

**THE RELATIONSHIPS BETWEEN MILITARY
SEXUAL ASSAULT, POST-TRAUMATIC
STRESS DISORDER AND SUICIDE, AND ON
DEPARTMENT OF DEFENSE AND DEPART-
MENT OF VETERANS AFFAIRS MEDICAL
TREATMENT AND MANAGEMENT OF VIC-
TIMS OF SEXUAL TRAUMA**

WEDNESDAY, FEBRUARY 26, 2014

U.S. SENATE,
SUBCOMMITTEE ON PERSONNEL,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:02 a.m., in room SR-222, Russell Senate Office Building, Senator Kirsten E. Gillibrand (chairman of the subcommittee) presiding.

Committee members present: Senators Gillibrand, McCaskill, Blumenthal, Hirono, Kaine, King, Graham, and Ayotte.

Committee staff member present: Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Jonathan D. Clark, counsel; and Gerald J. Leeling, general counsel.

Minority staff members present: Steven M. Barney, minority counsel; Samantha L. Clark, minority associate counsel; Allen M. Edwards, professional staff member; and Natalie M. Nicolas, minority staff assistant.

Staff assistants present: Lauren M. Gillis and Brendan J. Sawyer.

Committee members' assistants present: Jason D. Rauch, assistant to Senator McCaskill; Moran Banai, Brooke Jamison, and Kathryn E. Parker, assistants to Senator Gillibrand; Nick Ikeda, assistant to Senator Hirono; Karen E. Courington, assistant to Senator Kaine; Stephen M. Smith, assistant to Senator King; Bradley L. Bowman, assistant to Senator Ayotte; and Andrew N. King, assistant to Senator Graham.

**OPENING STATEMENT OF SENATOR KIRSTEN E. GILLIBRAND,
CHAIRMAN**

Senator GILLIBRAND. The subcommittee meets today to receive testimony about the relationship between military sexual assault, post-traumatic stress disorder and suicides, and the DOD and VA medical treatment and management of victims of sexual trauma.

There is zero doubt that sexual violence is occurring at an unacceptable rate within our military. Too often, our service men and women find themselves in the fight of their lives not in a theater of war, but in their own ranks, among their own brothers and sisters.

While Congress is not in full agreement on the extent of the reforms required to solve this crisis, last year's National Defense Authorization Act took positive steps forward, including 36 separate provisions to address sexual assault in the military, which were supported unanimously, and additional important legislation is still under consideration, including my bill, the Military Justice Improvement Act.

No matter where any one person falls in this debate, we can all agree that we must fully understand the long-term psychological toll on the survivors of sexual trauma in the military and the best practices for effective treatment.

Sexual assaults are obviously very traumatic events for victims, traumatic events that have long-lasting, frequently lifelong consequences, including post-traumatic stress disorder and suicides. Heath Phillips, a constituent of mine, shared his experience with me recently.

Heath grew up in a family that was devoted to the military. He joined the Navy shortly after he turned 17 and was excited to be part of the Navy family. When he reported to his duty station after boot camp, there was no one there to register him. So they told him he would have to come back.

He met a couple of other sailors from the ship and went into New York City with them. They went out drinking, and he blacked out. And when he came to, the other sailors were sexually assaulting him. They threatened him and told him no one would believe him.

He went back to the ship, where he reported the assault, only to be told that it was his own fault because he had been drinking and that he was lucky to not be in trouble for underage drinking. The sexual assaults continued aboard the ship. And when his commanders allowed these assaults by his shipmates to continue without any repercussions, Heath went AWOL.

Ultimately, he accepted a dishonorable discharge to end his torture. Not only was he suffering from PTSD, which led him to flee the ship, but now he is not eligible for VA benefits.

It is stories like these that motivated me to have this hearing. I want to make sure this doesn't happen to anyone else and that people like Heath aren't forced to choose between their mental health and the benefits they have earned from the United States Government.

This is not just an issue of anecdotal evidence. One study of Iraq and Afghanistan veterans found that, "Female veterans with a history of military sexual assault or harassment were five to eight times more likely to have current PTSD, three times more likely to be diagnosed with depressive disorders, and two times more likely to be diagnosed with alcohol use disorders compared to female veterans without military sexual trauma."

