to ensure that victims make an educated decision in which they are fully informed of their choices, we developed a Victim Preference Reporting Form (called DD 2910) which explains their options. This form is completed by the victim with the assistance of the SARC or Victim Advocate in every case. In each case, the SARC or Victim Advocate emphasizes that the victim should keep a copy of the DD 2910 in his or her personal files, as noted on the bottom of the form. (A sample of DD 2910 is included at the end of my testimony.)

Tracking Victim Care

The Department believes that comprehensive data collection and analysis are vital to policy analysis and program implementation. Thus, a Department-wide sexual assault database is currently under development. We have secured funding and will be soon awarding a contract for development.

Collaborating to Enhance Victim Care

Effectively preventing and responding to sexual assault are demanding undertakings. We know that we cannot do it alone. As a result, we have been collaborating with other Federal, state, and non-profit agencies to maximize our effectiveness. We have been working with the Department of Veterans Affairs since the inception of the program in 2005. In addition, we have recently begun to meet with a variety of veterans groups to identify what gaps there might be related to our issue as Servicemembers transition from active duty to veterans status. Meeting with non-governmental groups, such as Iraq and Afghanistan Veterans of America and the National Organization for Women, has helped us gain a fuller understanding of the challenges that veterans might be experiencing.

One of the key areas of collaboration has been related to documentation. In 2007, we contacted the staff of the Veterans Benefits Administration (VBA) and briefed them on our Victim Preference Reporting Form (DD 2910). We forwarded copies of the form to VBA, which said that it would agree to accept a copy of the form, signed by both the victim and the SARC or Victim Advocate, as evidence of reporting of sexual assault. While treatment for sexual assault in a VA facility does not require this document, service connection determinations require some kind of evidence in the military record. Our form is not typically part of the medical record that is provided to VA for service connection determinations; however, it can be submitted by victims as part of their paperwork for a service connection determination.

As noted throughout my testimony, reporting a sexual assault can be very challenging for a military victim—and many do not want the sexual assault in any kind of permanent record until they are ready to separate. As a result, corroborative evidence of sexual assault may be difficult to come by in a medical chart or other record system if the victim never reported the matter or if the member made a Restricted Reported and opted to not use medical care. Just as the DD 214 is the main basis for proof of military service, we would like the DD 2910, the Victim Preference Reporting Form, to be universally accepted as proof that a victim made a report of sexual assault.

Past this coordination on reporting form, let me mention a few additional ways we have collaborated:

- A representative from VA participates, per our request, on our Sexual Assault Advisory Council, which was the main oversight body for the Sexual Assault Prevention and Response program in the Department.

- We have teamed with members of VA's Military Sexual Trauma Support Team to present our respective programs at national conferences.
- Members of my staff have attended VHA's annual training conference for Military Sexual Trauma Coordinators and presented on the DoD Sexual Assault Prevention and Response Program for the past 3 years. In addition, my staff has also participated in VA webinars to educate VA providers about sexual assault and the DoD and VA programs.
- The MST Support Team and SAPRO often work together to ensure that victims of sexual assault are connected with the appropriate services. We have referred a number of victims to each other's offices for assistance.

Challenges in Caring for Military Victims of Sexual Assault

In addition to what has been done to date, there is more our two Departments can do together to assist victims of sexual assault, but we need assistance in removing at least one barrier to collaboration: that is, state mandatory reporting laws.

As I explained previously, prior to the implementation of Restricted Reporting, victims could not access medical care or advocacy services without the involvement of law enforcement and command. Restricted Reporting is critical to reducing the barriers that prevent victims from accessing care in the military. Despite all of its benefits, Servicemembers in a number of states, including California, do not have the option of Restricted Reporting if they wish to access medical care for a sexual assault. Victims cannot access private medical care and treatment either on or off base. California is an example of a state with this type of law. Section 11160 of California's Penal Code requires health care practitioners to make a report to law enforcement if they provide medical services for a physical condition to a patient whom he or she knows or reasonably suspects is a victim of various crimes of a sexual nature. That report must include the victim's name, whereabouts, and a description of the person's injury. There is no discretion on the part of a health care provider; the law requires mandatory reporting. Once the health care provider notifies civilian law enforcement, we cannot guarantee that they will not notify military law enforcement. Once military law enforcement is aware of a sexual assault, it must investigate and command must be notified.

If our active duty members could make Restricted Reports in federally funded facilities, such as a VA Medical Center—no matter where it is located—we believe this would allow us a wider variety of options to offer victims for care. We do not know how many more reports we would have received had the Restricted Reporting option been available in California. This is a challenge that we need help in resolving.

Conclusion

The Department of Defense and the Department of Veterans Affairs have made significant progress since 2005 in assisting victims of sexual assault. Both Departments have programs that truly address the needs of the victim.

As I conclude my testimony, I would like to share one last thought. Each day, our Servicemembers dedicate their lives to protecting our country and deserve no less than the very best care and support in return. This is why it is so very important that we work together to make this program the best it can be. We can thank our SARCs, Victim Advocates, and first responders for dedicating their lives to those in need and giving back to those who serve.

As mentioned earlier, since 2005, 3,486 individuals would not have received care and support had it not been for the creation of the Restricted Reporting and our program. That's remarkable progress. It's up to all of us (Department of Defense, Department of Veterans Affairs, and Congress) to continue to take the lead by working together to resolve issues so that our policy is effective for all of our Servicemembers.

Thank you for your time and for the opportunity to testify today. I would be happy to answer your questions.

DD Form 2910

VICTIM REPORTING PREFERENCE STATEMENT
(Please read Privacy Act Statement before completing this form.)

1. REPORTING PROCESS AND OPTIONS DISCUSSED WITH THE VA OR SARC

a. I, *(Full name)* _____, had the opportunity to talk with a Victim Advocate (VA) or a Sexual Assault Response Coordinator (SARC) before selecting a reporting option.

b. UNRESTRICTED REPORTING - REPORTING A CRIME WHICH IS INVESTIGATED.

INITIALS	
	I understand that law enforcement and my command will be notified that I am a victim of sexual assault and an investigation will be started. I understand I can receive medical treatment, advocacy services, and counseling, and an optional sexual assault forensic examination to collect evidence if indicated. The full range of victim protection actions may be available to me, such as being separated from the offender(s) or receiving a military protective order against the offender. Any misconduct on my part may be punished, but at the discretion of the commander may be delayed until after the sexual assault charge(s) is resolved.

S A M P L E

c. RESTRICTED REPORTING - CONFIDENTIALLY REPORTING A CRIME WHICH IS NOT INVESTIGATED.

	(1) I understand that I can confidentially receive medical treatment, advocacy services, and counseling, and an optional sexual assault forensic exam to collect evidence if needed, but law enforcement and my command will NOT be notified. My report will NOT trigger an investigation; therefore, no action will be taken against the offender(s) as the result of my report.
	(2) I understand that there are exceptions to "Restricted Reporting" (see back). If an exception applies, limited details of my assault may be revealed to satisfy the exception.
	(3) I understand that if I have not made an "Unrestricted Report" within 1 year of any evidence collected, it will be destroyed and no longer available for any future investigation or prosecution efforts.
	(4) I understand that all state laws, local laws or international agreements that may limit some or all of DoD's restricted reporting protections have been explained to me. In _____, medical authorities must report the sexual assault to _____.
	(5) I understand that the SARC will provide information that does not reveal my identity, nor that of my offender, to the responsible senior commander within 24 hours of my "Restricted Report" or within 48 hours if at a deployed location and extenuating circumstances apply. This information is required for the purposes of public safety and command responsibility.
	(6) I understand that by choosing "Restricted Reporting," the full range of victim protection actions may not be available, such as being separated from the offender(s) or receiving a military protective order against the offender(s).
	(7) I understand that if I talk about my sexual assault to anyone other than those under the "Restricted Reporting" option (SARC, sexual assault victim advocate, or healthcare providers), and chaplains, it may be reported to my command and law enforcement which could lead to an investigation.
	(8) I understand that I may change my mind and report this offense at a later time as an "Unrestricted Report," and law enforcement and my command will be notified. Delayed reporting may limit the ability to prosecute the offender(s). If the case goes to court, my victim advocate and others providing care may be called to testify about any information I shared with them.
	(9) I understand that if I do not choose a reporting option at this time, my commander and investigators will be notified.

PRIVACY ACT STATEMENT

AUTHORITY: Section 301 of Title 5, United States Code. and Chapter 55 of Title 10, United States Code.

PRINCIPAL PURPOSE(S): Information on this form will be used to document elements of the sexual assault response and/or reporting process and comply with the procedures set up to effectively manage the sexual assault prevention and response program.

ROUTINE USE(S): None.

DISCLOSURE: Completion of this form is voluntary; however, failure to complete this form with the information requested impedes the effective management of care and support required by the procedures of the sexual assault prevention and response program.

DD FORM 2910, JUN 2006 Adobe Designer 7.0

2. CHOOSE A REPORTING OPTION *(Initial)*	
	a. Unrestricted Report. I elect Unrestricted Reporting and have decided to report that I am a victim of sexual assault to my command, law enforcement, or other military authorities for investigation of this crime.
	b. Restricted Report. I elect Restricted Reporting and have decided to confidentially report that I am a victim of sexual assault. My command will NOT be provided with information about my identity. Law enforcement or other military authorities will NOT be notified unless one of the exceptions applies. I understand the information I provide will NOT start an investigation or be used to punish an offender.

3. RESTRICTED REPORT CASE NUMBER *(If applicable)*	
4.a. SIGNATURE OF VICTIM	b. DATE *(YYYYMMDD)*
5.a. SIGNATURE OF SARC/VICTIM ADVOCATE	b. DATE *(YYYYMMDD)*
6. I have reconsidered my previous selection of "Restricted Reporting," and I would like to make an "Unrestricted Report" of my sexual assault to authorities for a possible investigation.	
a. SIGNATURE OF VICTIM **S A M P L E**	b. DATE *(YYYYMMDD)*
c. SIGNATURE OF SARC/VICTIM ADVOCATE	d. DATE *(YYYYMMDD)*

EXCEPTIONS TO "RESTRICTED REPORTING"

In cases in which members elect restricted reporting, disclosure of covered communications is authorized to the following persons or organizations when disclosure would be for the following reasons:

1. Command officials or law enforcement when authorized by the victim in writing.

2. Command officials or law enforcement to prevent or lessen a serious and imminent threat to the health or safety of the victim or another person.

3. Disability Retirement Boards and officials when required for fitness for duty for disability retirement determinations. Disclosure is limited to only that information necessary to process the disability retirement determination.

4. SARC, victim advocates or healthcare provider when required for the direct supervision of victim services.

5. Military or civilian courts when ordered, or if disclosure is required by Federal or state statute.

SARCs, victim advocates and healthcare providers will first consult with the servicing legal office to determine whether the criteria of any of the above exceptions apply, and whether they have a duty to comply by disclosing the information.

NOTICE: DOCUMENTATION FOR RECORD KEEPING PURPOSES. Victims are advised to maintain a signed and dated copy of this form for their records. This form may be used by the victim in other matters before other agencies (e.g., Department of Veterans Affairs) or for any other lawful purpose.

DD FORM 2910 (BACK), JUN 2006

Prepared Statement of Bradley G. Mayes, Director, Compensation and Pension Service, Veterans Benefits Administration, U.S. Department of Veterans Affairs

Good Morning, Chairman Hall, Chairman Michaud, Ranking Members Lamborn, Brown, and Members of the Subcommittees: Thank you for the opportunity to appear to discuss the Department of Veterans Affairs' (VA's) work in identifying, treating and compensating Veterans for conditions related to military sexual trauma (MST). We are accompanied by Dr. Rachel Kimerling, Director of the Monitoring Division of the National Military Sexual Trauma Support Team in the Veterans Health Administration (VHA); and Dr. Patty Hayes, Chief Consultant for the Women Veterans Health Strategic Health Care Group (VHA).

It is a tragic fact that many Veterans suffered sexual trauma while serving on active military duty. Some are still struggling with fear, anxiety, shame, or profound anger as a result of these experiences. A number of individuals have never discussed their experiences or their feelings with anyone, and they're understandably reluctant to talk about them now. That is why we would like to thank the Members of the Subcommittees for their diligent efforts to address this very important issue.

What Is Military Sexual Trauma (MST)?

In both civilian and military settings, women and men can experience a range of unwanted sexual behaviors. Within VA, Veterans are likely to hear these sorts of experiences described as "military sexual trauma," the overarching term VA uses to refer to experiences of sexual assault or repeated, threatening acts of sexual harassment. The definition used by VA is from the U.S. Code (1720D of Title 38) and is "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." More concretely, MST includes any sexual activity where someone is involved against his or her will—he or she may have been pressured into sexual activities (for example, with threats of negative consequences for refusing to be sexually cooperative or with implied faster promotions or better treatment in exchange for sex), may have been unable to consent to sexual activities (for example, when intoxicated), or may have been physically forced into sexual activities. Other experiences that fall into the category of MST include unwanted sexual touching or grabbing; threatening, offensive remarks about a person's body or sexual activities; or threatening and unwelcome sexual advances. If these horrific experiences and often criminal acts occurred while an individual was on active duty or active duty for training, they are considered to be MST.

How Common Is MST?

Information about how commonly MST occurs comes from VA's universal screening program. Under this program, all Veterans seen at Veterans Health Administration (VHA) facilities are asked two questions—one to assess sexual harassment and the other to assess sexual assault that occurred during their military service; Veterans who respond "yes" to either question are asked if they are interested in learning about MST-related services available. Not every Veteran who responds "yes" needs or is necessarily interested in treatment. It is important to note that rates obtained from VA screening cannot be used to make any estimate of the rate of MST among all those serving in the U.S. military, as they are drawn only from Veterans who have chosen to seek VA health care. Also, a positive response does not indicate that the perpetrator was a member of the military. Approximately 1 in 5 women and 1 in 100 men seen in VHA respond "yes" when screened for MST. Though rates of MST are higher among women, because of the disproportionate ratio of men to women in the military, there are actually only slightly fewer men seen in VA who have experienced MST than women.

How Can MST Affect Veterans?

It is important to remember that MST is an experience, not a diagnosis or a mental health condition in and of itself. Given the range of distressing sexually-related experiences and crimes that Veterans report, it is not surprising that there are a wide range of emotional reactions that Veterans have in response to these events. Even after severely traumatizing experiences, there is no one way that everyone will respond—the type, severity, and duration of a Veteran's difficulties will all vary based on factors like whether he or she has a prior history of abuse, the types of responses from others he or she received at the time of the experiences, and whether the experience happened once or was repeated over time. For some Veterans, ex-

periences of MST may continue to affect their mental and physical health, even many years later. Some of the difficulties both female and male survivors of MST may have include:

Strong emotions: feeling depressed; having intense, sudden emotional reactions to things; feeling angry or irritable all the time;

Feelings of numbness: feeling emotionally "flat"; difficulty experiencing emotions like love or happiness;

Trouble sleeping: trouble falling or staying asleep; disturbing nightmares;

Difficulties with attention, concentration, and memory: trouble staying focused; frequently finding their mind wandering; having a hard time remembering things;

Problems with alcohol or other drugs: drinking to excess or using drugs daily; getting intoxicated or "high" to cope with memories or emotional reactions; drinking to fall asleep;

Difficulty with things that remind them of their experiences of sexual trauma: feeling on edge or "jumpy" all the time; difficulty feeling safe; going out of their way to avoid reminders of their experiences; difficulty trusting others;

Difficulties in relationships: feeling isolated or disconnected from others; abusive relationships; trouble with employers or authority figures; and

Physical health problems: sexual difficulties; chronic pain; weight or eating problems; gastrointestinal problems.

