

William & Mary Journal of Race, Gender, and Social Justice

Volume 19 (2012-2013)
Issue 3 *William & Mary Journal of Women and
the Law*

Article 6

May 2013

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Reid C. Schweitzer, *Veterans Affairs Benefits for Sexually Assaulted Male Veterans*, 19 Wm. & Mary J. Women & L. 637 (2013), <https://scholarship.law.wm.edu/wmjowl/vol19/iss3/6>

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VETERANS AFFAIRS BENEFITS FOR SEXUALLY ASSAULTED MALE VETERANS

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INTRODUCTION

The prevalence of sexual assault in the military is startling. The Department of Defense estimates that 19,000 servicemembers are raped or sexually assaulted every year.¹ There is evidence that same-sex rape is more common in the military than in the civilian population,² and some research has shown that the occurrence of sexual assault may be twice that of sexual assault in the general

1. DEP'T OF DEF., DEPARTMENT OF DEFENSE ANNUAL REPORT ON SEXUAL ASSAULT IN THE MILITARY: FISCAL YEAR 2010 97 (2011), *available at* http://www.sapr.mil/media/pdf/reports/DoD_Fiscal_Year_2010_Annual_Report_on_Sexual_Assault_in_the_Military.pdf (basing its data on 2,617 reported incidents of unwanted sexual contact, comprising approximately 13.5 percent of all incidences that took place in 2010, estimated at 19,000). Of those 2,617 incidences that were reported, 529, or about 20 percent, resulted in criminal charges brought in courts martial. *Id.* at 72. Less than half of the alleged assailants had any action brought against them at all by the military, including nonjudicial punishment and administrative discharge. *See id.*

2. MICHAEL SCARCE, MALE ON MALE RAPE: THE HIDDEN TOLL OF STIGMA AND SHAME 44 (1997).

population.³ The problem is highlighted by the number of veterans who have experienced Military Sexual Trauma (MST). According to the Department of Veterans Affairs (VA), “[a]bout 1 in 5 women and 1 in 100 men seen in [the Veterans Health Administration] respond ‘yes’ when screened for MST.”⁴

While sexual assault may be viewed as an issue that primarily affects women, a substantial number of men have been found to be survivors of sexual assault.⁵ Because the military is overwhelmingly male, the number of men and women reporting military sexual trauma are about equal.⁶ From 2002 to 2003, the Veterans Health Administration (VHA) found that although women as a group reported much higher rates of MST (twenty-two percent of female veterans screened) than men (about one percent of male veterans screened), the number of women and men that screened positive for MST were 29,418 and 31,797, respectively.⁷ Another issue that complicates MST is the rate of reporting. It has been suggested that sexual assaults of both men and women are not reported in sixty percent⁸ to eighty percent of cases.⁹ Given that “male rape survivors are much less likely to report” than female rape survivors,¹⁰ it logically follows that the rate of under-reporting is even higher than sixty to eighty percent for men. When combined with the 31,797 reported veterans who have experienced MST, one can conclude that there are undoubtedly tens of thousands of unaccounted-for veterans who are also survivors, the majority of whom are likely men. Therefore, while sexual assault disproportionately affects women, significant attention and resources must also focus on male veterans and servicemembers who have survived MST.

The purpose of this Note is twofold. The first purpose is to explore the status of and particular issues that affect male veterans

3. *Sexual Assault in the Military Part Three: Context and Causes: Hearing Before the Subcomm. on Nat'l Sec. & Foreign Affairs of the H. Comm. on Oversight & Gov't Reform*, 111th Cong. 29 (2009) (statement of Helen Benedict, Professor of Journalism at Columbia University).

4. MILITARY SEXUAL TRAUMA, DEP'T OF VETERANS AFFAIRS (2010), available at <http://www.mentalhealth.va.gov/docs/MilitarySexualTrauma-new.pdf>.

5. See Rachel Kimerling et al., *The Veterans Health Administration and Military Sexual Trauma*, 97 AM. J. PUB. HEALTH 2160, 2160 (2007) [hereinafter Kimerling et al., *The Veterans Health Administration*].

6. MILITARY SEXUAL TRAUMA, *supra* note 4.

7. Kimerling et al., *The Veterans Health Administration*, *supra* note 5, at 2162.

8. *Sexual Assault in the Military Part Three: Context and Causes: Hearing Before the Subcomm. on Nat'l Sec. & Foreign Affairs of the H. Comm. on Oversight & Gov't Reform*, 111th Cong. 2 (2009) (statement of Hon. John F. Tierney, Chairman, Subcomm.).

9. *Id.* at 4.

10. SCARCE, *supra* note 2, at 16.

who have experienced MST as related to the VA.¹¹ Specifically, this Note will address the special problems that veterans who have experienced MST encounter when applying for disability benefits related to sexual trauma.¹² The second purpose is to assess current efforts to improve the resources aimed at survivors of sexual assault and veterans' access to them.¹³

I. EFFECTS OF SEXUAL ASSAULT ON MALE SURVIVORS OF MILITARY SEXUAL TRAUMA (MST)

Research indicates that more than half of veterans that screen positive for MST suffer from Post-Traumatic Stress Disorder (PTSD).¹⁴ PTSD is “an anxiety disorder that occurs after a traumatic event in which a threat of serious injury or death was experienced or witnessed, and the individual’s response involved intense fear, helplessness, or horror.”¹⁵ Symptoms of PTSD include “[r]ecurrent and intrusive distressing recollections of the event,” avoiding “activities, places, or people that arouse recollections of the trauma,” “hyper-vigilance,” and social or occupational impairment.¹⁶ A further complication in male PTSD sufferers is the high likelihood of alcohol or other substance abuse.¹⁷ Male veterans have been found to have a higher rate of alcohol and drug abuse than female sufferers.¹⁸ One study found that nearly one-quarter of PTSD-diagnosed veterans of Operation Enduring Freedom and Operation Iraqi Freedom presented with substance abuse issues.¹⁹

In addition to the typical PTSD symptomology, male sexual assault survivors with PTSD often react in specific ways.²⁰ Acute

11. *See infra* Part I.

12. *See infra* Part II.

13. *See infra* Parts IV, V.

14. Rachel Kimerling et al., *Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning from Afghanistan and Iraq*, 100 AM. J. PUB. HEALTH 1409, 1410–11 (2010) [hereinafter Kimerling et al., *Military-Related Sexual Trauma*].

15. INVISIBLE WOUNDS OF WAR: PSYCHOLOGICAL AND COGNITIVE INJURIES, THEIR CONSEQUENCES, AND SERVICES TO ASSIST RECOVERY, RAND CTR. FOR MILITARY HEALTH POLY RESEARCH 12 (Terri Tanielian & Lisa H. Jaycox eds., 2008), available at <http://www.rand.org/pubs/monographs/MG720.html>.