Another study of Iraq and Afghanistan veterans seen at the VA found that both for women and men who reported a history of military sexual trauma were significantly more likely than those who

did not to receive a mental health diagnosis, including post-traumatic stress disorder, other anxiety disorders, depression, and substance use disorders.

I also want to address today how the Department of Defense and the VA handling of sexual assault reports impact survivors' mental health. The VA's own Web site says that how the military handles military sexual assault has actually made PTSD worse.

"Many victims are reluctant to report sexual trauma, and many victims say that there were no available methods for reporting their experiences to those in authority. Many indicate that if they did report the harassment, they were not believed or encouraged to keep silent about the experience. They may have had their reports ignored or, even worse, have been themselves blamed for the experience. Having this type of invalidating experience following a sexual trauma is likely to have significant negative impact on the victim's post-trauma adjustment."

I am alarmed by the following statistic, as should every person in this room. On average, 22 veterans commit suicide every single day. Twenty-two brave men and women commit suicide every single day.

It is critical that we look at the links between sexual assault and harassment and related PTSD and its role in the intolerable number of suicides. Today, the subcommittee meets to discuss these links, their consequences, and how they are addressed.

On our first panel, we have two survivors of sexual assault. Lance Corporal Jeremiah Arbogast, who is medically retired from the Marine Corps, and Jessica Kenyon, who served as a private first class in the U.S. Army. We have invited them to tell us about their experience as survivors of sexual assaults that occurred while they served in the military.

Did they suffer from PTSD? Did they consider suicide? If so, what kind of help did they receive to address these conditions? We hope to learn what worked, as well as what didn't work, and what we in the U.S. Senate can do to improve the care of survivors when sexual assaults unfortunately occur.

On the second panel, we have DOD and VA officials who will testify about the programs Department of Defense and VA have in place to address the needs of sexual assault survivors, including medical therapies for PTSD and suicide prevention efforts of these departments. We understand that the DOD and the VA maintain an evidence-based joint clinical practice guideline on the management of PTSD. We would like to learn more about how this works in practice and how DOD and VA ensure continuity of care when victims transition from active duty to veteran status.

From DOD, we have Dr. Karen Guice, a—or excuse me, Dr. Karen Guice, the Principal Deputy assistant Secretary for Health Affairs; Ms. Jacqueline Garrick, Director of the Department of Defense Suicide Prevention and Response Office; and Dr. Nathan Galbreath, senior executive adviser, Department of Defense Sexual Assault Prevention and Response Office.

From the Department of the VA, we have Dr. Susan McCutcheon, Mental Health Director, Family Services, Women's Mental Health, and Military Sex Trauma; and Dr. Margret Bell,

Director of Education and Training, National Military Sexual Trauma Support Team.

I would like to thank all of you in advance for your testimony and for your dedication on behalf of our servicemembers. These are not easy issues to deal with, but they are real consequences of these horrific crimes that are far too common in our military.

There is no greater responsibility for Congress and the military leaders than to care and provide for our servicemembers and their families. The Nation entrusts their sons and daughters to our military, and we must ensure that their service is safe from sexual assault, and if they are assaulted, that they receive best care and treatment possible while at the same time holding perpetrators accountable for their criminal actions.

I look forward to the testimony of our witnesses on the first panel. I encourage you to express your views candidly and to tell us what is working and what is not working. Help us to understand what we can do to address this unacceptable problem of sexual assaults in the military.

I want to thank Senator Graham. It has been a privilege to work with him as ranking member of this subcommittee. I have great admiration for Senator Graham's passion on behalf of our military servicemembers and families. When he joins us, he can deliver his opening remarks.

Mr. Arbogast, would you like to read your testimony?

**STATEMENT OF LANCE CORPORAL JEREMIAH J. ARBOGAST,
USMC (RET.)**

Mr. ARBOGAST. Madam Chairman, distinguished members of this committee, I am saddened to be here, but thankful for the opportunity to share my testimony. I wouldn't be here without the love and support of my amazing wife and caregiver, Tiffany Arbogast.