Among users of VA health care, medical record data indicate that diagnoses of post-traumatic stress disorder (PTSD), depression and other mood disorders, psychotic disorders and substance use disorders are most frequently associated with MST. Fortunately, people can recover from experiences of trauma, and VA has services to help Veterans do this.

How Has VA Responded to the Problem of MST?

Since 1992, VA has been developing programs to monitor MST screening and treatment, providing staff with training on MST-related issues, and engaging in outreach to Veterans. More recently, VA's Office of Mental Health Services (OMHS) established a national-level MST Support Team to support these objectives and promote best practices in care. Services available to Veterans include:

- All Veterans seen in VA are asked whether they experienced MST and all treatment for physical and mental health conditions related to experiences of MST is free for both men and women.
- Every VA facility has a designated MST Coordinator who serves as a contact person for MST-related issues. This person can help Veterans find and access VA services and programs. He or she may also be aware of state and federal benefits and community resources that may be helpful.
- Every VA facility has providers knowledgeable about treatment for the aftereffects of MST. Many have specialized outpatient mental health services focusing on sexual trauma. Vet Centers also have specially trained sexual trauma counselors.
- Nationwide, there are programs that offer specialized sexual trauma treatment in residential or inpatient settings. These are programs for Veterans who need more intense treatment and support.
- To accommodate Veterans who do not feel comfortable in mixed-gender treatment settings, some facilities have separate programs for men and women.

Collaboration

VA has developed a number of initiatives that promote coordination of care for active duty personnel and recently discharged personnel more broadly, but most coordination of clinical care for individual Veterans and active duty personnel seeking MST-related care happens on the local level and depends on the relationships that specific VA facilities have negotiated with local military installations. Local MST Coordinators often participate in or ensure inclusion of MST-related materials in local outreach events, particularly those post-deployment. At a national level, the VA MST Support Team has developed an ongoing relationship with the Department of Defense's Sexual Assault Prevention and Response Office (SAPRO). The OMHS MST Support Team and SAPRO have presented at each others' training events in order to share information about VA and DoD responses to sexual trauma with frontline clinicians. Staff from both the MST Support Team and SAPRO have given informational presentations about VA and DoD responses to sexual assault at a national VA training conference and at the International Society for Traumatic Stress Studies research conference. The two groups also communicate as necessary regard-

ing individual Veterans needing assistance in locating appropriate services to match their treatment needs.

VBA Procedures for PTSD Claims Based on MST

VA provides compensation payments for service-connected disabilities. The VA schedule for rating disabilities is based on the average earning loss resulting from the disabilities in the schedule. As the role of women in the military has expanded, the number of disability compensation claims received by VBA related to MST has increased. As you have already heard, MST may result in a number of disabling physical and mental conditions, but most often manifests itself as PTSD.

In order to better assist those Veterans with PTSD claims based on MST, VA promulgated 38 CFR § 3.304(f)(4) in 2002, which emphasizes that, if a PTSD claim is based on in-service personal assault, which includes MST, evidence from sources other than a Veteran's service treatment and personnel records may corroborate the in-service traumatic event. Such evidence may include, but is not limited to: records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow servicemembers, or clergy. In addition, evidence of behavior changes following the claimed assault constitutes another source of relevant evidence. Examples of such behavior changes include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes. The regulation prohibits the denial of claims for service connection for PTSD based on in-service personal assault without first advising the Veteran that information from sources other than the Veteran's service records or evidence of behavior changes may constitute credible evidence of the stressor and allowing the Veteran an opportunity to furnish this type of evidence or advise VA of potential sources of such evidence. The regulation also provides that VA may submit any evidence it receives to an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred.

This regulation takes into account the sensitive nature of MST and the difficulty with obtaining supporting evidence in many of these cases when service connection is claimed following the Veteran's separation from service. In those cases where PTSD is diagnosed during service and the claimed stressor is related to that service, VA regulations state that the Veteran's lay testimony alone may establish occurrence of the claimed stressor, provided that the claimed stressor is consistent with the circumstances, conditions, or hardships of the Veteran's service and in the absence of evidence to the contrary.

VBA field personnel who adjudicate PTSD cases based on MST were provided with detailed information on proper claims processing methods in a training letter issued in November 2005. Additionally, all regional offices have a Women's Veteran Coordinator, who is well-versed in MST issues and can provide assistance to Veterans as necessary. These procedural steps taken by VA ensure that Veterans filing claims for PTSD based on MST will receive a fair and thorough consideration of their claims.

CONCLUSION

VA recognizes the damage that MST can inflict on its victims, and it has developed responses that are focused on providing Veterans the care and support they need. We have achieved much, and are continually evaluating ways to improve. VA's MST Support Team is conducting a comprehensive study of providers of MST related mental health care. This will help us determine the number of unique providers at each facility who deliver MST related care, describe the characteristics of these providers, and assess the relationship of provider gender to patient gender to determine whether VA can consistently honor patients' expressed preferences for providers of a particular gender, as is VA's policy. These results will provide important information to help us ensure there is sufficient capacity for specialized MST related services at each VA facility. We look forward to sharing the results of this analysis with Congress when it is ready later this year.

Thank you again for the opportunity to appear. We are prepared to answer any questions you may have.

Statement of Denise A. Williams, Assistant Director for Health Policy, Veterans Affairs and Rehabilitation Commission, American Legion

Messrs. Chairmen, Ranking Members and Members of the Subcommittees:

The American Legion appreciates the opportunity to submit for the record our views on this very important issue.

Background

The Department of Veterans Affairs (VA) defines Military Sexual Trauma (MST) as sexual assault or sexual harassment that occurred while in the military. This includes any sexual activity where someone is involved against his or her will. In 1992 P.L. 102–585 authorized VA to provide up to 1 year of treatment to women veterans for psychological trauma resulting from physical assault, battery or harassment of a sexual nature. The Veterans Health Care Extension Act of 1994 (P.L. 103–452) granted VA the authorization to provide MST counseling to male veterans as well. On March 25, 2005 the Veterans Health Administration directive 2005–015 mandated that all enrolled veterans be universally screened for MST. In addition, the directive mandated that all VA medical facilities designate a MST coordinator to oversee MST screening and treatment and standardized training materials for MST.

The VA provides treatment and counseling to all veterans that are suffering from MST and any mental and physical conditions related to MST. This service is afforded to all veterans free of charge. It is not necessary to have reported the incident while in the military or be service connected for this condition in order to receive this treatment and counseling.

The Department of Defense (DoD) defines sexual assault as intentional sexual contact, characterized by use of force, physical threat or abuse of authority or when the victim does not or cannot consent. This includes rape, nonconsensual sodomy, indecent assaults, or attempts to commit these acts. In 2005, Congress directed the Secretary of Defense to develop a comprehensive policy for DoD to address the prevention and response to sexual assault involving servicemembers. In addition, the law requires that a standard definition for sexual assault be developed, DoD submits an annual report to Congress on reported sexual assault incidents involving servicemembers.

Issues

VA reported that in FY 2008 a total of 48,106 female veterans (21 percent) and 43,693 male veterans (1.1 percent) screened positive for Military Sexual Trauma. According to the DoD Sexual Assault Prevention and Response Office (SAPRO), in FY 2008 there were a total of 2908 official reports of sexual assault in the United States military; this is an increase from 2688 reported in FY 2007. Messrs. Chairmen, these numbers are alarming and The American Legion urges Congress, DoD and VA to act now to eliminate this disturbing trend.

In addition to these astounding numbers of MST and sexual assault cases, The American Legion is deeply concerned to learn that VA and DoD actions to address this dire issue are lagging. In March 2010 the Government Accountability Office (GAO) published a final report entitled *VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes* (GAO–10–287). It was based on site visits to nine VA medical centers (VAMCs) and ten Community Based Outpatient Clinics (CBOC) affiliated with these nine VAMCs, and eight Vet Centers, which are counseling centers that help combat veterans readjust from wartime military service to civilian life. GAO was asked to examine the on-site availability of health care to women veterans, the extent to which VA facilities are following VA policies that apply to the delivery of health care to women veterans, and key challenges that VA facilities face in providing health care to women veterans and how VA is addressing these challenges. The GAO report stated that only two of the VAMCs that they visited had specialized residential treatment programs specifically for women who have experienced MST. Although VA has taken steps to inform staff about their various programs offering MST treatment and counseling, this information is only available internally and VA has not provided this information on their external Web site where it can be easily accessed by veterans. The American Legion encourages VA to improve their transparency by making this information readily accessible to veterans and to also collaborate with the Veteran Service Organizations (VSOs) to disseminate this valuable information.

In order to help address this problem, The American Legion has made dealing with such issues with the proper sensitivity a priority in the training of its Depart-

ment Service Officers (DSOs). There are American Legion DSO's located in every State. These service officers can assist veterans and their families in filing a claim for benefits and gaining access to VA health care. DSO's are trained to recognize and handle benefits issues, claims and discharge upgrades for women veterans. DSOs are also encouraged to increase their own awareness of the available resources so as to better assist and inform veterans suffering from MST of those resources.

The American Legion has also made tackling the issues faced by women veterans a high priority by conducting seminars and panel discussions at various of its national meetings. We publish an annually updated guide for Women Veterans that is one of our most sought after resources, even used by VA at Vet Centers to inform women veterans of the resources available for their specific needs. While The American Legion is proud to provide such materials and resources to veterans, VA should not lag behind what is offered in the private sector in such matters.

Returning to the GAO study, the report also noted a lack of uniformity in the training practices of mental health professionals. VA policy on mental health (MH) professionals training is ambiguous and does not detail the necessary training for MH professionals who treat/counsel victims of MST or other sexual trauma. As a result, some VA facilities have implemented their own guidance on training and experience of MH providers. The American Legion recommends that the Secretary of VA intervene and amend the policy to clearly define the MH professional's requirement to treat/counsel MST patients. This effort would assure that our veterans are not deprived of the best quality of care available to them.

Unfortunately, the prevalence of sexual assault in the United States military continues to increase, regardless of the implementation of the DoD's Sexual Assault Prevention and Response (SAPR) program in 2005. In 2008, the Defense Manpower Data Center conducted a Service Academy Gender Relations Survey to assess the incidences of sexual assault and harassment at the three academies. The report found that 8.6 percent of women and 0.6 percent of men reported that they experienced unwanted sexual contact at the United States Military Academy. At the United States Naval Academy, 8.3 percent of women and 2.4 percent of men indicated they experienced unwanted sexual contact. At the United States Air Force Academy 9.7 percent of women and 1.4 percent of men reported they encountered unwanted sexual contact.

The American Legion recommends that the Department of Defense aggressively enforce sexual assault prevention training on a more frequent basis. Additionally, we recommend that all servicemembers be educated on the procedures of how to report a sexual assault. Servicemembers in leadership positions should be trained on how to recognize physical and psychological signs of sexual assault. The American Legion declares that DoD has to effectively enforce zero-tolerance towards sexual assault across the board with no exceptions.

There is a certain aspect of the military's culture that may discourage a victim from reporting their sexual assaults. According to the American Journal of Public Health, perpetrators are typically other military personnel, and victims often must continue to live and work with their assailant daily, which increases the risk for distress and for subsequent victimization. Unit cohesion may create environments where victims face strong encouragement to keep silent about their experiences, having their reports ignored or even being blamed by others for the sexual assault. The DoD themselves admitted that only a small percentage of sexual assault is reported. The American Legion believes that in order to combat this appalling issue, there needs to be more involvement from top leadership within the Department of Defense.

To further add to the aforementioned issues, veterans who suffer from MST encounter barriers when they file a claim for disability compensation through the Veterans Benefits Administration (VBA). The veterans are left with the burden to prove that they are eligible to receive compensation even though they have a diagnosis of Military Sexual Trauma from the Veterans Health Administration. As noted above, The American Legion has implemented a mandatory bi-annual training of our Department Service Officers to educate them on how to handle women veterans' issues and all MST claim cases whether male or female in a sensitive manner. We are trying to do our part to assist veterans in the handling of these difficult benefits claim cases and with the issue, in general. But it is incumbent on all of us, DoD, VA and the veterans' advocacy community, to make sustained efforts to deal with this growing problem or it will continue to fester. By having this hearing today, the Committee is obviously demonstrating its commitment to addressing the problem and we very much appreciate it.

Once again The American Legion thanks you for the opportunity to provide our views. We are happy to answer any questions the Subcommittees may have and look forward to working with both Subcommittees on rectifying this issue.

Statement of Beth K. Kosiak, Ph.D., Associate Executive Director, Health Policy, American Urological Association

I would like to thank the Subcommittee on Disability Assistance & Memorial Affairs and the Subcommittee on Health of the House Committee on Veterans' Affairs for your invitation to testify about urotrauma, a specific battlefield injury affecting a growing number of wounded military service personnel. Urotrauma is the term coined to refer to physical injury to the genitourinary system.

We are receiving reports from our physician members, particularly from our urologists who have recently served in the armed forces in Iraq and Afghanistan, that urotrauma is an increasingly prevalent condition among our active military personnel and veterans. An escalating number of soldiers suffer extensive, debilitating injuries to the genitourinary system. These injuries have far reaching effects for years to come—including impaired sexual function and difficulty conceiving children. While not as readily apparent as the loss of limb or scarring to an exposed area of the body, urotrauma is a serious and growing problem.

Urologists are disturbed that the knowledge and practice base is inadequate to meet this challenge. The American Urological Association (AUA), on behalf of its concerned surgeons, welcomes the opportunity to provide testimony and raise awareness about this condition.

I am Beth Kosiak, Ph.D., the head of Health Policy for the AUA, a member organization that represents over 92 percent of the more than 10,000 practicing urologists in the United States and over 16,000 world-wide. The long-standing mission of the AUA is to promote the highest standards of clinical urological care through education, research, and formulation of health care policy. Urologists are the specialists who most often diagnose and treat prostate cancer, the second leading cause of cancer deaths among men in the United States. In addition, urologists diagnose and manage the care for kidney stones, urinary incontinence, urinary tract infections, and benign prostatic hyperplasia (BPH), among other conditions.

There is insufficient data regarding the management of wartime genitourinary trauma. Neither a recent comprehensive review that examined available data from the 1960s to the present, nor a 1-year retrospective review of the United States Army trauma registry revealed substantial information on genitourinary trauma. While this latter registry provides valuable data on combat injuries, it does not record data specific to each genitourinary organ, nor does it detail what treatment modalities were used by urologists to manage genitourinary trauma.

This dearth of data presents serious challenges to the appropriate diagnosis and management of these injuries.

As battlefield rescues increase, more returning service personnel, particularly those who are victims of Improvised Explosive Devices (IEDs), are living with urotrauma injuries. Unfortunately, physicians must treat patients without the benefit of knowledge of the most effective treatments. Injury to urogenital organs accounts for between 1 percent and 12.5 percent[1] of all war injuries and most are associated with multiple lesions, especially abdominal.