16. *DSM Criteria for PTSD*, NAT'L CTR. FOR PTSD, U.S. DEP'T OF VETERANS AFFAIRS, <http://www.ptsd.va.gov/professional/pages/dsm-iv-tr-ptsd.asp> (last visited Mar. 23, 2013).

17. Shira Maguen et al., *Gender Differences in Military Sexual Trauma and Mental Health Diagnoses Among Iraq and Afghanistan Veterans with Posttraumatic Stress Disorder*, 22 WOMEN'S HEALTH ISSUES e61, e64 (2012).

18. *Id.*

19. *Id.* at e61, e64.

20. *E.g.*, SCARCE, *supra* note 2, at 20–21.

reactions include, “physical trauma, skeletal muscle tension, gastrointestinal irritability, genitourinary disturbance, and a wide gamut of emotional reactions.”²¹ Long-term reactions include:

increased motor activity (such as changing residence or traveling for support), disturbing dreams and nightmares, and “traumatophobia,” which includes such responses as fear of indoors if the survivor was raped in bed, fear of outdoors if the survivor was raped outside of his home, fear of being alone, fear of crowds, fear of people walking behind him, and a fear of engaging in or resuming consensual sexual activity.²²

These effects “can last a lifetime, especially in the absence of therapeutic treatment and a strong social support system from family or loved ones.”²³

Some reactions to sexual trauma may have adverse effects on the survivor’s ability or willingness to seek proper treatment. Survivors may exhibit amnesia, especially as to the event or events that caused the veteran’s difficulties.²⁴ This symptom “provide[s] a defensive wall by protecting the survivor from his own memory of the assault[,]” allowing him to “dissociate from [his] pain as a protective mechanism[]” and may “continue long term.”²⁵

Survivors of sexual assault commonly do not report their assaults to the authorities.²⁶ MST survivors face additional factors that further inhibit reporting assaults to the authorities.²⁷ MST survivors are often lower level enlisted men.²⁸ Their assailants are also typically fellow servicemembers, meaning that survivors are likely to be forced to see and interact with their attacker in the workplace.²⁹ This only increases the potential for subsequent abuse.³⁰ With that in mind, MST survivors may feel pressured against reporting so as not to disrupt unit cohesion.³¹ Furthermore, the general atmosphere of scrutinized masculinity may dissuade a male

21. *Id.* at 20.

22. *Id.* at 21.

23. *Id.* at 22.

24. *Id.*

25. *Id.* at 22–23.

26. Michael King et al., *The Prevalence and Characteristics of Male Sexual Assault*, in MALE VICTIMS OF SEXUAL ASSAULT 1 (Gillian C. Mezey & Michael B. King eds., 2d ed. 2000).

27. SCARCE, *supra* note 2, at 47; Kimerling et al., *The Veterans Health Administration*, *supra* note 5, at 2160.

28. See, e.g., SCARCE, *supra* note 2, at 47 (depicting a British military initiation ceremony in which soldiers and officers beat and sexually assault new recruits).

29. Kimerling et al., *The Veterans Health Administration*, *supra* note 5, at 2160.

30. *Id.*

31. *Id.*

MST survivor from opening himself up to attacks on his manliness and his ability to serve.³²

As described in this section, survivors of MST have a high likelihood—perhaps as much as fifty percent³³—of developing PTSD and therefore experiencing numerous symptoms that may greatly affect their ability to function in society.³⁴ In spite of these sometimes debilitating effects of trauma (or *because* of them), MST survivors regularly choose not to report assaults in the vast majority of cases.³⁵

II. VA DISABILITY COMPENSATION BENEFITS PROCESS

The VA's stated mission is "[t]o care for him who shall have borne the battle, and for his widow, and his orphan' by serving and honoring the men and women who are America's veterans."³⁶ To accomplish this mission, the VA supplies benefits and services through three main administrations: Veterans Benefits Administration (VBA), Veterans Health Administration (VHA), and National Cemetery Administration.³⁷ Through the VBA, the VA compensates veterans suffering from disabilities linked to their service.³⁸ In 2010, the total amount dispersed to veterans was \$56.6 billion.³⁹

Disability benefits are of vital importance to veterans suffering from PTSD and other conditions, not only because they provide monetary assistance necessary for veterans in difficult financial situations, but also because they serve as a means of securing critical medical attention.⁴⁰ The VA is required to provide necessary "hospital care and medical services . . . to any veteran for a service-connected disability; and . . . to any veteran who has a service-connected disability rated at 50 percent or more."⁴¹ Since 2004, the VHA has been

32. SCARCE, *supra* note 2, at 47.

33. Kimerling et al., *Military-Related Sexual Trauma*, *supra* note 14, at 1411.

34. See *DSM Criteria for PTSD*, *supra* note 16.

35. See DEPT OF DEF., *supra* note 1, at 15.

36. *About VA*, U.S. DEPT OF VETERANS AFFAIRS, http://www.va.gov/landing2_about.htm (last updated Feb. 17, 2012).

37. *VA Organization Chart*, U.S. DEPT OF VETERANS AFFAIRS (June 2009), <http://www.va.gov/ofcadmin/docs/vaorgchart.pdf>.

38. *Compensation*, U.S. DEPT OF VETERANS AFFAIRS, <http://www.benefits.va.gov/compensation> (last updated Feb. 14, 2013).

39. See Heather Ansley, *Advance Funding for the Department of Veterans Affairs is an Advance for Veterans*, VETSFIRST (Dec. 27, 2009), <http://www.vetsfirst.org/advance-funding-for-the-department-of-veterans-affairs-is-an-advance-for-veterans/>.

40. See Press Release, Office of Pub. & Intergovernmental Affairs, U.S. Dep't of Veterans Affairs, Disabled Veterans Get Health Care Priority from VA (Jan. 2, 2004), available at <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=715> (explaining that disabled veterans are entitled to both hospital and outpatient care).