Before I begin, I want to acknowledge the MST survivors who struggle day to day with losing their will to live while fighting for much-needed benefits, stability, and validations for the crimes committed against them, along with the MST victims who are no longer with us due to suicide.

I am a medically retired lance corporal who served in the U.S. Marine Corps. I am compelled by my oath to speak out about the injustices that have been done to survivors. The oath that I took has no expiration date. I urge each of you to stand with survivors of military sexual assault and to take proactive steps to fix the broken system of justice and survivor response.

I am a male survivor of military sexual trauma. I was drugged, rendered incapacitated, and sexually assaulted by my former staff sergeant from a previous command, a fellow marine, while on active duty. After this heinous crime, I was humiliated at the thought of my helplessness while a man and fellow marine took advantage of me sexually.

After 2 months of nightmares, anxiety, depression, and confusion, my world as I knew it was falling apart. I feared being blamed and retaliated against, and I was embarrassed. With the last shred of dignity, I turned to a base social worker, who felt it was her obligation to report the sexual assault to NCIS.

When NCIS started the investigation, they informed me I needed to provide proof of the assault. I felt humiliated because other individuals were now aware of what happened.

At a point during the investigation, I was forced to provide proof by confronting my rapist to try to get a confession. I was asked to make repeated recorded phone calls and then go to his home while wearing a body wire. I asked him to tell me what happened. I got a full confession, which I accomplished.

My perpetrator was arrested and charged with several counts, including sexual assault and sodomy. The trial lasted a week.

Even with overwhelming evidence, the court found him guilty of lesser charges. The court decided he would receive a bad conduct discharge, no jail time, and they took his 23 years of service as kudos.

He was ordered to NCIS headquarters for fingerprinting, where they determined he gnawed the skin from his fingertips on both hands so he could not be fingerprinted. He refused to register on the sex offenders database by simply saying, "No, I don't have to."

Nothing was done, and to this day, I don't know where my perpetrator is. Not knowing his location leaves me looking over my shoulder for the rest of my life.

I was not afforded the same rights as rape victims in the civilian world. Where are my choices?

While my perpetrator walked away with minimal consequences, I was formally retired from the U.S. Marine Corps due to military sexual trauma and post-traumatic stress disorder. I joined the Marines in order to serve my country as an honorable man. Instead, I was thrown away like a piece of garbage.

According to the American Psychiatric Association, 90 percent of all rapists and serial rapists will commit an average of 3 to 600 rapes in a lifetime. This is not just a military problem—this is not just a problem within the military. It becomes a societal and national security risk to us all.

While I tried to survive and hoped that my life would get better, even years later, the constant stigmatization, personal attacks, ostracism, and PTSD was never ending. Choosing death was my way of taking responsibility for my circumstances. I simply haven't found the resources to cope.

I sit here before you in this wheelchair due to a spinal cord injury that resulted in paraplegia from a self-inflicted gunshot wound from a 9mm handgun. I felt my death would spare my wife, daughter, and myself the dishonor the rape brought upon us.

This should send a clear statement of just how bad things can get in the lives of sexual assault survivors when they feel no hope and are not being offered the appropriate clinical support needed for them and their families. The armed forces were severely remiss and still are today in the treatment of MST survivors.

The VA healthcare system is overloaded and fails to keep up with the sheer number of growing—sheer growing numbers of MST victims. The VA mental health system lags in offering male MST survivors male-specific support groups, which is badly and urgently needed for millions of male veterans suffering from MST.

Twenty-two veterans are taking their lives every day, only 12 of which are combat related. The American Psychiatric Association

estimates that men who are denied proper counseling after rape are likely to attempt suicide at least twice in their lifetime. Therefore, DOD and VA providers and all military leaders need specific training in the nuances of trauma-related sexual assault, human sexuality, and the different effects of rape on both men and women.

The belief system about rape must change within the armed forces, and it will only change when the perpetrators are consistently prosecuted and no longer given leniency in their sentencing by their commanders.

In a recent article in the Military Times, a SAPRO official was quoted as saying, "We need to tell perpetrators 'don't rape.'" This approach will not stop rape in the military. You can't train rapists not to commit rape, but you can stop them from harming anyone else. Haven't we heard enough stories of broken lives and lives lost that have been told in front of these committees?