Most injuries observed during Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) were due to IEDs and other explosive ordinance, and gunshot wounds. The extensive soft tissue loss seen with blast and high velocity bullet injuries necessitated a staged approach to genital reconstruction in many patients.

More information needs to be gathered on the use of modern body armor in the prevention or minimization of genitourinary injury and to encourage improvements in the design of body armor to better protect the genitourinary area. The Joint Theater Trauma Registry was used to conduct a retrospective study of 2,712 trauma admissions to a United States Army Combat Support Hospital in Iraq. Casualties wearing body armor had a 2.1 percent rate of genitourinary injury versus 3.4 percent for those not wearing body armor.

The Department of Defense (DoD) is sponsoring a major effort to focus on traumatic brain injury (TBI), and considers this one of the signature military medical challenges facing the Department for years to come. The DoD will fully implement

[1] The figure of 12.5 percent was most recently supplied to us by Michael O'Rourke, head of Health Policy for the Veterans of Foreign Wars (VFW) in a personal communication on May 11, 2010.

a comprehensive TBI registry including a single point of responsibility to track incidents and recovery and expand corresponding treatment services. This effort provides a strong model for genitourinary trauma for which dedicated research on prevention and appropriate treatment could minimize long-term/permanent damage, and encourage the development of more effective body armor.

Given the urgent need for better data, information and clinical practice knowledge to treat and rehabilitate servicemen and women who experience such injury, the AUA has already taken several steps and plans to take more.

First, and most significantly, we have authored a bill recently introduced in the House by Representatives Zack Space (D–OH) and Carol Shea-Porter (D–NH), H.R. 5106, which would establish an Interagency Commission on Urotrauma, led by the U.S. Department of Defense, to investigate and advise on the research and action needed to advance treatment of this important condition. The urotrauma legislation includes the following key provisions:

- Creation of "The National Commission on Urotrauma," which will conduct a comprehensive study of the present state of knowledge and research on urotrauma, evaluate existing education and research resources, and identify knowledge and programmatic gaps.
- A long-range plan, based on the Commission's comprehensive study, for the use and organization of national resources to effectively deal with urotrauma, including: (1) researching innovations in the care and treatment of persons affected by urotrauma, (2) identifying ways to prevent or minimize these types of injuries, and (3) improving education and training to medical personnel caring for these individuals and raising awareness among the general public.

Second, we have prepared and asked the Representatives to circulate a letter to their colleagues that asks for their support for this bill.

Third, the AUA regularly produces evidence-based clinical practice guidelines which are gaining national attention for their scientific rigor, transparent methodology and timeliness. The AUA's Board of Directors has approved development of a clinical practice guideline on urotrauma; we anticipate that work will begin early in 2011. Our guidelines are publicly available on our Web site and are listed on the Federal National Guidelines Clearinghouse, sponsored by the Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ). Thus, once completed, the urotrauma clinical practice guideline would be similarly available.

Fourth, we have begun to engage our member urologists, particularly those who have served in military theaters, to provide their expertise to raise awareness and advance treatment knowledge about urotrauma.

Finally, we have reached out to the Deputy Undersecretary for the Office of Wounded Warrior Care and Transition Policy of the Department of Defense, and supplied information in response to their request. We plan to contact other organizations and Federal agency offices where appropriate, to help educate relevant parties about urotrauma as well as offer the expertise of our member surgeons.

I thank you for the opportunity to submit written testimony on this important topic, and offer the services of the AUA and its members to the Subcommittees if we can be of any further assistance.

Statement of Christina M. Roof, National Deputy Legislative Director, American Veterans (AMVETS)

Mr. Chairman, Ranking Members Lamborn and Brown, and distinguished committee members, on behalf of AMVETS, I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding the treatment of military sexual trauma within the Department of Veterans Affairs (VA), more specifically the Veterans Health Administration (VHA).

AMVETS feels privileged in having been a leader, since 1944, in helping to preserve the freedoms secured by America's Armed Forces. Today our organization prides itself on the continuation of this tradition, as well as our undaunted dedication to ensuring that every past and present member of the Armed Forces receives all of their due entitlements. These individuals, who have devoted their entire lives to upholding our values and freedoms, deserve nothing less.

By way of background and clarification, AMVETS understands that Military Sexual Trauma (MST) is in no way exclusive to the female veterans population, however much of our testimony today will be based on specialized treatments for women whom have experienced and are being treated for MST.

Women veterans are the fastest growing subgroup of the American military veterans' population today. In fact, 2009 estimates show that women compose 14 percent of today's military forces, and within the next 10 years this number is expected to nearly double. If those estimates hold true than upwards of 30 percent of America's military forces and veteran community will be comprised of women. Women are also being deployed to combat zones at a rate in which this country has never seen and are carrying out vital roles on the frontlines. A 2008 VA study showed that 45–49 percent of female OEF/OIF veterans were enrolled in the VA Health Care System and were using VA provided services on a regular basis. This same study also showed that over 50 percent of the women currently enrolled in the VA health care system, 46 percent were under the age of 30. Now, more than ever, we must make sure that VA is ready and equipped with the necessary staff, facilities, and gender specific care programs to offer the best available care to today's returning women servicemembers. According to VHA officials more than 1,000 new cases involving MST are uncovered each month, yet little is known to VHA staff about mental health needs of MST-exposed patients, or access to and utilization of services by these patients. While AMVETS understands that the VA health system is facing a very large endeavor in providing and implementing effective care models to their patients regarding MST, we also find self proclaimed lack of knowledge on the subject unacceptable. VA's health care providers must have the experience and knowledge to treat all wounds of war.

Treatment and care models of MST do not differ so dramatically from VHA to care provided by private sector physicians to the extent that VHA should be having trouble understanding MST and the related metal disorders that often accompany it. There are already many established and long used models that can serve as guiding principles for VA in the establishment and implementation of care relating to MST. If VHA believes they are lacking in the prior experience needed to effectively provide care, AMVETS believes VHA may be best served in reaching out to private sector or other agency care providers for guidance and assistance. In fact, on March 3, 2009, VA's Principal Deputy under Secretary for Health, Dr. Gerald Cross, stated "We believe it is essential that our medical professionals across the system be able to effectively recognize and treat the manifestations of sexual trauma and PTSD," further proving VA's agreement with AMVETS on this matter.

VA defines Military Sexual Trauma as sexual or psychological trauma resulting from sexual harassment or abuse that either men or women are subjected to while serving in the military. Due to further research by AMVETS, we were able to gather a further breakdown of the terms used to define MST as recognized by VA. AMVETS research of current VA policies produced the following definitions:

1. *Sexual Assault* is defined as intentional sexual contact, characterized by the use of force, physical threat, and/or abuse of authority when the victim does not consent.
2. *Sexual Assault* is further defined as encompassing force or the threat of force, coercion is used, or when the un-consenting party is asleep, incapacitated, or unconscious.
3. *Sexual Abuse* is defined as, but not limited to, insistence on unwanted touching, forcing of unwanted sexual acts and demeaning remarks, treating as a sexual object with no regards to emotional well-being.
4. *Sexual Harassment* is defined as a form of gender discrimination involving unwanted sexual advances, the requesting of sexual acts, and any other verbal or physical conduct of a sexual nature when a person's job, pay or rank are placed in jeopardy, creates an intimidating or hostile workplace, and/or offensive work environment.
5. *Sexual Misconduct* is defined as an act committed without intent to harm another and where, by failing to correctly assess the circumstances, a person believes unreasonably that effective consent was given without having met his/her responsibility to gain effective consent. Situations involving physical force, violence, threat or intimidation fall under the definition of Sexual Assault, not Sexual Misconduct.

AMVETS believes that it is very important to bring attention to the fact that the Department of Defense does not currently include *"Sexual Harassment"* in their definition of sexual assault, as VA does. This difference of definition poses a problem in itself. AMVETS believes there needs to be a single definition on what constitutes *"Military Sexual Assault"* used by both VA and DoD to better recognize and treat victims of MST, as well as removing any questions regarding reporting of sexually related incidents.

Studies conducted by VHA and private sector organizations from 2006–2009 show that on average 24 percent of all female veterans screened during their initial VA

health care assessment displayed the criteria necessary for having experienced a MST event during their service. One must remember that these numbers were obtained during initial screenings and do not factor in the female veteran population that were later given a diagnosis of a condition stemming from a MST event. Furthermore, with DoD and VA using separate definitions of MST it is impossible to know how many veterans have truly experienced a sexually traumatic event during their service.

MST and its correlation to a magnitude of mental health disorders has been long documented and accepted within the medical community. However, it has not been until recently that women veterans under VA care have been specifically studied for the correlations of MST to PTSD and other mental health disorders. In 1996, a survey to determine the prevalence of physical and sexual abuse experiences, during and outside of military service, was conducted among 828 women veterans at the Baltimore Veterans Affairs Medical Center. Data collection was through an anonymous, mailed questionnaire. Three questions were used to elicit histories of physical abuse, sexual abuse, and rape. From the survey, 429 completed forms (52 percent) were returned. Most of the veterans had at least some college education and about 50 percent served 4 or more years on active duty. About 68 percent of the respondents reported at least one form of victimization, while 27 percent reported to have undergone all three forms, of which sexual abuse was the most common, followed by physical abuse and then rape. It was during adulthood that all three forms of abuse took place, with one-third of the women reporting victimization during active duty. Coyle also found that single women and divorced women were more likely to report victimization than married women. In conclusion, physical and sexually abused women veterans were the ones more likely seeking care at the center.[i]

Research has shown that veterans who have experienced MST are at a high risk for developing a range of mental health conditions such as PTSD, major depression, anxiety, and panic disorder. MST victims may also struggle with other problems, including low self-esteem, difficulties with interpersonal relationships, and sexual dysfunction. To the best of AMVETS' knowledge, there have only been two scientifically valid studies conducted since 2001 that examined rates of DSM–IV PTSD diagnoses in women veterans with MST. First, Suris et al.,[ii] using a sample of female Veterans Administration (VA) patients, compared rates of PTSD related to two types of civilian sexual trauma with PTSD rates related to MST. Suris found that MST was more frequently traumatizing than civilian assault. Thus, the data indicates that MST is more predictive of PTSD than are other types of military trauma or civilian sexual trauma.

The second study was conducted in 2006 by Dr. Deborah Yaeger. Yaeger et al.,[iii] compares rates of Post Traumatic Stress Disorder (PTSD) in female veterans who had military sexual trauma (MST) with rates of PTSD in women veterans with all other types of trauma. Both studies had findings that suggested that MST is common and that it is a trauma especially associated with PTSD. Yaeger's research actually showed correlation between the MST group and Other Trauma group (r=.13, P=.07) reflected a weak relationship. Dr. Yaeger also conducted a logistic regression analysis in which PTSD was regressed on MST and Other Trauma. Both the MST group (Wald χ^2=20.3, df=1, P=.0001) and Other Trauma group (Wald χ^2=5.4, df=1, P=.02) significantly predicted PTSD, but MST predicted it more strongly. This finding is significant because the number of women positive for MST was less than half of those positive for Other Trauma, yet the relationship of the MST group with PTSD was stronger.[iv] This is only one example of data showing the almost unquestionable link between MST and PTSD. Finally, in 2007, the Medical University of South Carolina wrote an article that reviewed the literature documenting the nature and prevalence of traumatic experiences, trauma-related mental and physical health problems, and service use among female veterans. Existing research indicates that female veterans experience higher rates of trauma exposure in comparison to the general population. Emerging data also suggest that female veterans may

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[i] Coyle BS, Wolan DL, Van Horn AS. The prevalence of physical and sexual abuse in women veterans seeking care at a Veterans Affairs Medical Center. Mil Med. 1996 Oct; 161(10):588–93.

[ii] Suris A, Lind L, Kashner M, Borman PD, Petter F. Sexual assault in women veterans: an examination of PTSD risk, health care utilization, and cost of care. Psychosom Med. 2004; 66:749–56.

[iii] Deborah Yaeger, MD, Naomi Himmelfarb, PhD, Alison Cammack, BS, and Jim Mintz, PhD. DSM–IV Diagnosed Posttraumatic Stress Disorder in Women Veterans With and Without Military Sexual Trauma. J Gen Intern Med. 2006 March; 21(S3): S65–S69.

[iv] Deborah Yaeger, MD, Naomi Himmelfarb, PhD, Alison Cammack, BS, and Jim Mintz, PhD. DSM–IV Diagnosed Posttraumatic Stress Disorder in Women Veterans With and Without Military Sexual Trauma. J Gen Intern Med. 2006 March; 21(S3): S65–S69.

be as likely to be exposed to combat as male veterans, although not as directly or as frequently. Female veterans also report high rates of posttraumatic stress disorder, which has been associated with poor psychiatric and physical functioning. USC concluded that while sexual assault history has been related to increased medical service use, further research is needed to understand relationships between trauma history and patterns of medical and mental health service use. Researchers also are encouraged to employ standardized definitions of trauma and to investigate new areas, such as treatment outcomes and mediators of trauma and health.[v] AMVETS believes this review further demonstrates the importance of a uniformed definition of MST throughout all agencies, more specifically DoD and VA. AMVETS also believes these studies to show the importance of integrating mental health care, as outlined by VHA 1160.01, into all VAMCs and CBOCs providing primary care.

In 2005, VHA published VHA Directive 2005–015, authorized under P.L. 102–85 outlining specific policies, procedures and staffing requirements as they relate to the treatment and care of veterans who have experienced military sexual trauma (MST). To build upon this directive VHA 1160.01, as published in September of 2008, provided even more policies and procedures that all Veteran Affairs Medical Centers and Community Based Outpatient Clinics should employ when treating veterans having suffered MST. These policies and procedures provide guidance and outline all legally binding requirements of the treatment of veterans having experienced MST by all VAMCs and CBOCs. The measures are as follows:

- The constant availability, isolation and safety of "women only" areas in each medical facility treating women veterans.
- That all medical directors ensure that every patient receiving care is screened for MST.
- The use of MST software that allows tracking of VA's screening of veterans. The Women Veterans Health Program and the Mental Health Strategic Work Group utilize the national MST report to respond to Congressional inquiries and for expansion of MST programs and initiatives.
- Veterans receiving MST-related counseling and treatment are not billed for inpatient, outpatient, or pharmaceutical co-payments; however, applicable co-payments may be charged for services not related to military sexual trauma or for other non-service connected conditions.
- Scheduling priority for outpatient sexual trauma counseling, care, and services is consistent with the VHA performance standard of scheduling within 30 days for special populations and mental health clinics.
- Accurate documentation of screening, referral, and treatment services provided to veterans, aggregated by gender, is maintained. This process includes use of the MST software and the MST clinical reminder to track and monitor the level of compliance with the standard (100 percent of enrolled veterans screened). The nationwide tracking system to ensure consistent data on screening and treatment of victims of military sexual trauma must be used.
- MST counseling is provided by contract with a qualified mental health professional if it is clinically inadvisable to provide in Departmental facilities or when VA facilities are not capable of furnishing such counseling to the veteran economically because of geographic inaccessibility or the inability of the medical center to provide counseling in a timely manner.
- Veterans who report experiences of MST, but who are otherwise deemed ineligible for VA health care benefits based on length of military service requirements, may be provided MST counseling and related treatment only.
- The MST software application that activates the MST Clinical Reminder within CPRS has been installed at the facility. All veterans receiving VHA health care must be screened for MST using this clinical reminder.
- Veterans screening positive and requesting treatment are provided free care, with no inpatient, outpatient, or pharmacy copayments, for mental and physical health conditions resulting from their experiences of MST. Determination as to whether care is MST-related is made by the clinician providing care. All MST-related care must be designated by checking the MST box on the encounter form for the visit.
- The time frames for evaluations of veterans for possible mental disorders resulting from MST must follow the requirements in paragraph 13, of VHA 1160.01.
- Evidence-based mental health care is available to all veterans diagnosed with mental health conditions resulting from MST.