41. 38 U.S.C. § 1710(a)(1) (2006).

required to schedule a veteran with a service-connected disability for a health evaluation within thirty days of his request.⁴² If there is no availability at a VA facility, the VHA must arrange for the veteran to be seen at another unaffiliated facility in order to meet that thirty-day deadline.⁴³

A. Basic Requirements for Disability Compensation

In order for a veteran to receive compensation for PTSD related to his service, he must prove “service connection” because conditions or illnesses that were not caused or exacerbated by a veteran’s military service are not eligible for VA compensation.⁴⁴ Service connection for PTSD has three elements that the veteran must prove: (1) a medical diagnosis of PTSD, (2) an in-service event or “stressor,” and (3) a link between the stressor and his PTSD.⁴⁵ The most notable element for veterans claiming PTSD related to an MST is the requirement that the existence of the stressor be shown by “credible supporting evidence.”⁴⁶ That said, the standard of proof placed on veterans in VA disability compensation claims is to provide evidence such that there is at least “an approximate balance of positive and negative evidence regarding any issue material to the determination of a matter.”⁴⁷ In situations where the positive and negative evidence are in equipoise, the VA “shall give the benefit of the doubt to the claimant.”⁴⁸

The VA receives approximately 188,000 claims for disability compensation every year.⁴⁹ Of those claims, about 20,000 are for PTSD.⁵⁰ While disability benefits claims are generally successful in eighty percent of cases, claims for PTSD have a success rate of only fifty percent.⁵¹ The success rate for PTSD claims involving MST is

42. Press Release, *supra* note 40. Treatment for conditions that are not connected to service does not need to be scheduled by the VA within this timeline. *Id.*

43. *Id.*

44. See 38 C.F.R. § 3.304(f) (2011).

45. *Id.*

46. *Id.*

47. 38 U.S.C. § 5107(b) (2006).

48. *Id.*; see also *Ortiz v. Principi*, 274 F.3d 1361, 1365 (Fed. Cir. 2001) (“The statutory benefit of the doubt rule thus would apply only when the factfinder determines that the positive and negative evidence relating to the veteran’s claim are ‘nearly equal,’ thus rendering any decision on the merits ‘too close to call.’”).

49. CONG. BUDGET OFFICE, COST ESTIMATE, H.R. 5892 VETERANS DISABILITY BENEFITS CLAIMS MODERNIZATION ACT OF 2008, at 3 (July 28, 2008) [hereinafter COST ESTIMATE], available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/96xx/doc9626/hr5892.pdf>.

50. *Id.*

51. *Id.* at 2–3.

even lower, around thirty-two percent.⁵² In most of these cases, PTSD claims were denied for lack of service connection.⁵³ Unfortunately, the VA does not keep, or has not produced, accurate data on the success of claims for PTSD related to sexual trauma.⁵⁴

B. General Problems with the VA Disability Compensation System

The VA has been under fire for years over the complicated and years-long process that veterans must go through in order to receive disability compensation.⁵⁵ The first step in the process is filling out a “23-page application” on which the VA “takes three years to train a new employee on how to read.”⁵⁶ The system has several layers in the appeals process from a Regional Office, to a Decision Review Officer, to the Board of Veterans’ Appeals (BVA), to federal court at the Court of Appeals for Veterans’ Claims.⁵⁷ Veterans must wait an average of eighteen months to receive a decision from the BVA (let alone the time it took to get the decision from the Regional Office or the time it might take to appeal the case to federal court).⁵⁸ Veterans struggle with the system for years, even decades, before they may finally be granted benefits.⁵⁹

Additionally, there are strict deadlines that a veteran must meet in order to appeal an administrative decision ranging between 120 days and one year.⁶⁰ If he fails to submit his appeal before these deadlines, he may lose any chance of success for his claim.⁶¹ Veterans can

52. Sandra Park, *We Must Honor the Service of All Veterans, Including Sexual Assault*, ACLU BLOG OF RTS. (July 20, 2012, 4:55 PM), <http://www.aclu.org/blog/womens-rights/we-must-honor-service-all-veterans-including-sexual-assault-victims>.

53. COST ESTIMATE, *supra* note 49, at 2.

54. *Eliminating the Gaps: Examining Women Veterans’ Issues: Joint Hearing Before the Subcomm. on Disability Assistance & Mem’l Affairs & the Subcomm. on Health of the H. Comm. on Veterans Affairs*, 111th Cong. 12 (July 16, 2009) (opening statement of John J. Hall, Chairman of Subcomm.).

55. See, e.g., John McChesney, *Disabled Veterans Face a Faceless Bureaucracy*, NPR (May 11, 2010, 1:00 PM), <http://www.npr.org/templates/story/story.php?storyId=126676864>.

56. *Id.*

57. DANIEL T. SHEDD, CONG. RESEARCH SERV., R42609, OVERVIEW OF THE APPEAL PROCESS FOR VETERANS’ CLAIMS 2–4 (2012).

58. *VA Claims Backlog Ready to Hit 1 Million*, ARMY TIMES (June 18, 2009), http://www.armytimes.com/news/2009/06/ap_vaclaimsbacklog_061809.

59. McChesney, *supra* note 55 (“It took me from 1972 to 2006 for the VA to admit that I had post-traumatic stress disorder.” (quoting Vietnam veteran John Wood)).

60. See 38 U.S.C. § 7266(a) (2006) (requiring veterans to file a Notice of Appeal within 120 days of a decision by the BVA in order to obtain review at the Court of Appeals for Veterans Claims); 38 C.F.R. § 20.302(a) (2012) (requiring that a veteran submit a “Notice of Disagreement” with the decision of a Regional Office within one year of that decision in order to be able to appeal to the BVA).

61. See 38 U.S.C. § 7266(a) (2006); 38 C.F.R. § 20.302 (2012).

try to “reopen” their claim but will be required to produce “new and material evidence” in order to have their decision reviewed.⁶² At any time after a veteran has been denied benefits he may claim that the VA adjudicator committed “clear and unmistakable” error.⁶³ This is a very high standard, however, and is rarely successful.⁶⁴ And of course, this highly technical process is likely completely dumbfounding to the layperson, let alone veterans coping with severe PTSD.

In addition to these structural obstacles, the VA is simply overwhelmed by the number of claims on its docket.⁶⁵ About 440,000 veterans of the wars in Afghanistan and Iraq have filed claims for disability compensation.⁶⁶ This has resulted in the VA being backlogged by more than 750,000 outstanding claims.⁶⁷ That number rose by more than 300,000 from just one year prior.⁶⁸

C. Barriers to PTSD Disability Compensation Due to Military Culture

A number of issues related to military culture make it particularly difficult for a veteran seeking PTSD disability claims. Firstly, there are “negative attitudes within the military culture associated with having and treating a mental disorder.”⁶⁹ This culture can present a “major barrier” to a veteran seeking or receiving needed care either during his service or after.⁷⁰ Seeking mental health care may have “significant career implications, particularly in some career tracks that require higher fitness standards (e.g., Air Force pilots).”⁷¹ Questions about a servicemember’s mental health may also affect his security clearance or chances of promotion.⁷²

Another cultural disincentive to seeking treatment is the perception of “malingering” or faking an illness to avoid one’s duty:

62. 38 C.F.R. § 3.156(a) (2012).

63. 38 C.F.R. § 3.304(b) (2012).