This is an epidemic. In 2012, approximately 14,000 men and 12,000 women were sexually assaulted in the armed forces, according to DOD's own Sexual Assault Prevention and Response Report. DOD has been claiming to try to fix this problem for over 20 years and to no avail. Sorry to say we cannot take the attitude of wait and see, not even for one more year, which was the recommendation from our Commander in Chief.

Half measures do not work, and neither do false promises. We need Congress to move past ego and political stalemates. These perpetrators must be stopped from continuing in their planned acts of terrorism against their fellow servicemembers. We need a justice system that ensures these criminals are held accountable for their crimes and prevented from victimizing any other servicemembers.

The first step to fixing this problem and ensuring the health and welfare of our servicemembers must be creating a professional impartial justice system because sexual assault is not an occupational hazard. I and countless others have lost so much in this battle. These losses are nothing unless the DOD and VA leadership hear our pleas for more accountability, an end to victim blaming and retaliation, and access to humane care for survivors.

Our servicemembers deserve the same duty, honor, and courage from you in solving this epidemic and its consequences that they have shown through their selfless sacrifices for this country. We expect nothing less from Congress when it comes to accountability in providing adequate care to our Nation's warriors. Your help is needed so our military can continue to be the finest fighting force this world has known.

Before I close, I would like to leave you some words from Gandhi. "You must be the change that you wish to see in this world."

Thank you.

[The prepared statement of Mr. Arbogast follows:]

[SUBCOMMITTEE INSERT]

Senator GILLIBRAND. Thank you.

STATEMENT OF JESSICA KENYON, FORMER PRIVATE FIRST CLASS, USA

Ms. KENYON. Distinguished members of the committee, I want to thank you for having me and affording me the opportunity to speak

today. I feel it is my duty, as someone who is able and willing to speak on behalf of myself and those who are unable.

I want to thank my loving husband, Brendan Brinkman, for his continued efforts in supporting me through this extremely difficult struggle, being there throughout unconditionally. I also want to thank the rest of my family who has been there for me and those families who do all they can for other survivors with very little support for themselves.

I joined the military as an Apache crew chief in 2005, a year after the implementation of the new sexual assault regulations. During the initial training, none of us received any training in what to do regarding in a real sexual assault situation. The truth was, at that point, I had to Google what to do when it happened to me.

I immediately experienced the flaws and repercussions. From there, it was instance after instance of a failed system in which I became ostracized, singled out, publicly shamed, disciplined for getting treatment, and treated as though I was the one who did something wrong.

From my experience, I can speak clearly to the loopholes in the current system that allows commanders, perpetrators, investigators, and anyone with outside influences and conflicts of interest to distort justice and degrade the military discipline and readiness.

These loopholes perpetuate a current state of affairs that when a case is handled or mishandled, I, like many others to this day, can be made an example of and held up as what will happen if you report anything. This shows other victims, as well as perpetrators, how their crimes will be handled.

This promoted me to leave the military and inspired me to expose the injustices they allow. I did not want anyone else to be put through what I was put through, but I also saw the potential for much worse situations, and I could not stand for it whether I was ready to leave the military or not. Given the situation I was put in, I felt no other option than regretfully leaving the military.

My work to help other survivors and families and fix this broken system is my way to continue to serve our country. Since my honorable medical discharge, I have worked with thousands of veterans, active duty, and their families.

I currently suffer from severe depression, bouts of insomnia, debilitating memories, thoughts, triggers of all sorts, anger, chattering in my head, constant anxiety to the point that I am forced to use all of my focus to appear normal, which hinders my abilities to read, write, have a conversation, remember much of anything in the short term. This level of keeping my head above water is where I have found what passes for a level of peace.

While I do hope to improve it, it is a very hard road, and some days I am not able to maintain my composure, and my husband and loved ones bear the brunt of it. I have to live with that guilt every day. I am just praying my son doesn't ever know me like this or, worse, what I was like before I gained some balance.

Most of my scars are invisible. So my needs are treated as less than important.