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[v] Zinzow HM, Grubaugh AL, Monnier J, Suffoletta-Maierle S, Frueh BC. Trauma among female veterans: a critical review. Trauma Violence Abuse. 2007 Oct; 8(4):384–400. Review. PubMed PMID: 17846179.

While AMVETS does realize that VA has been making efforts to provide better care to all women veterans, we were quite troubled by two recent GAO reports on the standards of care our female veteran population has been receiving at VAMCs and CBOCs, especially in the areas of mental health and MST treatments. In March 2010, GAO published a report entitled "VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes," as a follow up report to the July 2009, GAO report entitled" VA Health Care: Preliminary Findings on VA's Provision of Health Care Services to Women Veterans."

AMVETS believes that what GAO reported in March 2010 is unacceptable and quite negligent by many VAMCs in providing the most basics of care to our women veterans. For example, in the 2009 report GAO found that none of the facilities they visited were compliant with privacy requirements outlined by VA. Regrettably, in the more recent 2010 report, GAO reported that most facilities still had not improved their measures to provide the required privacy to women veterans. Another area in need of compliance, as pointed out by GAO numerous times, are the requirements for treating veterans who have experienced any sort of MST, as outlined by P.L. 102–85 and 38 U.S.C. § 1720D. Federal law specifically requires VA to establish a program to provide these MST-related services and to provide for appropriate training of mental health professionals and such other health care personnel as the Secretary determines necessary to carry out the program effectively. These laws state that every VA facility to be equipped and able to provide immediate care for any veteran who has experienced any psychological trauma as a direct result of a physical assault or harassment that was sexual in nature during their time in service.

VA's MST-related policies require that VAMC directors appoint an MST Coordinator and that necessary staff education and training be provided. The MST coordinators are responsible, among other things, for monitoring and ensuring that VA policies related to MST screening, education, training, and treatment are implemented at the facility. GAO reported that VA had taken some steps internally to make information about MST programs more readily available to VA providers. Specifically, VA has conducted monthly, nationwide MST conference calls which have included basic information on the structure and focus of the various residential and outpatient programs offering MST or sexual-trauma-specific treatment, as well as detailed presentations by key providers from several programs. VA also has a list of the various programs on its internal Web site, which is accessible by VA providers. However, GAO went on to say that VA had not made the same information accessible to veterans through VA's external Web sites or printed literature accessible to all veterans. As of November 2009, the Web site pages reviewed by GAO from VA's national Web site did not provide complete lists of facilities that have MST-related treatment programs or specialized programs for women veterans. The sites that did list specific residential treatment programs usually listed a single program, while nine VAMCs have relevant programs. AMVETS is quite concerned that VA's outreach to women veterans is falling short. While most of us here today are very familiar with VA programs, the average veteran is not. It is the responsibility of VA to not only design and implement these MST specific programs, but to also educate the veterans living in all parts of the country on the services available to them. How can a veteran receive the care and assistance they need if they do not even know that the care exists?

It was the understanding of AMVETS that ensuring the privacy and integrity of all women veterans seeking care in a VAMC or CBOC was a requirement of federal law, not a suggestion. Women veterans seeking care for the most private and potentially damaging experiences, such as MST, must feel safe and that only their best interests are at hand by VA medical providers. What sort of message are we sending our returning female servicemembers, who have suffered a traumatic sexual experience, when VA is not able to offer them something as simple as an OB table facing away from the examine room door or a private and separate sleeping area from the male patients? Can VA honestly say, to this congressional Subcommittee and to all veterans, that the oversight they have exercised over the implementation of these care measures has been nothing less than their best? Can AMVETS be assured that every VAMC and CBOC is doing everything in their power to correct the deficiencies that have been repeatedly pointed out to them regarding the care of America's returning war fighters?

AMVETS offers the following recommendations regarding military sexual trauma care and treatment issues:

1. AMVETS recommends these Subcommittees set forth a strict timeline in which VA will have to report all updates on the implementation of MST policies and

procedures in every VAMC and CBOC, and that the Committee holds VA accountable to a specific date of systemwide total implementation. AMVETS further recommends that any requests for exception on meeting the specified deadline are required to be made in writing directly to the Secretary for final approval.

2. AMVETS recommends VA immediately update the information on their Web site, as well as written literature, to guarantee that all veterans are aware of the services available to them and where they may go to receive said services.
3. AMVETS recommends these Subcommittees maintain strict oversight on the implementation of VHA 1160.01 as it pertains to the availability of treatment for MST and all mental health care provided by VA, in efforts to implement and maintain uniformed mental health care systemwide.

Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

We are here this morning with our colleagues from the Subcommittee on Disability Assistance and Memorial Affairs to discuss issues surrounding Military Sexual Trauma (MST).

Sexual assault and harassment is unacceptable in any sector of American society and is a particularly serious matter in our military and veteran populations.

Because it occurs in a hierarchical and highly stressed environment, the negative physical and psychological effects of MST can be intensified and make one more likely to develop a mental health condition. The most common mental health condition observed among those veterans who report MST is post-traumatic stress disorder (PTSD).

It is particularly troubling to me that a servicemember who is a victim of sexual assault is often hesitant to disclose their experience because they fear negative social stigma, peer pressure, and risking their career.

It is encouraging that VA has come a long way since initially establishing a program to provide MST treatment in the 1990's. In 2003, VA began screening every patient seeking health care at a VA facility for MST and providing those who disclose it with free, confidential treatment and counseling. To receive such care, a veteran does not need to be service-connected, have reported the incident previously, or have documented that it occurred.

Additionally, each VA facility has a designated MST point of contact, coordinated through VA's national MST Support Team. With the recently enacted Caregivers and Veterans Omnibus Health Services Act, Congress mandated sexual trauma training and certification for VA mental health providers to ensure proper provision of the supportive services veterans with MST experience need and deserve.

VA's universal screening program is a good model to promote early detection and increase access to mental health care. However, there is still a great need to promote and develop effective therapies and conduct research to help us learn more about how to successfully treat veterans who experienced MST.

When the men and women of our Armed Forces devote their time in service to our country, they knowingly accept the threat of danger from America's enemies. But what they should never have to accept is the threat of sexual trauma from their fellow servicemembers.

I look forward to hearing from our witnesses on how we can all do a better job of combating MST and supporting the healing of those who have tragically experienced it. I thank you all for being here for this difficult and important conversation.

Most importantly, I hope that any servicemember or veteran with MST who may be listening today will be encouraged to report their experiences and seek help at their local VA. I yield back the balance of my time.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Subcommittee on Health
Washington, DC.
June 14, 2010

Phyllis Greenberger
President and Chief Executive Officer
Society for Women's Health Research
1025 Connecticut Avenue, NW Suite 701
Washington, DC 20036

Dear Ms. Greenberger:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs' and Subcommittee on Health's joint oversight hearing on, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," held on May 20, 2010. We would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Wednesday, July 21, 2010.

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Due to the delay in receiving mail, please provide your responses to Jian Zapata by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

John J. Hall
Chairman
Subcommittee on Disability Assistance and Memorial Affairs

Michael H. Michaud
Chairman
Subcommittee on Health

Questions from the House Committee on Veterans' Affairs Subcommittees on Disability Assistance and Memorial Affairs and Health "Healing the Wounds: Evaluating Military Sexual Trauma Issues" May 20, 2010

Question 1: In your opinion, what training is needed to ensure that commanders treat military sexual trauma as it is, a crime?

Response: The Society for Women's Health Research (SWHR) is dedicated to improving women's health through advocacy, education, and research. We appreciate the opportunity to offer insight into proven approaches in responding to sexual assault and to offer suggestions as to what we believe needs to be done in order for military sexual trauma (MST) to be taken seriously as a crime.

First, it is clear that a top-down approach needs to be integrated into all MST training. Leaders within the military must emphasize that MST is not just an acronym—it is rape and it is a crime that affects a person both on an emotional and physical level. This must be clearly conveyed to those servicemembers that they lead. The actions and level of seriousness that leaders take toward MST should be reflected in the actions and behavior of those being instructed. By making clear from the beginning what is not tolerated or appropriate, leaders will be doing their part to foster an atmosphere of zero tolerance for sexual harassment and assault.

SWHR commends the efforts of the Sexual Assault Prevention and Response Office (SAPRO) within the Department of Defense (DoD) for their efforts educating servicemembers and commanders about MST, and for their bystander outreach campaign targeting the vast majority of military members who are not sexual offenders. However, according to SAPRO reports, almost 100 percent of MSTs occur with the knowledge of, help of, or assistance from another individual. By educating what words and behaviors to watch for, and learning ways to respond and report as a bystander, SAPRO is helping to equip members with information to help stop these crimes from happening and to prevent the trauma and destruction in the first place.

SAPRO has different training programs specific for commanders within the military; these programs help to educate commanders and leaders on sexual assault and harassment throughout their careers. SWHR applauds the leadership SAPRO has taken in addressing MST within the military, and hopes that their research and reporting on this topic will guide policy decisions that will eliminate the risk of MST for those who serve.

Second, we will not understand the full scope of the problem unless better and more complete reporting systems are in place that emphasize coming forward for treatment, reduce stigma, and eliminate any threats to the victim's career. To ensure MST is treated as a crime, reporting of MST must be uninhibited, provide for privacy and be held with the highest discretion, and the repercussions must be swift, severe, and uniformly applied. According to a Department of Defense (DoD) report in 2009, only 10 percent or fewer of sexual assaults are estimated to have been reported to law enforcement or military Sexual Assault Resource Centers. Studies completed by the VA in 2007 conclude that 20–30 percent of female veterans were raped or assaulted while serving. It is likely that there is a higher number of MST survivors not yet accounted for, as less than 50 percent of female veterans have come forward to claim VA benefits or care, and as a result have not been included in the most recent VA surveys.

Treatment is especially important for female victims of MST because of their likelihood to develop subsequent complications, such as sexually transmitted infections ((STI) or Post Traumatic Stress Disorder (PTSD). Sex-based research has found that women are more likely to acquire a STI than a man, and many of these infections can have potentially lifelong consequences. Additionally, women are twice as likely as men to develop depression and PTSD because of exposure to traumas. Prolonged feelings of fear, if not treated, can lead to increased levels of stress and anxiety, all with body wide impacts. Appropriately timed and sex-based interventions after MST could prevent overwhelming mental and physical health burdens on the victim as well as an avoidable financial burden to the Department of Veteran Affairs (VA).

One reason why both men and women do not report MST stems from threats (explicit or implied) from the person(s) whom harmed them sexually and the stigma that comes with reporting being a victim of MST. An August 2009 article in *The Seattle Times* relayed a story from a male MST victim and his fear in coming forward because of death threats he had received. The men who gang raped him worked alongside him day in and day out; because of the close ties and personal connections with these fellow military men, he reports he felt lost on how to deal with the problem. Victims of MST are often filled with shame and humiliation, at a loss for what to do, especially when threatened if they speak up about their issues. This case highlights the fact that MST can and does happen to both men and women. If both sexes fear coming forward after MST because of threats of harm or career loss, stigmatization or because of the humiliation they as victims feel, the military faces a great challenge in overcoming this atmosphere of shame and suffering in silence.

The VA Web site discusses the fact that victims of MST can experience a disturbance in their career goals (delayed promotions, demotions or dishonorable discharges) possibly due to factors such as a perpetrator who is a superior not recommending her for promotion, or because the woman is not performing at her best due to PTSD or avoiding certain assignments to avoid her assaulter. This is a great disadvantage to those who wish to advance up the ladder, however, choose not to once they realize they will be working alongside their perpetrator(s).

Question 2: What training would you recommend for VBA benefits staff to ensure that they are properly recognizing the connections between MST and PTSD?

Response: In response to the near doubling of female veterans in the past 5 years the Veterans Benefits Administration (VBA) is making great strides in improving the resources available to the increased number of women veterans. With *45.9 percent of servicewomen surviving MST going on to develop PTSD* according to the VA's Web site update in 2009, the connection between MST and PTSD is strong. In order to properly recognize, best assist, effectively treat, and ideally prevent PTSD in MST victims, a few interventional steps should be taken. The VBA will benefit from recognizing the numerous symptoms and side effects that can occur in any combination and with varying levels of severity; distinguishing the unique stresses and environmental triggers, addressing the looming emotional toll, and formulating individualized assistance.

While the VBA coordinates benefits in addition to disability payments including reintegration, housing, education and rehabilitation, the medical personnel practicing within the VA medical centers must also take a multifaceted approach to best

serve those surviving MST, with or without PTSD, including combining psychotherapy, medication and group reinforcement when appropriate.

Symptoms of PTSD can appear immediately after the trauma, relatively late or in fluctuating intervals. The VA reports that while 94 percent of females suffering from MST will experience some symptoms of PTSD within 2 weeks, 30 percent will experience some symptoms nine or more months later. With such a great variety in time between the trauma and onset of symptoms, and with many women trying to cope with MST on their own, it is especially important that all medical personnel are *actively* looking for and using medical questioning and testing to highlight any symptoms. Accordingly, the VBA must be flexible in designating timelines for claiming PTSD and related assistance. A report in July 2010 from the VA discusses the new regulations broadening the range of incidents that could cause PTSD and easing access to the benefits a veteran could receive. Increased research into the different experiences for women after MST, with or without PTSD, will help VA and civilian medical providers stand ready to better serve all victims with more targeted treatment regimens. Improved sex-based responses to MST and PTSD are not only crucial to preventing long term consequences of MST and effectively treating PTSD, but also to preventing the 13 percent of women suffering from PTSD that are more likely to abuse alcohol, the 26 percent of women that are more likely to abuse drugs and the countless female veterans that have contemplated suicide.

Triggers, anything from a scent to a situation that causes the body to be reminded of the sexual assault, can reinforce PTSD caused by MST, enhancing memory consolidation and often causing a woman to react more negatively than a man. The case of MST with PTSD is especially unique in that the veteran had oftentimes lived side-by-side with the aggressor for some period of time, including after the assault. The unique stresses and overexposure to environmental triggers greatly influence the sufferer's psychological state and tend to have an even *greater* impact on women due to fluctuations in hormone levels and rates of memory consolidation. According to Margaret Alternus, speaking on the issue of sex differences at a 2008 Society for Women's Health Research conference on *Posttraumatic Stress Disorder in Women Returning from Combat,* women tend to react more negatively to interpersonal stressors, have a greater frequency and intensity of negative emotions due to fluctuating hormone levels, and have a heightened sensitivity to the hormone catecholamine, which is key to memory reconsolidation. While ultimately the DoD needs to be cognizant of the impact triggers may have on a woman who survived MST but continues to serve, it is imperative that the VA is equipped with a full scope of sex-specific treatment options for all veterans, and the VBA stand ready to provide assistance where necessary. Veteran benefits, health care, and reintegration efforts all need to coordinate to help the victim regain a sense of normalcy and reenter the community after the assault and after a tour of duty.