64. See 38 C.F.R. § 20.1403(a) (2012) (“Clear and unmistakable error is a very specific and rare kind of error. It is the kind of error, of fact or of law, that when called to the attention of later reviewers compels the conclusion, to which *reasonable minds could not differ*, that the result would have been manifestly different but for the error.” (emphasis added)).

65. McChesney, *supra* note 55.

66. *Id.*

67. Gregg Zoroya, *Backlog Buries Veterans’ Claims*, USA TODAY (Apr. 7, 2011, 12:19 AM), http://usatoday30.usatoday.com/news/military/2011-04-07-1Abacklog07_ST_N.htm.

68. *Id.* Outstanding claims numbered 448,000 one year prior. *Id.*

69. INVISIBLE WOUNDS OF WAR, *supra* note 15, at 273.

70. *Id.*

71. *Id.* at 280.

72. *Id.*

“The view that many soldiers with PTSD are faking their symptoms was common in focus groups conducted with senior [Non-Commissioned Officers].”⁷³ Indeed, some members of the military leadership believe that as many as seventy-five percent of servicemembers seeking PTSD treatment are faking.⁷⁴

Lack of confidentiality also likely inhibits seeking treatment for mental disorders.⁷⁵ Servicemembers seeking mental health care must be escorted to the facility by a comrade even in instances of self-referral.⁷⁶

D. Evidentiary Issues Specific to MST

The VA has recognized the difficulties that survivors of sexual assault face in proving that a stressor occurred.⁷⁷ In its guidelines for employees reviewing claims for disability compensation, the VA acknowledges:

[A] personal trauma is an extremely personal and sensitive issue[.]
[M]any incidents of personal trauma are not officially reported, and the victims of this type of in-service trauma may find it difficult to produce evidence to support the occurrence of the stressor. It is often necessary to seek alternative evidence.⁷⁸

While the VA does not have standards of proof specific to MST, it has delineated standards for proving “personal assault,”⁷⁹ defined as “an event of human design that threatens or inflicts harm,” which includes “[r]ape, physical assault, domestic battering,” and the like.⁸⁰ In 2002, the VA amended its policy on the requirements for proving the existence of an in-service assault to include specific language

73. *Id.*

74. *Id.*

75. INVISIBLE WOUNDS OF WAR, *supra* note 15, at 279.

76. *Id.* (explaining that those with command referrals must be escorted, and there is a perception that even self-referrals must be escorted).

77. Kimerling et al., *Military-Related Sexual Trauma*, *supra* note 14, at 1409 (“The Veterans Health Administration has recently invested significant resources in the detection and treatment of military sexual trauma, implementing universal military sexual trauma screening in 2002 and providing free care for all related conditions.”).

78. U.S. DEP’T OF VETERANS AFFAIRS, ADJUDICATION PROCEDURES MANUAL REWRITE, M21-1MR, pt. IV, subpt. ii, ch. 1, § D(17)(m) (2008), *available at* http://www.benefits.va.gov/WARMS/M21_1MR4.asp (follow “Section D” hyperlink under “Part 4. Compensation DIC, and Death Compensation benefits: Subpart II—Compensation: Chapter 1—Development”) (last visited Mar. 23, 2013).

79. 38 C.F.R. § 3.304(f)(5) (2012).

80. U.S. DEP’T OF VETERANS AFFAIRS, ADJUDICATION PROCEDURES MANUAL REWRITE, *supra* note 78, at M21-1MR, pt. IV, subpt. ii, ch. 1, § D(43).

recognizing evidence outside of a veteran's service record that may be used to corroborate his testimony.⁸¹ The regulation now expressly permits evidence such as "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 service members, or clergy."⁸²

In particular, the regulation suggests that veterans submit evidence of behavioral changes at or after the time of the alleged stressor incident such as "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."⁸³

Even with these guidelines intended to aid the veteran and the VA Regional Office handling his claim, documentation is still often hard to come by in cases of MST.⁸⁴ Even when a veteran can produce corroborating circumstantial evidence, such as proof of behavioral changes, VA adjudicators may miss or ignore non-conclusive pieces of evidence that indicate, but do not definitively prove, that an assault occurred.⁸⁵ This raises the burden of proof for veterans,⁸⁶ in spite of the fact that the regulations specifically call for evidence that is not concrete or obvious⁸⁷ and VA adjudicators are instructed to "resolv[e] every reasonable doubt in favor of the veteran."⁸⁸

The process veterans must go through to receive compensation for their service-connected disabilities is long and complicated.⁸⁹ Complicated evidence requirements, coupled with strict deadlines for appeal and a backlog nearing one million claims, have resulted in a limited number of success stories for veterans with PTSD, often

81. Post-Traumatic Stress Disorder Claims Based on Personal Assault, 67 Fed. Reg. 10,330 (Mar. 7, 2002) (to be codified at 38 C.F.R. pt. 3).

82. 38 C.F.R. § 3.304(f)(5) (2012).

83. *Id.*

84. *Patton v. West*, 12 Vet. App. 272, 279 (1999).

85. Jennifer C. Schingle, *A Disparate Impact on Female Veterans: The Unintended Consequences of Veterans Affairs Regulations Governing the Burdens of Proof for Post-Traumatic Stress Disorder Due to Combat and Military Sexual Trauma*, 16 WM. & MARY J. WOMEN & L. 155, 171 (2009) ("[A]djudicators look for obvious, blatant, and concrete evidence, rather than subtle, nuanced evidence that is more likely to be in the claims file.").

86. *Id.*

87. 38 C.F.R. § 3.304(b)(1) (2012) (calling for consideration of "all other material evidence").

88. Schingle, *supra* note 85, at 159 n.29 (quoting *The Nexus Between Engaged in Combat with the Enemy and PTSD in an Era of Changing Warfare Tactics: Hearing Before the Subcomm. on Disability Assistance & Mem'l Affairs of the H. Comm. on Veterans' Affairs*, 111th Cong. 4 (2009) (statement of Rep. Doug Lamborn)).