The psychological ramifications of PTSD take a severe emotional toll on the sufferer and influence the ability to maintain conventional relationships, even long after the attack. By recognizing any prominent or underlying signs of relationship problems in the victim and a spouse, child or other immediate family members, a *personalized* and *targeted* care regimen could be created. A veteran's return to civilian life is a difficult adjustment for the individual and family, and the VBA is uniquely equipped to aid the veteran and family members during the transition with training, compensation, and education benefits. VBA should expect that a victim of MST, with or without PTSD, may require aid that is different from a servicemember not experiencing MST or PTSD. In addition, some regular family counseling should be made readily accessible, so that veterans will have a strong, well-informed emotional support system.

The most important aspect to recognizing the connection between MST and PTSD and effectively treating it is through *individualized attention.* Flexibility within the VBA structure will allow for sex-based and individual-based differences in needed assistance. Every woman's suffering was caused by a different event, is perpetuated by varying triggers, is influenced by unique hormone levels, and is characterized by personal combinations of symptoms. By recognizing these various factors, whether apparent or concealed, and creating individualized treatments, each female veteran has the ability to overcome her PTSD.

Question 3: For female MST victims, you recommend that VA provide treatment and benefits that meet their gender specific needs. Do you believe that MST related benefit claims should be processes only by VBA staff of the same gender as the veteran claimants?

Response: MST related benefit claims can be processed equitably and uniformly by a well-trained VBA staffer of either sex, however, the VBA may consider making case review by same-sex staffers an option if requested by a veteran.

While the sex of the VBA staff adjudicating MST and PTSD related claims should not make a difference, there are obvious concerns about the sex of the health care provider and the participants of group therapy within VA medical centers that must be acknowledged and worked into VA care models. SWHR strongly believes that the VA should strive to provide evidence-based, gender-specific treatment options at each level of care. According to a June 2010 article in *Time* magazine, the VA has been working to implement policies to provide and improve sex-specific care and treatment for veterans. One example includes all-female therapy groups, especially for those women surviving sexual assault. This is a step in the right direction and SWHR hopes to see more improvements for veterans through the research and application of sex-specific care.

Question 4: Your testimony discussed the importance of VA working with non-VA providers to ensure that veterans receiving private treatment for MST issues are nonetheless afforded the highest quality of care that meet VA's standards. Please elaborate on how VA can better collaborate with such providers to share clinical guidance and other important information on the treatment of conditions that result from military sexual trauma.

Response: SWHR has learned through interviews with women veterans that a common reason why women seek care with non-VA providers is to ensure confidentiality. For the VA to ensure veterans are receiving the best care possible within their facilities they should start by making their care models more accessible and inviting, while ensuring privacy of records and during appointments.

Another suggestion deals with training for non-VA providers. According to an article within *The New York Times* in July 2010, the VA is equipped with its own training programs that help to ensure proper treatment and care specifically for veterans. Tom Pamperin, an Associate Deputy under Secretary for Policy and Programs at the Veterans Department, states "VA and VA-contact clinicians go through a certification process. They are familiar with military life . . ." The VA could consider allowing non-VA providers to take this certification course, allowing public or private medical centers an opportunity to better ensure that veterans seen in these settings are provided with tailored treatment and care that fully meet VA standards. Another possibility would include allowing medical groups to model their own training session after the VA's model or seek consulting from the VA for proper treatment and care. In the setting of rising numbers of veterans, the VA may benefit from drawing up well trained non-VA providers to help in addressing in a timely fashion the needs of all veterans. SWHR supports recent recommendations calling for permitting outside clinicians to document PTSD for the purpose of claiming VA benefits, given the number of women who feel most comfortable seeking non-military assistance in dealing with MST or PTSD related issues.

Also within *The New York Times* article, Eric Shinseki, Secretary of the VA, states "This Nation has a solemn obligation to the men and women who have honorably served this country and suffer from the emotional and often devastating hidden wounds of war". The VA's new policy for veterans with PTSD, easing barriers to claiming compensation, is a step in the right direction; however, considering the high number of war veterans, both male and female, who have PTSD because of MST, the VA should consider additional expansions in care and benefits recognizing the unique hardships and challenges faced by returning victims of MST.

Question 5: Do you have suggestions on how the VA and DoD can better work together to ensure a smooth transition for servicemembers who have experienced a military sexual trauma?

Response: The efforts of the VA and DoD to implement a mutually shared electronic health record is commendable. These advancements in technology and communication are establishing an unprecedented path towards seamless medical coverage that will certainly improve the health care delivered to servicemembers throughout their lifetime. Currently, the Virtual Lifetime Electronic Record (VLER) system is being strategically implemented, monitored and improved so as to facilitate the transition from military to civilian life. With some slight modifications, this system can also better monitor the effects of MST in the increasing number of female veterans.

The VLER system right now seems to focus primarily on the sharing of medical records pertaining to pharmaceuticals and drug allergies. These records should conversely cover all aspects of the medical realm so as to allow for the complete interoperability of personal health information between the VA and DoD. This might include all the tests, screenings and any forms of therapy undergone while in the military. In addition, medical records prior to deployment could be scanned into the system, providing the most complete picture. This would highlight any previous condi-

tions or trauma that might potentially impact a servicemember's health or susceptibility to PTSD. By integrating all medical records, the DoD and VA would be able to provide seamless medical coverage to individuals entering the military, throughout their deployment and as a veteran. With their unique access to data concerning male and female servicemembers, both the VA and DoD have an opportunity to be leaders in sex-based differences research, improving health for women and men, military and civilian.

As a record number of women join the military scene and an increasing number of women are achieving veteran status, the VA and DoD must also collaborate to recognize the unique medical problems women are facing, and the various treatment options. It is imperative that the VA increase the amount of sex-based research being conducted, in order to meet its goal of creating evidence-based practices that are beneficial for the health and health care of women. One crucial topic of research should be studying the effects that MST and PTSD have on a woman's life span and health.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Subcommittee on Health
Washington, DC.
June 14, 2010

Helen Benedict
Professor of Journalism, Columbia University
2950 Broadway
New York, NY 10027

Dear Ms. Benedict:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs' and Subcommittee on Health's joint oversight hearing on, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," held on May 20, 2010. We would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Wednesday, July 21, 2010.

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Due to the delay in receiving mail, please provide your responses to Jian Zapata by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

John J. Hall
Chairman
Subcommittee on Disability Assistance
and Memorial Affairs

Michael H. Michaud
Chairman
Subcommittee on Health

Answers to Questions from the House Committee on Veterans' Affairs Subcommittees on Disability Assistance and Memorial Affairs and Health "Healing the Wounds: Evaluating Military Sexual Trauma Issues" May 20, 2010

From Professor Helen Benedict

Question 1: Professor Benedict, you suggest that MST could be reduced by promoting women and taking other steps to increase respect for women amongst commanders and the troops overall. As a member of the Visitors Board at West Point, I've long supported women military leaders, what steps do you suggest be taken to better promote women servicemembers within the ranks?

Response: I have heard many stories of individual officers and NCOs who so resent the presence of women in their units that they deny them deserved promotion, recognition and even medals. In one case in my book, for example, a female army

specialist helped to save four soldiers in a mortar attack at great risk to herself. Her immediate superiors recommended her for a Bronze Star, but the commander of her platoon, who had a long history of antagonism toward all the women in his unit, blocked the reward. She was never recognized for her bravery.

Officers should be taught not to overlook women in this way, of course. But there should also be some oversight from the command to check whether the promotions and rewards in any particular mixed-sex unit shows a conspicuous lack of women recipients.

The adequate recognition of women is a problem in the civilian realm, too, a product of the age-old habit of not taking women seriously or recognizing their work. Within the military, this attitude is exacerbated by the Pentagon's ban against women in combat, which relegates them to second-class status in many eyes.

Fixing this bias against women usually takes conscious and deliberate attention. I am not suggesting that the military use quotas for rewards and promotions, only that if no women are among those put up in any particular unit, a high-ranking commander or review board should sound the alarm and start an investigation.

Question 2: You also recommend that the military screen and perhaps reject recruits with history of being sexual violent perpetrators and victims. What impact do you predict this type of scrutiny can have on reducing MST?

Response: First, to make clear, I absolutely did NOT recommend rejecting *victims* of sexual violence from enlisting in the military. That is a misreading of my statement. If we did that, we would lose about one sixth of our male recruits and about half of our female recruits. And we would be further punishing the victims of a crime that is no fault of their own.

No, what I said was that we should reject anyone who has a history of COMMITTING sexual or domestic violence. The reason is clear: rape is a serial crime. Most rapists rape again and again, and most men who are violent against women at home will continue that behavior in the military. Rejecting those men will screen out many potential assailants from the military.

I also recommend child sexual and physical abuse counselors for all the military, because VA studies show that about half our troops come from violent homes. Such counselors may be able to prevent anger, sexual violence and suicidal behavior among servicemembers with troubled backgrounds.

Question 3: Since a DoD survey reveals that men may make up more than one-third of military sexual harassment victims, what type of training do you recommend DoD and VA employ to prevent MST amongst both men and women?

Response: It is essential that all sexual assault prevention training begin with a proper definition of sexual assault and rape. It needs to be made clear that assailants are not acting out of pent-up lust, or responding to seduction, but are predators taking advantage of their power or circumstances to force others into sexual contact.

Sexual predators are more interested in dominating and degrading their victims than in satisfying sexual frustration.

In short, it should be emphasized that the victim is never to blame. Even if he or she is drunk or flirtatious, or makes a careless or even serious mistake (such as leaving a weapon unattended), this is not the same thing as asking to be assaulted.

The lack of blame and de-sexualization of rape and assault will help men and women feel safer to report and to seek treatment.

For men, it needs to be emphasized that rape does not happen because either the victim or the perpetrator are homosexual. In fact, studies show that most rapists of men are heterosexual.

For male victims, it is also essential that the Don't Ask, Don't Tell rule be repealed. While it exists, most male victims are too afraid to report an assault in case they are then labeled as homosexual and expelled from the military.

Question 4: In your testimony, you mentioned that victims who did not report an assault while on active duty have often been denied treatment through VA. However, VA is responsible for treating all servicemembers who screen positive for MST, even if they do not have a service-connection. Can you elaborate on this point?

Response: The contradiction here is about the gap between the rules and the practice. Even though troops are entitled to MST counseling, in practice many are told that their problems are a "pre-existing personality disorder," and so are not covered by the military or the VA. Others are told that their problems are in their heads, that they are malingering, or otherwise lying. I say this because I have heard dozens of stories from soldiers themselves about this.

Several news stories have come out about the way this diagnosis of pre-existing personality disorders is used by the VA to deny treatment and save money. It will

take congressional oversight and condemnation to end this practice. The need is urgent, because the problem is widespread and devastating, and it affects not only MST victims, but even soldiers with physical wounds and traumatic brain injury.

I know Congress has already held hearings on the problems soldiers face getting the counseling and treatment they need and deserve. National Public Radio and several other news outlets have been covering this problem for some time. The bottom line seems to be that the VA is instructing its psychologists and doctors to deliberately misdiagnose problems as pre-existing conditions in order to save money. This needs to be unearthed and stopped immediately.

In short, the answer to this question is to better police the medical practices toward our troops both within the military and the VA.

See *http://veterans.house.gov/news/PRArticle.aspx?NewsID=111.*

Yours,

Helen Benedict
Professor, Columbia University

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Subcommittee on Health
Washington, DC.
June 14, 2010

Joy Ilem
Deputy National Legislative Director
Disabled American Veterans
807 Maine Avenue, SW
Washington, DC 20024

Dear Ms. Ilem:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs' and Subcommittee on Health's joint oversight hearing on, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," held on May 20, 2010. We would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Thursday, July 21, 2010.

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Sincerely,

John J. Hall
Chairman
Subcommittee on Disability Assistance and Memorial Affairs

Michael H. Michaud
Chairman
Subcommittee on Health

POST–HEARING QUESTION FOR JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR OF THE DISABLED AMERICAN VETERANS FROM THE SUBCOMMITTEES ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS AND HEALTH HEARING, Healing the Wounds: Evaluating Military Sexual Trauma Issues, COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES HOUSE OF REPRESENTATIVES, MAY 20, 2010

Question 1: Ms. Ilem, you raise a good point, that military sexual trauma (MST) victims, both men and women, often do not report sexual trauma when it happens initially. As a result, these MST victims have difficulty in demonstrating the injuries caused by sexual trauma are "service-connected" in the context of VA disability

claims. Can you elaborate on the particular challenges faced by men in the military in reporting sexual trauma? What can DoD and VA do to increase prompt reporting of MST by victims, men and women alike?

Answer: It has been my experience in working with male veterans who report MST, that they too find it extremely difficult to come forward and report the incident to their superiors. They report feeling shame, humiliation, weakness, and a loss of trust among other military servicemembers along with many other typical responses to personal assaults. Some male victims have noted it is especially difficult to report these incidents given the "warrior" culture of the military, and the general (and mistaken) belief in our society that this type of assault is a crime against women. In fact, even in VA, it is most generally and incorrectly associated with women veterans—and is often considered "a women veterans' issue." It is not. For a more detailed explanation, see my response below to Question no. 4.

In our opinion, DoD and VA have many similar challenges before them to increase prompt reporting of MST incidents. The issue of stigma cuts across both agencies and likely only a concerted and lengthy campaign to reduce the stigma associated with MST would enable noticeable change to occur. Over the past several decades, this issue has been a catalyst for a number of high profile scandals in the military service branches, and has stimulated task force reports, policy changes, negative media coverage, as well as new research. A continuing focus on *prevention* of MST in the ranks, along with a no-tolerance policy and accountability of military leadership to address MST, would be critical and necessary steps to be made before victimized servicemembers will readily come forward to report these incidents. Until victims of MST feel assured that they will be believed, the incident will be properly investigated, the perpetrators appropriately punished and their military careers will not be negatively impacted because of their reporting MST incidents—it is unlikely that DoD will be able to increase prompt and routine reporting from within this population.

Within VA health care programs, it is clear there is a much better chance that a veteran (male or female) will report MST in conjunction with seeking medical care or mental health services for conditions consequent to sexual trauma. However, male and female veterans still face a number of barriers in the Veterans Benefits Administration (VBA) related to verifying stressors and establishing service connection for conditions related to sexual assaults when those events were not reported during their military service. Many of these claims are denied, and veterans report that the VA's denial of their claim adds to the mental anguish resulting from the assaults.

Question 2: From your testimony, it appears that the key differences between restricted and unrestricted reporting is that restricted reporting permits MST victims to secure examinations and treatment assisted by a Sexual Assault Response Coordinator (SARC) and Victim Advocate without notifying the victim's chain of command or law enforcement authorities. According to DoD, nearly 4,000 cases of sexual assault have been documented via a restricted reporting system, with just 15 percent of these cases ultimately being moved to the "unrestricted" category, which I understand is necessary for prosecution under the Uniform Code of Military Justice (UCMJ). What are your thoughts on the two track reporting system? Do you have any concerns?

Answer: Although somewhat controversial at first the "two track" reporting system does allow servicemembers, who in the past may have stayed silent, to come forward and receive necessary medical and mental health services for conditions related to sexual assaults—and most importantly the time to reflect (up to 1 year) and choose if they wish to pursue criminal actions against their perpetrators. DAV's biggest concern, highlighted in our testimony, is these same veterans' inability (and ultimately VA's) to access examination and treatment records that could be used to verify reports of sexual assault to establish service connection for MST-related conditions. For all essential purposes these critical records seem to be in permanent limbo or even worse, destroyed, due to an ineffective DoD administrative policy, and overabundance of caution concerning privacy, or simple bureaucratic red tape. We believe DoD needs to revamp its all-service branch policy dealing with standardizing the retention rules and making these records available to both the victims themselves, and to their official representatives, or VA benefits personnel, in appropriate circumstances, and with proper controls to protect privacy and confidentiality.

Question 3: Your testimony cited several studies by VA on the number of veterans who reported having suffered a military sexual trauma while being screened. Do you think that the screening is capturing most of the veterans who suffered an

MST, or is it likely that there is a significant number slipping through the cracks, due to stigma or otherwise?

Answer: Research on this issue reflects that an effective screening program that promotes the detection of MST and access to evidence-based mental health care helps to reduce the burden of illness for those who have experienced MST. To that end, VHA's nationwide policy and universal screening program for MST represents one of the most comprehensive responses to sexual violence in any health care system in the United States. MST screening in VHA is part of all veterans' routine medical visit protocol that provides an opportunity for clinical staff to educate patients on mental and physical health conditions associated with a history of such trauma, inform them of specialized programs and treatment options to ultimately increase access to effective treatments. Performance monitoring indicates that in FY 2006, 86.7 percent of all VHA patients had been screened for MST, and prior research indicates that the remaining 13.3 percent who were not screened were atypical users of the system—those who used significantly fewer VHA services than screened patients.

Even with this prospective approach to screening in VA, it is likely that some veterans are still falling through the cracks, but probably more so due to the general nature of stigma associated with sexual trauma and reporting. According to research findings, only 26 percent of sexual assaults in the United States are ever reported. That said, most victims likely will never feel comfortable disclosing that a sexual assault occurred. However, VA's universal screening opens the door for the providers to counsel patients about mental and physical outcomes of a victim of sexual assault or other trauma who does not receive services. It is suggested that universal screening may be an effective and non-stigmatizing means of detection—especially for assessment of male patients for whom sexual trauma is rarely a focus of provider attention. VA researchers stated that although not all patients who screen positive for MST require mental health treatment, men and women with positive screens are approximately three times more likely than those with negative screens to be diagnosed with having a mental disorder. These research findings strongly suggest that VHA's screening program for MST has *increased* rates of mental health treatment among patients who screen positive for such trauma, and DAV believes that this finding represents very good progress.

Additionally, research findings from female veterans of the 1991 Persian Gulf War note that rates of sexual assault, physical sexual harassment and verbal sexual harassment were higher than those typically reported in a peace-time military sample, suggesting that exposure to these types of experiences may be more prevalent during times of combat. Researchers stated that given the longer deployments and increased stressors associated with the current wars in Iraq and Afghanistan relative to the Gulf War, recent war veterans eventually could report even higher rates of sexual assault and harassment.

Question 4: You noted that the population of women being treated by VA for MST is nearly equal to the number of men receiving such treatment. Yet VA reports that, during FY 2009, 21 percent of women screened reported MST, compared to 1.1 percent of men. Is the discrepancy between the percent of each gender population screening positive for MST and the total number receiving treatment simply attributable to the fact that the population of men receiving treatment in VHA is far larger than the population of women? Or do some women who screen positive for MST not receive treatment? If so, why not?

Answer: There is no discrepancy in the information provided to the Subcommittees. In my testimony I noted that, ". . . the size of each VA clinical population (men to women) who *reported* MST within VA treatment programs is almost equal: 53,295 women and 46,800 men respectively." To be clear this reference refers to how many veterans seen in VHA have reported or screened positive for MST, not the number of veterans who were treated. According to VA's FY 2009, Military Sexual Trauma Screening Report, 21.9 percent (or 53,295) of female veterans screened positive for MST, compared to male veterans at 1.1 percent (or 46,800). In the same report, VA also stated that every VA facility provided MST-related care to both men and women in FY 2008 with specifically:

- 474,966 MST-related [treatment] encounters, comprising 314,128 encounters with female veterans (80.2 percent of these were mental health care) and 160,838 encounters with male veterans (78.0 percent of these were mental health care)

The VHA has over 6 million unique users of its health care system. Approximately 95 percent of those users are men and approximately 5 percent are women. Of the

95 percent of male users or 5.5 million patients, 1.1 percent or (46,800) screened positively (meaning, they reported MST). Of the 5 percent of women (approximately 500,000) using the system, 21.9 percent or (53,295) screened positively (meaning, they reported MST). VHA testified that 1 in 5 women and 1 in 100 men seen in VHA respond "yes" when screened for MST. Although rates of MST are higher among women than men, the disproportionate ratio of men-to-women serving in the military, results in only slightly fewer men being seen in VHA with MST than women. In other words, the actual *number* of men-to-women who were screened and reported MST is nearly equivalent.

VA researchers concluded that the high numbers of MST reported among its entire patient population underscore the contention that military sexual trauma represents a significant problem with particular relevance to VHA. Of particular note is the opportunity for VHA to focus on early detection and treatment of MST to prevent chronic long-term health consequences associated with MST such as chronic post-traumatic stress disorder, anxiety, depression and substance-use disorders—especially in the most recent generation of veterans coming to VHA for care.

For further information and data related to my responses to questions no. 3 and 4, please see *Evaluation of Universal Screening for Military-Related Sexual Trauma,* ps.psychiatryonline.org, June 2008, Vol. 59, No. 6. [a VA Research and Development-funded study published in the journal of the American Psychiatric Association].

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Subcommittee on Health
Washington, DC.
June 14, 2010

Kaye Whitley, Ed.D.
Director, Sexual Assault Prevention and Response Office
Office of the Under Secretary of Defense for Personnel and Readiness
U.S. Department of Defense
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Washington, DC 20301

Dear Ms. Whitley:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs' and Subcommittee on Health's joint oversight hearing on, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," held on May 20, 2010. We would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Wednesday, July 21, 2010.

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Due to the delay in receiving mail, please provide your responses to Jian Zapata by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

John J. Hall
Chairman
Subcommittee on Disability Assistance and Memorial Affairs

Doug Lamborn
Ranking Member
Subcommittee on Disability Assistance and Memorial Affairs

Michael H. Michaud
Chairman
Subcommittee on Health

Henry E. Brown, Jr.
Ranking Member
Subcommittee on Health

Hearing Date: May 20, 2010
Committee: HVAC, Member: Congressman Hall, Congressman Brown, Congressman Michaud, Congressman Lamborn, Witness: Dr. Whitley

Date of Sexual Harassment and Sexual Assault in the Military

Question 1: According to DoD's study issued over 15 years ago, in 1995, before the current conflicts in Iraq and Afghanistan, it was estimated that 78 percent of women and 38 percent of men had been victims of sexual harassment. What is the rate of sexual harassment and sexual assault in the military today? And what training is in place for commanders (both at the officer and non-commissioned officer level) to ensure that military sexual trauma is treated as it is—a crime?

Answer: In order to generate an estimate of the incidence of sexual assault in the military, the Department of Defense (DoD) relies on the information collected through its quadrennial Gender Relations Survey (GRS). The most recent GRS from 2006 found that 6.8 percent of women and 1.8 percent of men on active duty experienced some form of unwanted sexual contact (e.g., a sexual assault) during the previous year. In the same study, 34 percent of women and 6 percent of men experienced some form of sexual harassment. The 2010 GRS is currently underway and this data will be available in FY 2011.

Regarding the issue of training, the DoD Instruction 6495.02, Sexual Assault Prevention and Response Program Procedures, specifies sexual assault program training requirements for both commanders and senior enlisted leadership. This training occurs at numerous stages throughout their military careers and addresses their responsibility in appropriate prevention and response to the crime of sexual assault.

Impact of Screening Military Recruits for Prior Sexual Violence

Question 2: Military Sexual Trauma (MST) experts have suggested MST could be curbed by DoD screening its recruits for history of sexual violence. What is the potential impact of this type of scrutiny to DoD's mission? Also, if such screening was implemented, would you prefer barring sexual assault perpetrators and victims from military service or rather providing them with extra training and counseling if needed?

Answer: The Department already screens and denies entry for recruits with a history of sexual assault perpetration. Paragraph 4.7 of Department of Defense (DoD) Directive 6495.01, Sexual Assault Prevention and Response (SAPR), makes it DoD Policy to "Prohibit the enlistment or commissioning of personnel in the active duty Armed Forces, National Guard or Reserve components when the person has a qualifying conviction for a crime of sexual assault."

Screening out victims of sexual violence would not realistically contribute to reducing the incidence of sexual assault in the military. Such a disqualifier would only serve to punish a victim for having reported a crime that occurred prior to service. Servicemembers who have been victims of sexual violence prior to accession into the military may currently report that abuse to SAPR personnel and receive assistance, to include counseling and treatment in a military treatment facility.

Retention and Disposition Policy of DoD for MST Records

Question 3: What is the retention and disposition policy of DoD for MST records, restricted and unrestricted, and is that policy different across military service branches?

Answer: The Department has two primary forms used in for documentation of sexual assaults, DD Form 2910, Victim Reporting Preference Statement, and DD Form 2911, Forensic Medical Report: Sexual Assault Forensic Examination.

- Currently, signed and dated copies of DD Form 2910, Victim Reporting Preference Statement, are kept indefinitely by the Military Services by the Sexual Assault Response Coordinator (SARC) to whom the sexual assault was reported. In the Air Force and Army, the forms are kept at the installation where the sexual assault was reported. In the Navy, the forms are entered into its Case Management System—an electronic database. In the Marine Corps, the SARC maintains the form for 3 years and after that time period, the SARC forwards the forms to be maintained at HQ Marine Corps. The Department of Defense is currently formulating additional guidance to standardize the retention, storage and retrievability of both documents in the long term.
- When the DD Form 2911, Forensic Medical Report: Sexual Assault Forensic Examination, is completed by a Department of Defense medical care provider, the

form is to be included as part of the victim's military medical record if the report is unrestricted.

In a restricted report, the DD Form 2911 remains with the Sexual Assault Forensic Examination kits that is maintained by a designated custodian and then is destroyed at the 1-year mark.

Each Service has its own forms and retention policies for sexual harassment complaints:

- In the Army, a formal sexual harassment complaint is filed using a DA Form 7279, *Equal Opportunity Complaint Form.* After a complainant's case is closed, the complaint packet (with DA Form 7279) will be filed by the first Equal Opportunity Advisor (EOA) in the complainant's chain of command. The EOA retains the file for 2 years from the date of the final decision on the case.
- The Navy uses the *Navy Equal Opportunity Formal Complaint Form* (NAVPERS 5354/2) for recording formal harassment complaints. Per the Navy policy, a command must maintain completed complaints and investigations for 36 months.
- The Marine Corps uses the *Equal Opportunity Contact Sheet* to record reports of sexual harassment. Closed complaints are maintained by the receiving command for 2 years.
- The Air Force uses two forms for documenting allegations of sexual harassment: AF Form 1587, *Equal Opportunity Formal Complaint Summary,* and AF Form 1587–1, *Equal Opportunity Informal Complaint Summary.* Hardcopy forms must be kept for a period of 2 years after complaint closure at the installation EO office where the sexual harassment complaint was filed. Additionally, all complaint information is entered in the Air Force Complaint Management System, Equal Opportunity Network (EONet).

Unrestricted Sexual Assault Records

Question 4: If a record of a sexual assault is made unrestricted by the victim, this means a DoD criminal investigation is triggered. It also usually means that the victim has agreed that details of the attack, and his or her identity, can be used in prosecuting a suspect for a sexual assault. What is the reason for maintaining the record associated with the investigation of the unrestricted case (as well as the forensic examination record) in a different place than that of the individual's military personnel record when the victim has given consent that this information can be made available to others? Is there a basis at some point, after the case is disposed of, and perhaps after the victim leaves the military, for the MST record to be filed in the official military personnel record?

Answer: According to the 2006 Defense Manpower Data Center (DMDC) Gender Relations Study, one of the primary reasons victims choose not to report a sexual assault is because they are afraid that doing so negatively impacts their career. Given that, including a copy of the DD Form 2910, Victim Reporting Preference Statement, in a Servicemember's official personnel record could discourage reporting of sexual assault by victims, as they could perceive it could disparage their record and halt their career advancement. Victims also fear losing control of private information. Requiring the DD Form 2910 in official personnel records would further erode a victim's control and privacy, which is already partially destroyed by a sexual assault.

Copies of DD Form 2910, Victim Reporting Preference Statement, are kept indefinitely by the Military Services. For unrestricted reports, the completed DD Form 2911, Forensic Medical Report: Sexual Assault Forensic Examination is part of the Servicemember's military medical record. For restricted reports, DD Form 2911 remains with the Sexual Assault Forensic Examination (SAFE) Kit that is maintained by the designated custodian, and then is destroyed at the 1-year mark.

Restricted Sexual Assault Records

Question 5: In a case of MST where a restricted record is created, does the victim who wants no investigation or prosecution of the perpetrator receive a copy of that completed record for his or her personal information? If not, can you explain why not?

Answer: Yes. The victim receives a signed and dated copy of the completed DD Form 2910, Victim Reporting Preference Statement, for his or her personal information. Below is text from that form encouraging victims to keep a copy for their records:

"NOTICE: DOCUMENTATION FOR RECORD KEEPING PURPOSES. Victims are advised to maintain a signed and dated copy of this form for their records. This form may be used by the victim in other matters before other agencies (e.g., Department of Veterans Affairs) or for any other lawful purpose."

Centrally Archiving MST Records within SAPRO

Question 6: Has consideration been given to centrally archiving MST records within SAPRO itself so that Veterans Business Administration and Veterans Service Officer National Service Officers with power of attorney would have one unified DoD source for searching such records? What are the negative implications for SAPRO's collecting all such reports in a central archive?

Answer: Yes, consideration has been given to centrally archiving MST records. The Department will have a central archive of sexual assault reports when the Defense Sexual Assault Incident Database (DSAID) managed by SAPRO comes online. In order to prevent negative implications such as the unapproved release of personally identifying information (PII), DSAID will not record PII of victims who make restricted reports. Inquiries from the Department of Veterans Affairs about supporting documentation on restricted and unrestricted Reports of sexual assault should be answered by the Military Service that provided assistance, care, and investigative support to that victim.

Percentage of Reported Sexual Assaults

Question 7: Your testimony noted that DoD has found that about 8 of 10 sexual assaults in the military go unreported. Does this number represent an improvement from the percentage that went unreported prior to the implementation of the "restricted reporting" disclosure option?

Answer: The number of victims opting to make a restricted report has increased 18 percent since FY 2007, and has been rising since the inception of the restricted reporting option in 2005. The Department believes these victims would not have come forward had there not been the option for restricted reporting. In addition, given the rise in restricted reporting, the Department believes that the percentage of sexual assaults going unreported is decreasing.