89. *See, e.g., VA Claims Backlog Ready to Hit 1 Million*, *supra* note 58.

only after years of delay and confusion.⁹⁰ A military culture which stigmatizes seeking mental health treatment and often suspects service members of faking illnesses presents another barrier to veterans suffering from PTSD in coming forward and being diagnosed, treated, or compensated for their condition.⁹¹ Lastly, although the VA sets a nominally low standard of proof in favor of veterans (that the evidence shows that it is “as likely as not” that a traumatic event occurred or that a servicemember suffers from a disability related to that event), MST survivors’ files often lack hard evidence and their claims may fail because of that fact.⁹²

III. PROPOSED CHANGES TO SERVICE CONNECTION REQUIREMENTS FOR SEXUAL ASSAULT

In 2011, Congresswoman Chellie Pingree announced a proposed amendment to the VA regulation controlling the evidence required for PTSD claims related to sexual assault.⁹³ The House Bill, H.R. 930 (along with an identical Senate Bill, S. 1391, proposed by Senator Jon Tester),⁹⁴ would change the VA’s regulations for service connection to require that claims for PTSD or other conditions related to sexual trauma need only contain “a diagnosis . . . by a mental health professional,” “written testimony by the veteran” describing the in-service event, and “a written determination by the professional” that the condition is related to the alleged event.⁹⁵ While the current regulation for proving an in-service stressor requires *some* corroborating evidence, the proposed amendment would require only the word of the veteran and his doctor.⁹⁶

This change comes in the wake of recent changes to the standards for proving combat exposure in PTSD claims.⁹⁷ This 2010 amendment loosened the requirements for veterans seeking disability compensation for PTSD, eliminating the need for corroborating

90. *See id.*

91. INVISIBLE WOUNDS OF WAR, *supra* note 15, at 280.

92. *See* U.S. DEP’T OF VETERANS AFFAIRS, ADJUDICATION PROCEDURES MANUAL REWRITE, *supra* note 78, at M21-1MR, pt. IV, subpt. ii, ch. 1, § D(41).

93. *Bill Would Help Veterans Who Suffered Sexual Assault During Their Service*, CONGRESSWOMAN CHELLIE PINGREE (July 2, 2011), http://pingree.house.gov/index.php?option=com_content&task=view&id=126&Itemid=24.

94. S. 1391, 112th Cong. (2011).

95. H.R. 930, 112th Cong. (2011). This bill closely matches recommendations made in an article published in this Journal and written by Jennifer Shingle, an Associate Counsel at the Board of Veterans’ Appeals. *See* Schingle, *supra* note 85, at 177.

96. *Compare* 38 C.F.R. § 3.304(f)(5) (2012), *with* H.R. 930, 112th Cong. § 1(c) (2011).

97. *See* Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843 (July 13, 2010) (to be codified at 38 C.F.R. pt. 3).

evidence of combat exposure.⁹⁸ Under the new standard, if a veteran's claimed stressor is "related to the veteran's fear of hostile military or terrorist activity," the veteran's testimony, along with a diagnosis by a VA mental health professional relating the symptoms to the claimed stressor, will be sufficient to establish service connection for PTSD so long as the stressor is "consistent with the places, types, and circumstances of the veteran's service."⁹⁹ This change is a direct result of the changing form of modern warfare in which a servicemember's typical non-combat duty has become more acutely stressful and life-threatening.¹⁰⁰

IV. ISSUES WITH THE PROPOSED CHANGES

The change proposed by Congresswoman Pingree and Senator Tester is aimed at the striking difficulties that MST survivors face when seeking disability benefits.¹⁰¹ These legislators recognize that the VA has not been adequately serving these veterans in the difficult process for attaining disability compensation and other benefits.¹⁰² Their bills would certainly eliminate some of the barriers that impede MST survivors in getting benefits. We must, however, consider what other consequences this proposed solution would have on the process and whether it goes too far.

An important difference between the recent amendment to the combat-related PTSD standards and the sexual assault-related standards is that while both eliminate the need for recorded evidence of a specific event in service the combat-related standard still maintains a necessary level of consistency between the claimed stressor and the circumstances of the veteran's service.¹⁰³ This maintains a level of reliability found in all service connection standards that is notably absent in the proposed changes to assault-related claims.¹⁰⁴ Such requirements help to ensure that the limited funds available for disability compensation are given to the proper recipients and for the right claims.

98. *Id.*

99. 38 C.F.R. § 3.304(f)(3) (2012).

100. *See, e.g.*, Rachel Martin, *VA Eases Claims Process For PTSD Treatment*, NPR (July 12, 2010, 1:52 PM), <http://www.npr.org/templates/story/story.php?storyId=128467680> ("[Y]ou have truck drivers who drive the streets of Baghdad every day, and they get hit with IEDs. . .").

101. *Bill Would Help Veterans*, *supra* note 93; S. 1391, 12th Cong. (2011).

102. *Id.*

103. 38 C.F.R. § 3.304(f)(3) (2012).

104. *See* Stressor Determinations for Posttraumatic Stress Disorder, 75 Fed. Reg. 39,843 (July 13, 2010) (to be codified at 38 C.F.R. pt. 3) (setting out the reliability standard for PTSD claims).

A. Diagnostic Issues

In determining the wisdom of reducing the standards for establishing service connection for PTSD disability benefits, it is useful to inquire as to the reliability of the evidence that would be required under H.R. 930.

Research on memory in trauma survivors creates a difficult question on the reliability of survivor reports.¹⁰⁵ One study compared subjects diagnosed with PTSD, subjects who had experienced trauma but were not diagnosed with PTSD, and a control group that did not report experiencing serious trauma.¹⁰⁶ Researchers found that the traumatized subjects were significantly more susceptible to clinical implantation of false memories than the control subjects.¹⁰⁷ Among the subjects that had experienced trauma, those with PTSD were even more susceptible to false memory implantation than members of their cohort without PTSD.¹⁰⁸ It should be noted that this research tested only subjects' susceptibility to the implantation of small memories, merely the recollection of words in a list.¹⁰⁹ The researchers admitted that "memory for words presented in lists may be very different from memory for traumatic events. . . ."¹¹⁰ Nonetheless, their research shows "indirect support that the illusion of remembering events that never happened can happen quite easily and that trauma exposure or PTSD may heighten this possibility."¹¹¹ Various longitudinal studies have shown that patients with PTSD remembered their traumatic experiences (of various types) as more severe than previously described as their symptoms became more numerous and pronounced over time.¹¹² Importantly, it is not asserted in the research—or in this Note—that survivors are lying or intentionally embellishing:

[T]raumatic memories, like all autobiographical memories, are reconstructed from encoded elements distributed throughout the brain. The context of retrieval, including clinical state, affects how these recollections occur. Although scientists, who study fear conditioning in rats, once believed that emotional memories

105. Lori A. Zoellner et al., *Are Trauma Victims Susceptible to "False Memories"?*, 109 J. ABNORMAL PSYCHOL. 517, 517 (2000).

106. *Id.* at 518.

107. *Id.* at 520.

108. *Id.*

109. *Id.* at 519.

110. *Id.* at 523.

111. Zoellner et al., *supra* note 105, at 523.

112. See, e.g., Richard J. McNally, *Progress and Controversy in the Study of Post-traumatic Stress Disorder*, 54 ANN. REV. PSYCH. 229, 233 (2003).

are indelible, they have recently discovered that even these memories are subject to alteration. What is true for rats is even more true for people. Although people retain traumatic memories very well, even recollections of the most horrific events are not immune to alteration of time.¹¹³

One study compared data from separate screenings for PTSD symptomology and history of trauma.¹¹⁴ It found that seventy-eight percent of their sample (patients seeking treatment for major depression) screened positive for PTSD symptomology, while only fifty-two to sixty-five percent were found to have experienced one or more traumatic events.¹¹⁵ Perhaps most importantly, the proportion of traumatized subjects were of equal proportions in the PTSD-positive and PTSD-negative groups.¹¹⁶ In other words, exhibiting PTSD symptoms makes it no more likely that a given subject had actually experienced a reported trauma. The researchers concluded from this that “it may be hazardous to assume that these symptoms were *caused* by trauma, even if an unequivocal traumatic event occurred.”¹¹⁷

This research is included here not to discredit or make light of the pain and suffering of the thousands of veterans diagnosed with PTSD, nor is it intended to discount efforts to reduce the stigma and impediments to PTSD diagnoses. It is also not taken as a given that this study is conclusive proof that some of the criteria for PTSD may be erroneous¹¹⁸ or that a significant number of veterans have false memories that form the basis of their PTSD diagnoses.¹¹⁹ It is included only to highlight potentially serious problems inherent in the current system of mental health diagnostics.

Diagnostics is an imperfect science. Research indicates that the current criteria used for diagnosing PTSD may be especially

113. *Id.* at 234 (citations omitted).

114. J. Alexander Bodkin et al., *Is PTSD Caused by Traumatic Stress?*, 21 J. ANXIETY DISORDERS 176, 176 (2007).

115. *Id.* at 180. As part of the method for coding subjects as having experienced a trauma researchers required that two coders independently determine whether a given subject's stated experiences met the standard for trauma under the DSM-IV definition of PTSD. The range in these results, as reported here, reflects all subjects whose experiences were coded as traumatic by one or more coders (at the high end) and those that were coded as nontraumatic (at the low end). *Id.*

116. *Id.*

117. *Id.* at 181.

118. The researchers themselves noted several of the study's limitations, including the ability to generalize from a sample group composed of patients seeking clinical help for major depression: “[I]ndividuals in the community, not seeking psychiatric care for depression, might exhibit a more specific association of trauma with the symptom cluster of PTSD.” *Id.*

119. As previously noted, the research cited merely shows short term word recall is altered in subjects who have experienced a trauma. The researchers noted that studies of actual traumatic memories are inconsistent. Zoellner et al., *supra* note 105, at 523.

flawed.¹²⁰ This is of great importance when considering that H.R. 930 would rely solely on a PTSD diagnosis and self-reported traumatic events to establish service connection for disability benefits.¹²¹ Under the proposed amendment, service connection could be founded entirely upon the memory of the patient (which may be flawed), a diagnosis of PTSD (which Bodkin's research suggest may have little predictive value on establishing the existence of a traumatic experience), and the opinion of a doctor that the two are related.¹²² This creates a possibly troublesome dynamic in which every bit of evidence of a claim might be unreliable and, without a shred of corroborative evidence, service connection would be granted.

B. Unintended Consequences

One serious flaw in the proposed amendment to lessen the burden on veterans trying to prove a sexual assault for VA compensation is its nearly exclusive reliance on the memory of a service-member suffering from PTSD, memory that has been shown to be of questionable validity.¹²³ This amendment might also place greater burdens on already overwhelmed mental health professionals working within the VHA, which now results in veterans with severe PTSD experiencing months-long delays in receiving mental health referrals.¹²⁴ There is a chance that, without greater funding or more efficient management of veterans' health care, the way the amendment bases a veteran's entire case for establishing a claim for PTSD due to MST on his story and the opinion of a doctor could worsen these delays or lower the quality of care in order for doctors to see more patients. With that said, by reducing the standard for required evidence for survivors of MST, the amendment could shorten delays in the VBA's processing of compensation benefits claims.

V. NECESSARY CHANGES

A. Changes Within the Armed Forces

The most obvious issue that is in profound need of improvement is prevention within the armed forces. Recent changes to the Uniform

120. Bodkin et al., *supra* note 114, at 181.

121. H.R. 903, 112th Cong. (2011).

122. *Id.*

123. McNally, *supra* note 112, at 233.

124. *See, e.g.,* Veterans for Common Sense v. Shinseki, 644 F.3d 845, 853–54 (9th Cir. 2011), *rev'd en banc on other grounds*, Veterans for Common Sense v. Shinseki, 678 F.3d 1013 (9th Cir. 2011).

Code of Military Justice (UCMJ) that removed the requirement that an assailant exert force in order to be guilty of rape were a step in the right direction.¹²⁵ These changes did not, however, alter the rape law's common law definition that excludes the rape of men.¹²⁶ Assailants may be found guilty under other sexual assault provisions of the UCMJ, but this disparate treatment of male and female survivors affirms common fears among survivors about reporting sexual assaults and reinforces the stigma against male survivors of MST.¹²⁷ This disparity should be removed from the law.

More must be done to reduce the stigma and fear of reporting instances of sexual assault. Leadership in the armed forces must discredit the belief that "victims get punished while perpetrators do not" and eradicate any retaliation that does occur against MST survivors and increase efforts to prosecute their attackers.¹²⁸

It remains to be seen what effect the repeal of the "Don't Ask, Don't Tell" policy barring gay and lesbian servicemembers from serving openly in the military will have on the rate of MST.¹²⁹ On one hand, gay men are often targets of sexual assault, comprising a disproportionate number of male sexual assault survivors.¹³⁰ On the other, fear of being labeled "homosexual," and perhaps even facing a dishonorable discharge, represented another barrier to reporting sexual assault until "Don't Ask, Don't Tell" was repealed in 2011.¹³¹ The repeal may even prevent further sexual harassment

125. 10 U.S.C. § 920 (2006) (subjecting an assailant to prosecution for rape if any one of five methods of coercion are present including "threatening or placing that other person in fear that any person will be subjected to death, grievous bodily harm, or kidnaping;" or "administering to another person by force or threat of force, or without the knowledge or permission of that person, a drug, intoxicant, or other similar substance and thereby substantially impairs the ability of that other person to appraise or control conduct").

126. See *United States v. Wilkins*, 71 M.J. 410, 413 (C.A.A.F. 2012) (noting that the statutory definition of a "sexual act" does not include penetration of the anus or mouth).

127. Jessica A. Turchik & Susan M. Wilson, *Sexual Assault in the U.S. Military: A Review of the Literature and Recommendations for the Future*, 15 *AGGRESSION & VIOLENT BEHAV.* 267, 272 (2010) (noting that fear of retaliation and breaches of confidentiality represent current barriers to sexual assault reporting in the military).