Since 2005, 3,486 victims have made restricted reports. The Department's baseline data started in 2005 when the Sexual Assault Prevention and Response (SAPR) program was put in place.

VA Services for DoD Victims of Sexual Assault

Question 8: Please discuss in greater detail how DoD and VA work together to ensure that transitioning servicemembers who have suffered a military sexual trauma are referred to or informed of the appropriate VA services.

Answer: The Department of Defense (DoD) has been working with the Department of Veterans Affairs (VA) since the inception of the Sexual Assault Prevention and Response (SAPR) program in 2005. One of the key areas of collaboration has been related to documentation. Victims of sexual assault are provided with a signed, dated copy of DD Form 2910, Victim Reporting Preference Statement, that they may present during a disability evaluation should they so choose. The Department provided a blank copy of this form and education about its use to the Veterans Benefits Administration (VBA) in 2007. The VBA agreed to accept the document as evidence of having made a report of sexual assault.

Additional areas of coordination include:

- A representative from VA sits on the Sexual Assault Advisory Council, which is the main oversight body for the Sexual Assault Prevention and Response program in the Department.
- DoD's Sexual Assault Prevention and Response (SAPR) staff team with members of VA's Military Sexual Trauma Support Team brief on their respective programs at national conferences.
- Members of the Department of Defense's SAPR staff have attended Veterans Health Administration's annual training conference for Military Sexual Trauma Coordinators and briefed on the DoD Sexual Assault Prevention and Response Program for the past 3 years.
- DoD participates in VA seminars to educate VA providers about sexual assault and the DoD and VA programs.

- DoD and VA are working on a joint brochure for distribution to Servicemembers leaving active duty to remind them of the sexual assault support services available within each Department.

To ensure the Department of Defense does not overlook any potential area of connection, the DoD SAPR staff meet with a variety of veterans groups to identify any gaps there might be related to the issue of sexual assault as Servicemembers transition from active duty to veteran status. Meeting with non-governmental groups, such as Iraq and Afghanistan Veterans of America and the National Organization for Women, has provided a fuller understanding of the challenges that veterans might be experiencing.

Disciplinary Actions Taken against Servicemembers Convicted of Sexual Assault

Question 9: Please describe in detail the disciplinary actions taken against servicemembers convicted of a sexual assault. Please describe the range of severity of the punishments available, and how the specific disciplinary action taken is determined in each case.

Answer: Disciplinary actions taken against Servicemembers convicted of a sexual assault follow the Uniform Code of Military Justice (UCMJ). Convictions for sexual assault may result in confinement, reductions in rank, forfeiture of pay and allowances, and/or punitive discharge from Service, or any combination. Under Article 120 of the UCMJ, the maximum punishment for the crime of rape is "Death or such other provided punishment as a court martial may direct."

Commanders have discretion under the UCMJ to dispose of offenses by members of their command. Disposition of offenses range from administrative action to courts-martial, depending on the severity of the offense and the evidentiary considerations.

Educating Servicemembers on Reporting MST

Question 10: What steps has DoD taken to educate servicemembers on how to go about reporting MST and how to do so anonymously, if they feel that is necessary?

Answer: The DoD Instruction 6495.02, Sexual Assault Prevention and Response Program Procedures, requires that every Servicemember receive training on the restricted and unrestricted reporting options for sexual assault, and how to report an incident. As a result, the Military Services have incorporated training about sexual assault reporting and prevention into a wide variety of settings, including:

- Accession Training
- Annual Training
- Professional Military Education
- Leadership Development Training
- Pre-Command Training
- Flag and General Officers/Senior Executive Service Training
- Training for civilians who supervise Servicemembers
- Pre-Deployment Training
- Post-Deployment Reintegration Training

This training is supported by a numerous reminders of how to prevent and respond to sexual assault, including posters, brochures, Web sites, and public service announcements.

The assessment of the lasting awareness of these outreach and training efforts is key to ensuring these messages are being retained as desired. To that end, as part of the strategic plan for the Office of the Under Secretary of Defense for Personnel and Readiness, the Department will be measuring awareness levels and adjusting outreach and training as appropriate.

Deployed vs. Home Reporting

Question 11: Where do most reporting events occur? How easy is it for someone to report an event in a combat theater of operations vs. being on home base.

Answer: According to the 2006 Gender Relations Survey of the Active Duty by the Defense Manpower Data Center, of the 6.8 percent of women and 1.8 percent of men who indicated they had experienced an incident of unwanted sexual contact in the 12 months prior to the survey, three-quarters of respondents indicated that it occurred at a military installation. Also, about two-thirds of respondents indicated

the incident occurred at their current permanent duty station which could also be a military installation. Additionally, 28 percent of women and 44 percent of men indicated that the incident occurred while deployed.

Sexual assault may be reported anywhere. The Department has sexual assault response coordinators, victim advocates, and other personnel who may receive a restricted or unrestricted report are stationed in garrison and deployed around the world. Annual refresher training and pre-deployment training is designed to remind Servicemembers of their sexual assault reporting options and how to make a report no matter their location.

Given the nature of war, certain areas in the combat theater of operations may pose unique challenges to Servicemembers' immediately accessing sexual assault response personnel. Sexual assault response personnel receive specialized training on how to receive reports at home base and in combat theater of operations.

Access to DoD Restricted MST Reports

Question 12: Some other witnesses testified about the need for gaining access to DoD's restricted MST reports in order to provide documentation for service connection. What do you think of that suggestion? Do you have any concerns regarding privacy or other issues when outsiders are given access to these confidential documents?

Answer: The greater the number of individuals given access to confidential documents, the less confidential those records become. Even with strict safeguards, the situation that many victims fear is losing control of their private information. Department surveys show that victims of sexual assault do not report the assault to an authority because they feel uncomfortable making a report, think they will be labeled a troublemaker, and do not want anyone to know about the incident. Victims who make restricted reports do so because they fear the negative repercussions of being a victim of sexual assault.

Victims should certainly have access to their records. For example, they can access their records under the Privacy Act. That access should be provided in a way that best guards their confidentiality. Others who seek documentation to determine service connection should inquire with the Military Service that provided assistance, care, and investigative support, and obtain consent from the victim to access the victim's records.

Sexual Assault Prevention and Response efforts with National Guard and Reserve Forces

Question 13: Can you comment on sexual assault prevention and response efforts with National Guard and Reserve forces? Is data from Guard and Reserve components studied and included in your reports? If not, why not and how can we correct this oversight?

Answer: The Department's Sexual Assault Prevention and Response (SAPR) policy applies to activated National Guard and Reserve members who are sexually assaulted when performing active service and inactive duty training. The Service Secretaries are responsible for establishing comprehensive SAPR policies, procedures, and programs and ensure implementation, monitoring, and evaluation at all levels of military command, including those levels at the National Guard and Reserve components, and training for members of their Military Departments.

The Department has also incorporated the National Guard and Reserve components into its oversight framework and works with closely with the respective SAPR program managers to ensure program accountability. Data from the Guard and Reserve components are studied and included in the Department of Defense Annual Report on Sexual Assault in the Military. The National Guard Bureau is currently working with the Department in the development of the Defense Sexual Assault Incident Database to record and manage all reports of sexual assault involving members of the National Guard into the system.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Subcommittee on Health
Washington, DC.
June 14, 2010

Susan McCutcheon, R.N. Ed.D.
Director, Family Services, Women's Mental Health and Military Sexual Trauma
Office of Mental Health Services, Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20240

Dear Ms. McCutcheon:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs' and Subcommittee on Health's joint oversight hearing on, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," held on May 20, 2010. We would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Wednesday, July 21, 2010.

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Sincerely,

John J. Hall
Chairman
Subcommittee on Disability Assistance and Memorial Affairs

Doug Lamborn
Ranking Member
Subcommittee on Disability Assistance and Memorial Affairs

Michael H. Michaud
Chairman
Subcommittee on Health

Henry E. Brown, Jr.
Ranking Member
Subcommittee on Health

Questions for the Record
The Honorable John Hall, Chairman, The Honorable Doug Lamborn, Ranking Member, Subcommittee on Disability and Memorial Affairs and The Honorable Michael Michaud, Chairman, The Honorable Henry Brown, Jr., Ranking Member, Subcommittee on Health, House Committee on Veterans Affairs, Healing the Wounds: Evaluating Military Sexual Trauma Issues, May 20, 2010

Question 1: In addition to PTSD, experts point out that Military Sexual Trauma (MST) can also lead to women's cancer and sexual transmitted diseases amongst men and women. To combat these diseases, stakeholders recommend that DoD and VHA dedicate greater funding on research and screening that is gender specific. What is VHA's position and plans on this viewpoint?

Response: VA fully supports research on the critically important impact of military sexual trauma (MST) on the health of Veterans—both women and men. VA research has clearly indicated that MST is associated with wide range of diverse physical and mental health outcomes, including sexually transmitted diseases (STDs) and Post-Traumatic Stress Disorder (PTSD). MST research will continue to be a high priority for VA, as our understanding of its health consequences (including possible links to cancer) leads to better screening, treatment, and improvements in care and health.

VA research has recognized the need for gender specific approaches and for better understanding of gender differences related to MST. Currently, VA has a number of research studies that are examining gender differences related to MST. One of these studies is examining the impact of gender, combat and sexual trauma, and

other factors on medical and psychiatric outcomes and stress associated condition. A second study is examining the stigma and gender differences in barriers to health care use, including those related to sexual assault.

The first comprehensive evaluation of VA's mandated MST screening and treatment program included both female and male Veterans, and suggested that the comprehensive VA policies surrounding MST are of significant clinical benefit for patients. An ongoing study is further analyzing VA's MST screening assessment tools including differences in interpretation and responses to the screening questions by gender.

In addition to focusing on gender-specific issues, several studies addressing the health consequences of sexual assault, MST, and other military traumas include a focus on STDs and women's cancer. VA research has found that MST is associated with a number of chronic medical conditions, as well as obesity or weight loss among women. Several VA studies are now analyzing the relationships between sexual violence and women Veterans' gynecological health, including associations between sexual assault and sexual risk behaviors, barriers to obtaining gynecological examinations and cervical cancer screening, and the incidence and prevalence of abnormal cervical cytology (which could lead to cervical cancer if untreated).

A longitudinal study of both male and female Marines is also examining MST effects on health behavior, including the association between MST and cancer and STDs, as well as actual health outcomes related to cancer and STDs. A new VA study of Vietnam women Veterans will provide another opportunity to assess the relationships between stressful and traumatic experiences and mental and physical health outcomes, including cancers.

VA plans to continue the important focus on research related to the health consequences of MST. Expanded research informatics (for example, linking screening and clinical reminders) and research infrastructure capabilities, like the Women Veterans' Practice-based Research Network (PBRN) will support this research and gender-specific approaches to improve screening, access to care and treatments that best meet the needs of Veterans who have experienced MST. The PBRN involves development of infrastructure and building of research capacity in order to examine new treatments, quality performance and improvements, models of care (e.g., integrated mental health and primary care), and provider education and training innovations. The PBRN will facilitate VA research-clinical partnerships to enhance the implementation and dissemination of innovations and best practices. It also seeks to build capacity in VA women's health research, facilitate meeting Federal requirements to recruit and include women in relevant VA research locally and across sites, and to facilitate testing and disseminating VA-based women's health-related interventions.

Question 2: We also understand that many MST treatment programs and residential facilities don't offer separate settings for men and women victims. MST victims complain that Veterans Health Administration (VHA) treatment programs lack the privacy needed for them to open up concerning their injuries. More alarming are reports that MST victims in mixed-gender settings are being sexually harassed by other patients and even health providers. Can you point out any downside of segregating patients by gender, and if you favor gender specific treatment facilities for MST victims, what resources are needed to make this a reality?

Response: The recently issued Uniform Mental Health Services Handbook codifies the longstanding VA practice of promoting treatment in environments that are sensitive to gender-related issues. For example, all inpatient and residential programs must provide separate and secured sleeping accommodations for women. Mixed gender units must ensure safe and secure sleeping and bathroom arrangements, including, but not limited to, door locks and proximity to staff.

For a subset of Veterans, there are advantages to models of care in which treatment occurs in an environment where all Veterans are of one gender. Both male and female survivors of MST may have concerns about their safety, ability to disclose and engage fully in treatment, and address gender-specific concerns in mixed gender environments.

Among VA's residential programs that provide specialized MST-related care, approximately half treat only women, and one treats only men. Veterans who feel a strong need for a same gender treatment environment would be able to receive MST-related mental health care from these programs with a single gender environment.

There are also advantages to mixed gender programs that provide specialized MST-related care to include: helping survivors to challenge assumptions and confront fears about the opposite sex; fostering respect for appropriate boundaries in relationships; and promoting an emotionally corrective experience. Also, mixed-gen-

der treatment programs can help improve accessibility to care and maximize efficient use of resources. This is particularly true for programs operating on "cohort" models in which a program runs a specified number of weeks with a group of patients beginning and ending the program together.

Given there are advantages associated with each approach, VA does not promote one model as universally appropriate for all treatment settings. Rather, we encourage careful consideration of the needs of specific Veterans and use of single-gender programs when they are clinically appropriate.

Sexual harassment from VA employees is unacceptable and is subject to disciplinary action. Sexual harassment by another Veteran resident is also unacceptable and subject to disciplinary action. With respect to sexual harassment from other Veterans, each resident is provided sexual harassment prevention training as part of his/her orientation to the program. Annual safety and security reviews of mental health residential programs carefully monitor compliance with this requirement. Should sexual harassment occur, victims are provided support and more extensive clinical intervention and psychotherapeutic support as clinically indicated. The treatment team also addresses the sexual harassment clinically with the perpetrator to ensure that it does not re-occur. During this clinical interaction, staffs work with the perpetrator to assess the factors leading up to the event and provide counseling to the Veteran and any needed adjustments to the treatment plan. As one potential result of such an event, disciplinary action by the treatment team can include counseling, restrictions and/or discharge from the program. Staffs treat reports of possible criminal activity with the highest priority, including notifying the appropriate law enforcement agency, which could include VA Police in accordance with VA policy and regulations. More generally, the VA's MST Support Team, a national education and monitoring team established by VA Office of Mental Health Services, fosters discussion among providers and program directors about the potential impact of additional sexual harassment for survivors of previous sexual trauma.

Question 3: If a Veteran is uncomfortable with the gender of an MST coordinator at a given VA facility, is there a protocol to match them with somebody else able to perform a similar role?

Response: The facility MST Coordinator focuses on ensuring that the facility meets mandates related to screening, treatment, education/training, and outreach. MST Coordinators in many cases serve as the initial point of contact for MST survivors entering the system before they are assigned to a clinical provider who will work with them on an ongoing basis. If a Veteran does not feel comfortable having even this initial contact with an individual of a certain gender, facilities will make arrangements as needed to assist the Veteran in engaging in care without necessitating a meeting with the MST Coordinator. With regard to treatment, national outreach materials specifically state that "Veterans should feel free to ask to meet with a provider of the same or opposite sex if it would make them feel more comfortable." Furthermore, the Uniform Mental Health Services handbook strongly encourages facilities to give Veterans the option of being assigned a same-sex mental health provider or an opposite-sex provider if the trauma involved a same-sex perpetrator.