128. *Id.* There is some evidence to support the belief that sexual assault prosecutions are often ineffective. *Sexual Assault in the Military Part Three: Context and Causes: Hearing Before the Subcomm. on Nat'l Sec. & Foreign Affairs of the H. Comm. on Oversight & Gov't Reform*, 111th Cong. 27 (2009) (statement of Helen Benedict, Professor of Journalism at Columbia Univ.) ("In 2008, a mere 10.9 percent of all reported assaults went to court-martial, and among those men found guilty, 62 percent were given punishments so mild they amounted to a mere slap on the wrist.").

129. See *Don't Ask, Don't Tell Repeal Act of 2010*, Pub. L. No. 111-321, 124 Stat. 3515 (2010).

130. SCARCE, *supra* note 2, at 18.

131. Turchik & Wilson, *supra* note 127, at 272.

and assaults on gay servicemembers now that such actions are no longer quasi-justified in the minds of assailants as enforcing United States law.¹³²

The armed forces must also pay closer attention to recruits' history of criminal activity. The global war on terror has brought with it scores of men with criminal backgrounds, including sex crimes, who have been given waivers to the normal screening criteria.¹³³ The crimes that have been waived include "aggravated assault, rape, and sexual assault."¹³⁴ The military must maintain the highest standards of conduct, which includes screening out individuals that have a history of sexual violence and enforcing a "zero-tolerance" policy against such behavior.¹³⁵

These proposals are but a sampling of the methods by which the armed forces could work to prevent sexual assault and increase victim reporting and treatment. There are undoubtedly many more areas of improvement and untold innovative solutions to this problem. For this reason, the armed forces should conduct research on sexual assault against male survivors and the effects that such assaults have on the survivors. There has been a minimal amount of research in the area.¹³⁶ Given the scope of this problem, the Armed Forces and those organizations that treat and provide resources to survivors need better information and standards to help them recover.

B. Changes in VA Treatment and Benefits Procedures

The VA is plagued with structural and fiscal problems that have made it incapable of adequately meeting the needs of veterans seeking benefits and services to which the law entitles them.¹³⁷ Some of the problems could be solved or greatly reduced with increased funding and staffing. The backlog of 756,000 claims at the Board of Veterans' Appeals is a product of understaffing, under-training, and underfunding.¹³⁸

132. See Aaron Belkin, *Don't Ask Don't Tell: Is the Gay Ban Based on Military Necessity?*, 33 *PARAMETERS* 108, 112 (2003) (citing research in Canada, Britain, and Israel that turned up little or no "gay-bashing" or assaults targeting gay and lesbian servicemembers after lifting bans on open service); see also Turchik & Wilson, *supra* note 127, at 273–74 (stating that "Don't Ask, Don't Tell" promoted intolerance and discrimination).

133. See Turchik & Wilson, *supra* note 127, at 273.

134. *Id.*

135. *Id.*

136. *Id.* at 268.

137. See, e.g., Zoroya, *supra* note 67.

138. *Id.* The VA did recently expand its workforce of claims processors from 11,000 to 14,000, although they are a "relatively inexperienced workforce." *Id.* "They make mistakes," a VA Undersecretary for policy stated. *Id.* Problems with undertrained staff and mismanagement have resulted in reports of VA staff shredding documents crucial to veterans'

Rather than reducing the standards for proving a service-connected disability, as H.R. 930 proposes,¹³⁹ the VA should do a better job of evaluating the evidence that is in a veteran's record. While proving an unreported sexual assault years prior to seeking disability benefits is certainly difficult, the current provisions specifying evidence outside of the veteran's military record and evidence of behavioral changes that should be considered in determining service connection allow for a wealth of evidence to be sought and produced to support the veteran's case.¹⁴⁰ VA administrators must help bear this burden for the veteran, developing his claim by seeking out the necessary evidence.¹⁴¹ As the Court of Appeals for Veterans Claims has stated,

because of the unique problems of documenting personal-assault claims, the [VA Regional Office] is responsible for assisting the claimant in gathering, from sources in addition to in-service records, evidence corroborating an in-service stressor, by sending a special letter and questionnaire, by carefully evaluating that evidence including behavior changes, and by furnishing a clinical evaluation of behavior evidence.¹⁴²

The VA simply must live up to this mandate.

Furthermore, the VA must adjudicate the claims properly, abiding by the proper standards of proof and evidence, and

accept as sufficient proof of service-connection of any disease or injury alleged to have been incurred in or aggravated by such service satisfactory lay or other evidence of service incurrence or aggravation of such injury or disease, if consistent with the circumstances, conditions, or hardships of such service . . . and, to that end, shall resolve every reasonable doubt in favor of the veteran.¹⁴³

Proof of service connection can be effectively established with circumstantial evidence, so long as the VA upholds its end of the bargain.

As it stands, the practices of VA doctors are not sufficiently tailored to the diagnostic needs of veterans who are survivors of

claims. Amanda Ruggeri, *Military Veterans' Benefit Claims Records Wrongly Headed for VA Shredders*, U.S. NEWS & WORLD REPORT (Oct. 31, 2008), <http://www.usnews.com/news/national/articles/2008/10/31/military-veterans-benefit-claims-records-wrongly-headed-for-va-shredders>.

139. H.R. 930, 112th Cong. (2011).

140. 38 C.F.R. § 3.304(f)(5) (2011).

141. 38 C.F.R. § 3.159 (2012) ("VA will make reasonable efforts to help a claimant obtain evidence necessary to substantiate the claim.").

142. *Patton v. West*, 12 Vet. App. 272, 282 (1999).

143. 38 U.S.C. § 1154 (2006).

MST.¹⁴⁴ Research has shown that VA programs treating PTSD patients have had little evidence of success.¹⁴⁵ Compare this with programs for civilians suffering from PTSD that have resulted in sixty-seven percent of patients no longer meeting the criteria for PTSD.¹⁴⁶

The VHA should do more to cater to the tens of thousands of veterans that have been victims of MST. There are in-house treatment programs scattered throughout the United States,¹⁴⁷ but these are inadequate to handle thousands of veterans suffering from the effects of sexual assault.¹⁴⁸ A “\$7 million, 24,000-square-foot inpatient mental health facility at Ft. Harrison,” Montana, opened in June 2011, but its psychiatric wing intended to treat veterans suffering from PTSD and MST remains empty and unused.¹⁴⁹ The funding is there, but the VA has been unable to recruit psychiatrists to provide care to prospective patients.¹⁵⁰ As a result, some veterans have had to travel hundreds of miles to available treatment facilities in places like Utah, California, and Florida.¹⁵¹ As the Director of the VA Montana Health Care System pointed out, the most troubling casualties of this failure are not those veterans who have to travel out of state to receive treatment, but those veterans who never seek treatment because of the added burden.¹⁵²

One of the problems faced by male survivors of MST is the tendency for advocacy and resources in this area to focus on female survivors.¹⁵³ As acknowledged at the outset, this is not surprising or entirely inappropriate given the highly disproportionate effect that sexual assault has on women.¹⁵⁴ But, with roughly equal numbers

144. See B. Christopher Frueh et al., *US Department of Veterans Affairs Disability Policies for Posttraumatic Stress Disorder: Administrative Trends and Implications for Treatment, Rehabilitation, and Research*, 97 AM. J. PUB. HEALTH 2143, 2144 (2007).

145. *Id.* at 2143. Frueh and his co-authors argue that this is due, at least in part, to the link between diagnosis and disability compensation, creating a disincentive for veterans for improvement (which would reduce compensation). *Id.* Others hypothesize that “the power of expectancy” and “resilience” are contributing factors in the stagnant rate of PTSD improvement in veterans. David Dobbs, *The Post-Traumatic Stress Trap*, 300 SCI. AM. 64, 65 (2009). These views are not espoused in this Note.

146. Frueh et al, *supra* note 144, at 2143.

147. MILITARY SEXUAL TRAUMA, *supra* note 4.

148. See, e.g., Cindy Uken, *VA Acute Mental Health Facility Faces Chronic Lack of Docs*, HELENA INDEP. REC. (Mar. 6, 2012, 11:57 PM), http://helenair.com/news/local/military/va-acute-mental-health-facility-faces-chronic-lack-of-docs/article_f12c1226-6822-11e1-9787-0019bb2963f4.html.

149. *Id.*

150. *See id.*

151. *Id.*

152. *Id.*

153. Turchik & Wilson, *supra* note 127, at 268.

154. See Amy Street & Jane Stafford, *Military Sexual Trauma: Issues in Caring for Veterans*, in IRAQ WAR CLINICIANS GUIDE 66, 66 (2nd ed. 2004), available at http://www.ptsd.va.gov/professional/manuals/manual-pdf/iwcg/iraq_clinician_guide_ch_9.pdf

of male and female veterans who have suffered the effects of MST, there must also be equal resources available for all sufferers.¹⁵⁵ The first wave of attention and resources to focus on the issue of sexual assault in the military came in 1992 with the increased scrutiny of female veterans' issues.¹⁵⁶ Counseling services for survivors of a sexual trauma were only made available to female veterans,¹⁵⁷ until Congress amended the statute to include services for male veterans.¹⁵⁸

Evidence has surfaced that doctors employed by the VA have been discouraged from properly diagnosing veterans with PTSD and were told to instead consider a diagnosis of Adjustment Disorder, a less chronic disorder that offers fewer benefits and inappropriate treatment for veterans with PTSD.¹⁵⁹ Clearly, this type of unethical behavior must stop if it has not already. Beyond this, the VA must provide greater funds and specifications for VA doctors, especially if the VA is going to require that veterans obtain PTSD diagnoses from VA doctors. Ongoing investigations seek to discover whether military and VA doctors are "‘rubber-stamping’ a soldier with the diagnoses [sic] of PTSD."¹⁶⁰ Veterans must be given proper diagnoses and appropriate treatment, given the broad spectrum of causes and manifestations of PTSD and related conditions.¹⁶¹ A twenty-three-year-old veteran dealing with MST will get little out of a PTSD support group populated by Vietnam combat veterans.

CONCLUSION

The problems faced by male veterans suffering from PTSD and other conditions resulting from MST are legion.¹⁶² Symptoms of such

(stating that the occurrence of sexual assault in the military is about six percent for female servicemembers and about one percent for male servicemembers).

155. See MILITARY SEXUAL TRAUMA, *supra* note 4.

156. Street & Stafford, *supra* note 154, at 68.

157. Veterans' Health Care Act, Pub. L. No. 102-585, 106 Stat. 4943 (1992).

158. Veterans Health Programs Extension Act, Pub. L. No. 103-452, 108 Stat. 4783 (1994).

159. Pia Malbran, *VA Staffer Discourages PTSD Diagnoses*, CBS NEWS (Feb. 11, 2009, 2:57 PM), http://www.cbsnews.com/2100-500690_162-4102226.html.

160. Hal Bernton, *Madigan Memo on PTSD Costs Sparked Army Review*, SEATTLE TIMES (Feb. 6, 2012, 10:00 PM), http://seattletimes.com/html/localnews/2017443047_madiganfolo07m.html.

161. See Belleruth Naparstek, *Troops from Iraq & Afghanistan Different from Vietnam Vets*, HEALTH JOURNEYS (Feb. 1, 2010), <http://belleruthnaparstek.com/update-from-belleruth/troops-from-iraq-afghanistan-present-different-challenges-from-vietnam-vets.html> (noting that veterans of Iraq and Afghanistan differ from Vietnam veterans in their incidence of drug use and especially in their treatment preferences, often opting for self-help methods instead of talk therapy).

162. Street & Stafford, *supra* note 154, at 66–67.

a disorder coupled with individual reactions to events as traumatizing as sexual assaults by fellow servicemembers can severely debilitate veterans long after the event or their separation from service.¹⁶³ Some of these symptoms and reactions even inhibit survivors from seeking help, either in the form of legal action or psychological diagnosis and treatment.¹⁶⁴ Such veterans have a uniquely difficult task in proving their claims for due compensation by the VA.¹⁶⁵

As the proponents of H.R. 930 and S. 1391 recognize, the process and standards involved in proving claims for disability compensation present serious problems.¹⁶⁶ Endless paperwork, years of waiting, and the potential for re-traumatization in forcing survivors of sexual assaults to prove that their trauma is legitimate create substantial barriers to their just compensation and may well inhibit veterans from ever coming forward in the first place.¹⁶⁷

Clearly there is no magic bullet that can fully address every problem encountered by those who have suffered from MST. A combination of active prevention within the armed forces, streamlining of the disability benefits process, and increasing access to treatment in the VA would certainly be a step in the right direction. Indeed, perhaps the most important step that must be taken is to recognize, as a society, the prevalence of male survivors of MST and reduce the damaging effects of gendered misconceptions about sexual assault. This is only the first step on the path to recovery for the brave men who paid too high a cost for their service, a cost no one bargained for and few seem willing to compensate.

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163. *Id.* at 67.

164. Turchik & Wilson, *supra* note 127, at 272.

165. *See, e.g.*, Patton v. West, 12 Vet. App. 272, 276–79 (1999).

166. *See* H.R. 930, 112th Cong. (2011); S. 1391, 112th Cong. (2011).

167. *See* McChesney, *supra* note 55.

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