Ensuring the capacity of facilities to be able to meet this request for a preferred provider gender is a priority for the Office of Mental Health Services. To determine this capacity the VA's MST Support Team is preparing an in depth study of providers of MST-related mental health care. This study will elucidate several important factors about providers of MST-related care, and will: a) determine the number of unique providers at each facility who deliver MST-related mental health care and describe the characteristics of those providers, and b) assess the relationship of provider gender to patient gender to determine whether patients are able to express preferences for same gender providers, as is VHA policy. These study deliverables will provide important information in helping to ensure sufficient capacity for specialized MST-related mental health services at each VHA facility.

Question 4: Please elaborate on VA's separate-gender treatment programs. How many women-only programs does VA have for treatment of MST and PTSD?

Response: Many facilities have specialized outpatient mental health services focusing on women and/or sexual trauma. For Veterans who need more intense treatment and support, there are also 8 programs that provide specialized women's mental health care in residential or inpatient settings. One additional VA program provides specialized care for women in a residential setting in conjunction with a local non-VA non-profit program for homeless and at-risk Veterans. These programs are considered regional and/or national resources, not just a resource for the local facility. Some of these specialized women's programs focus on MST only, while others focus on specialized women's care in general (including MST). These programs are

a subset of the larger number of programs able to provide specialized care in a VA residential or inpatient setting for mental health conditions related to MST.

Question 5: Dr. McCutcheon, we understand that VHA is treating almost 75,000 Veterans for sexual trauma related injuries. Your testimony suggests that Veterans who are denied VBA disability benefits based upon the finding that their sexual trauma-related injuries are not service-connected, may still be entitled to treatment by the VHA if your therapists conclude that the injuries suffered by Veterans are service-connected. Should VBA provide greater weight to the medical findings of trained VHA therapists and health professionals re: service-connection injuries from MST?

Response: As stated in testimony, Veterans are entitled to free VHA counseling and care and services to overcome 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 whether or not their disabilities are service-connected.

Service-connection and disability ratings are determined by the Veterans Benefit Administration (VBA) based on all the evidence of record. VBA considers the findings of VHA's trained therapists with respect to diagnosis, service connection, and extent of a Veteran's disability. VBA adjudicators assign weight to the evidence according to its credibility and other factors. In some cases, VBA asks VHA professionals to review a Veteran's records to see if there are markers that can be found denoting reduced level of functioning.

Question 6: In your estimation, of the Veterans treated by VHA for sexual trauma injuries, what percentage of such Veterans has service-connected conditions?

Response: Of the 37,132 female MST positive Veterans who received MST-related outpatient care from VHA in fiscal year (FY) 2009, 68.1 percent had service connection as indicated on their VHA medical record. Of the 24,826 male MST positive Veterans who received MST-related outpatient care from VHA in FY 2009, 54.9 percent had service connection as indicated on their VHA medical record. Based on the available data we are unable to determine if their service connection was for injuries or conditions related to their MST.

Question 7: Disabled American Veterans (DAV) cited in its testimony the effectiveness of prolonged exposure therapy and advocated for its universal expansion to VA Medical Centers for treating MST. Does VA have plans to expand the use of such therapy? If so, please elaborate.

Response: As part of its commitment to making the best treatments available to Veterans, VA has provided national training to disseminate and implement both Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT), and continues to provide such training to additional staff. These two evidence-based psychotherapies for PTSD are recommended in the VA/Department of Defense Clinical Practice Guidelines for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." Both PE and CPT have been examined in a number of randomized controlled trials and shown to be effective, in similar degree, for PTSD related to multiple types of trauma, including sexual trauma and combat-related trauma. In addition, they are recognized in the 2008 Institute of Medicine report, "Treatment of Post-Traumatic Stress Disorder", as the only therapies with proven effectiveness for treatment of PTSD. PE and CPT are used throughout VHA to treat Veterans with PTSD related to military sexual trauma (as well as to other types of trauma), and VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, now requires that all Veterans with PTSD have access to PE or CPT.

As part of VA's efforts to make PE and CPT widely available to Veterans, VA's national-level programs have trained more than 2,700 VA mental health staff in PE and/or CPT. In addition, more than 400 VA mental health staff are being trained in the use of Cognitive Behavioral Therapy (CBT) or Acceptance and Commitment Therapy (ACT) for depression, the second most common mental health diagnosis for women Veterans clinically judged to be a consequence of MST. The training for all of these psychotherapies includes specific information relevant for adapting the clinical approach for Veterans whose mental health problems are a result of MST. The MST Support Team has worked with each of these national initiatives to include materials relevant to MST survivors and to promote attendance by clinicians working with MST survivors.

Initial program evaluation data show significant gains in therapist competency following the training, as well as significant clinical improvements among Veterans

receiving these treatments. Plans are underway to provide additional, intensive staff training in PE, CPT, CBT, and ACT in FY 2011, with a focus on sites that have fewer trained staff in these therapies. Plans are also underway to establish decentralized training capacity within all Veterans Integrated Service Networks (VISNs), further broadening dissemination and promoting sustainability over time.

Question 8: VA's efforts to screen all Veterans accessing VHA for MST are to be commended. However, this screening does not capture Veterans who are not seeking care through VHA. What is VA doing to reach out to Veterans who are victims of MST but who have not accessed VHA?

Response: VA recognizes the importance of engaging in outreach to ensure that Veterans are aware VA has MST-related services available. VA conducts outreach in accordance with existing statutory authority and VHA policy. To this end, the VA's MST Support Team has developed MST-related educational handouts, posters and brochures to educate Veterans about VA services, describe symptoms associated with sexual trauma, and highlight the availability of effective treatments. These materials are distributed to MST Coordinators who display them in VHA facilities and distribute them to local communities. This includes reaching out to local military bases and/or attending demobilization events when appropriate. MST Coordinators often receive invitations to present at local events and will take this opportunity to speak about VA's services and general commitment to this issue.

Question 9: The American Legion's statement for the record discusses the work of their services officers in helping women Veterans receive treatment and compensation for conditions that result from military sexual trauma. Does VA collaborate with American Legions service officers and those of other VSOs?

Response: Yes, VA has coordinated nationally with the American Legion to distribute outreach materials. Also, at the local level many MST Coordinators and facilities work collaboratively with partner organizations to engage in outreach and other activities.

Question 10: In her testimony, Dr. Whitley stated that reports of sexual assault have increased about 10 percent annually over the past 3 years, due to outreach and education. As DoD has persuaded more victims of MST to come forward, has VA experienced an increase in the number of Veterans seeking treatment for MST? If not, do you anticipate an increase, or were many of the Servicemembers now coming forward while in service already willing to seek treatment through VA?

Response: Surveillance reports from the VA's MST Support Team indicate that in the past 3 years, the proportions of VHA patients who report MST have remained relatively constant, ranging from 21.9–22.2 percent among women, and 1.1–1.3 percent among men. However, as the total numbers of Veterans seeking VHA care increases, there has been a corresponding increase in absolute numbers of MST patients. The proportions of these patients who receive MST-related care each year is also increasing, with the highest increases being among Veterans recently returned from Iraq and Afghanistan.

However, it is important to note that there are several complications to comparing DoD figures and VHA MST surveillance data. First, pursuant to 38 U.S.C. 1720D, VA is authorized to treat both sexual assault and sexual harassment under a single construct, Military Sexual Trauma. DoD's Sexual Assault Prevention and Response Office (SAPRO) figures reflect only sexual assault. Also, because only a portion of Veterans ever seek VA care after separation from military service, estimates of the prevalence of MST in VA health care are not reliable indicators of overall increases in the prevalence of sexual assault or sexual harassment in the general Veteran population. Shifts in DoD rates of reported sexual assault may or may not correspond with an increased rate of Veterans seeking care from VHA. Finally, Veterans need not have reported MST during military service to receive MST-related care from VHA after separating from military service. Veterans captured in VA figures may or may not be the Veterans captured by SAPRO figures.

Question 11: Does VA offer any other intensive inpatient MST programs besides the National Women's Trauma Recovery Program in California?

Response: Veterans with experiences of MST can receive treatment through most of VA's residential/inpatient treatment programs. There are 14 programs able to provide specialized care in a VA residential or inpatient setting for mental health conditions related to MST. One additional program provides specialized care in a residential setting in conjunction with a local non-profit program for homeless and at-risk Veterans. These programs are considered regional and/or national resources, not just a resource for the local facility. Eight of these residential/inpatient pro-

grams are MST/sexual trauma treatment programs. Six of these residential/inpatient program are more general treatment programs that have multiple staff with expertise in MST/sexual trauma. Although these programs do not necessarily have an explicit focus on MST/sexual trauma, staff can often work individually with Veterans who need MST-specific care as an adjunct to the care they receive through the more general program. Veterans also may be able to receive specialized MST-related group or individual therapy through the outpatient clinic at the facility that offers the specialized residential or inpatient program.

Question 12: Once a Veteran screens positive for having suffered an MST, what steps does VA take? What happens to those Veterans who decline treatment? Does VA take special steps to help this subset of Veterans?

Response: All Veterans seen in VHA are screened for MST. Those Veterans who screen positive are offered a referral for free MST-related care. If a Veteran refuses this referral, clinicians respect this decision, recognizing that there are many good reasons why a Veteran may decline a referral for care at the time of screening positive. Some Veterans may not feel ready to enter treatment; others may have engaged in treatment in the past and/or feel that their experiences of MST are not currently impacting their lives in a way that warrants current treatment. Veterans who screened positive but who decline a referral are informed that if they change their mind, they may request services at any time in the future. Clinicians also make outreach and informational materials on MST and the local MST Coordinator's name and contact information available to Veterans who screen positive.

Question 13: What is the extent of the coordination between VA and DoD to prevent incidents of MST?

Response: As a health care system working primarily with Veterans and other individuals already discharged from the military, VA's prevention efforts mainly address secondary and tertiary prevention issues—that is, prevention of developing or worsening of aftereffects related to MST. VA is not in a position to address primary prevention—that is, prevention of experiences of MST to begin with—but has developed a strong collaborative working relationship with the DoD's SAPRO in order to facilitate coordination of responses across the Departments. In an effort to ensure that all providers and staff are aware of each Department's services, VA's national MST Support Team and DoD's SAPRO have presented at each others' national MST/sexual assault trainings. The two entities also communicate as needed to help connect individual Veterans to services that match their treatment needs.

Question 14: Ms. Bhagwati's testimony stated that MST survivors describe the horror of using VA Medical Centers nationwide. She also asserts that Veterans are often ignored, isolated, or misunderstood at VA facilities because their PTSD is not combat-related and that women who do attend the residential treatment programs have experienced sexual harassment by staff or fellow patients. Please respond to this testimony.

Response: We regret that Ms. Bhagwati has this perspective of VA care, and would be happy to work with her to hear more about her concerns and share more about what we have done and continue to do to ensure accessible, quality care for MST survivors. Please also note the earlier response to Question 2. VA's commitment to such care is established in longstanding VA policies and most recently reinforced in VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics." The Handbook contains key provisions addressing the treatment of conditions related to MST. For example, all Veterans seeking VA care must be screened for MST and all Veterans who screen positive for MST are entitled to free VHA counseling and care and services to overcome psychological trauma as described in 38 U.S.C. 1720D(a)(1). Every facility must have a designated MST Coordinator who serves as the point of contact for MST-related issues, including staff education and training and monitoring of MST-related screening and treatment. MST is an experience that is associated with a number of health conditions, necessitating both widespread working knowledge of issues related to MST among VA staff in general as well as the availability of providers with specialized expertise in this area who can provide targeted evidence-based care.

Further reflecting its commitment to ensuring that Veterans receive the support they need and deserve, in FY 2007, the OMHS established a national-level VA Military Sexual Trauma (MST) Support Team to conduct monitoring of MST screening and treatment, to oversee MST-related education and training, and promote best practices in care for Veterans who experienced MST. As noted earlier, OMHS has funded national training initiatives to promote evidence-based practices for PTSD, depression, and anxiety. Because these conditions are commonly associated with

MST, these national initiatives have been an important means of expanding MST survivors' access to cutting-edge treatments. Several of these treatments were developed and originally tested primarily with rape victims and child sexual abuse survivors. As such, the MST Support Team has worked with each of these national initiatives to include materials relevant to MST survivors and to promote attendance by clinicians working with MST survivors.

Additionally, the MST Support Team is completing a study of patient perceptions of the quality of VHA health care among Veterans who are MST survivors. Results revealed that patient perceptions of overall quality ratings were fairly high for both men (78.5 percent) and women (72.3 percent), and did not significantly differ among patients who did and did not report MST. These results suggest that MST patients' perceptions of overall quality of care are commensurate to those of other VHA outpatients.

Committee on Veterans' Affairs
Subcommittee on Disability Assistance and Memorial Affairs
Washington, DC.
June 23, 2010

Bradley G. Mayes
Director, Compensation and Pension Service
Veterans Benefits Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20402

Dear Mr. Mayes:

Thank you for testifying at the House Committee on Veterans' Affairs' Subcommittee on Disability Assistance and Memorial Affairs' and Subcommittee on Health's joint oversight hearing on, "Healing the Wounds: Evaluating Military Sexual Trauma Issues," held on May 20, 2010. I would greatly appreciate if you would provide answers to the enclosed follow-up hearing questions by Thursday, July 21, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for material for all full committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively on letter size paper, single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your responses to Cecelia Thomas by fax at (202) 225–2034. If you have any questions, please call (202) 225–3608.

Sincerely,

John J. Hall
Chairman

Questions for the Record
House Committee on Veterans' Affairs, The Honorable John J. Hall, Chairman, Subcommittee on Disability Assistance and Memorial Affairs, "Healing the Wounds: Evaluating Military Sexual Trauma Issues"
May 20, 2010

Question 1. One witness today urged DoD to enter into a MOU to share with VA records and other information related to MST claims. Does VBA believe that it has the access to DoD files, particularly restricted records, needed to properly adjudicate MST claims?

Response: An MOU between VA and DoD outlining each agency's role will be explored. VBA released Fast Letter 10–25 on July 15, 2010, outlining the roles and responsibilities of each agency, and a process will be put in place to ensure that these procedures are clear and available to all. The Fast Letter also updated procedures that require regional offices to request and accept DoD Form 2910, *Victim Reporting Preference Statement* and Form 2911, *Forensic Medical Report: Sexual As-*

sault Examination, along with other similar forms, as corroborating evidence of a report of MST.

Question 2. I appreciate that VBA has provided its claims personnel a training letter describing special processing methods involving MST related claims and that all regional offices have a Women's Veteran Coordinator, who is well-versed in MST issues. Yet, given the complexity of MST and the often hidden wounds, many stakeholders suggest that VBA provide more training and other resources to its staff to address MST related claims. How does VBA respond to this recommendation? What more do you plan to do or should be done?

Response: VBA agrees with this recommendation and has already increased the number of conference calls with WVCs from quarterly to monthly. These conference calls routinely address the sensitivity of handling MST claims and feature guest speakers who specialize in the needs of women Veterans and personal trauma issues. At the 2009 WVC Training Conference, a VHA staff psychologist spoke on the care that VA provides for MST and how MST affects the men and women who experience this trauma (physiologically, emotionally and cognitively). VBA will continue to provide this specialized training in future conferences. Meanwhile, VBA hosts information regarding Women Veterans on our WVC SharePoint site. VBA continues to strengthen the training programs for all staff engaged in claims development and rating of MST cases.

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