The current command environment makes it hard to keep outside influences away from all criminal cases in a command, regard-

less of the commander's view or the unit's view of them as commanders. Removing all judicial punishment decisions from the command will keep them clear of all repercussions, including to their command, their career, and their general morale of the unit.

Leaving judicial punishment with commanders is not just a problem in the mishandling of sexual assault cases with the victim blaming, and I have experienced it as well as others. A command environment is simply not a top-down environment.

My new—a new commander may take command in an established structure, and the disruption of the structure, regardless of how honorable their intentions, can lead to challenges to that command. This removal of judicial punishments from the command would remove conflicts both to and from the commander.

This also prevents a commander from lessening the charge to whatever keeps it in the command or at its lowest levels, either out of concern that the accused's talents would be lost or the command would look bad.

As of right now, there is no accountability for those who mishandle cases. But even if the commander wants to do the right thing, there is often pressure from the top to make it go away or downplay the severity. Discipline problems within a command will usually be reflected on the service record and cost them promotions. This environment is—this is not an environment for justice for victims, for perpetrators, or commanders.

As it currently stands, the VA handles sexual assault in the military similar to civilian cases. But it is critical to note psychologically they are very different. I have found it is much closer psychologically to the results of incest and should be treated as such.

As a civilian, sexual assault does not address the inherent trust victims give their command, nor the betrayal of that trust when a sexual assault occurs and the subsequent case is mishandled. This continues to be true even if the case is handled properly.

Survivors of sexual assault, like many others who suffer from PTSD, are rarely in a state emotionally, financially, or otherwise to navigate the complex and detailed paperwork and procedures that the VA requires for rating. This paperwork barrier receiving assistance often exacerbates the survivor's issues and all too often driving them to the point of poverty, homelessness, alcohol and drug abuse, and much, much more.

Rather than proper counseling, it is often the case that medications are prescribed. Many times, pills are almost immediately prescribed by various VA caregivers with no experience of what they might actually do to the mental health of the individual other than the list of warnings, which are often not taken seriously.

These mountains of drugs are also being mixed and matched constantly and most of which were never supposed to be mixed with anything other, let alone the numbers in which the VA doles them out. It is not uncommon to hear of veterans being prescribed dozens of medications at a time.

In more than a few cases, caregivers will refuse treatment if an individual refused to take the prescribed drugs, despite their helping or making things worse. The survivors have little to no recourse if things were to go wrong.

For those of us who do not wish to be drowned in psychoactive drugs, many of our cases are left to wither and our wellness opportunities are hard to come by or are too expensive or unavailable. There is no right way to have PTSD, and therefore, no cookie cutter treatment is not what most need. Offering and supporting programs and caregivers outside of the VA would go a long way to lifting their burden.

I also want to point out that servicewomen are more than twice as likely to have PTSD, but only half as often to get diagnosed with it. They are more likely to be diagnosed with a personality disorder or an adjustment disorder.

Thank you.

[The prepared statement of Ms. Kenyon follows:]

[SUBCOMMITTEE INSERT]

Senator GILLIBRAND. Thank you very much for your testimony. Your full statements will be submitted for the record.

I would now like to turn it over to the ranking member. Senator Graham?

STATEMENT OF SENATOR LINDSEY GRAHAM

Senator GRAHAM. Thank you, Madam Chairman.

I appreciate both of you testifying before the subcommittee.

I think there is almost unanimous support, I would hope, in the Senate for finding a way to provide treatment to people who have been victims of sexual assault. I know it has got to be one of the most traumatic experiences one could go through, and I do appreciate you sharing with us what you see as flaws in the current system, the VA counseling.

And I really look forward to hearing from the second panel. I think there has been some major monumental changes in the military about how we deal with this problem in terms of reporting, treatment, and just awareness.

The one thing I would say, with all due respect to our witnesses and to my fellow colleagues, from my point of view that this is a problem that will never be solved if you tell the commander this is no longer your problem.

Been in the military for 31 years. I do believe that the role of the commander, when it comes to dispensing military justice, is essential, and there is accountability in the reforms we have made.

That when sexual assault cases are brought to a commander and they refuse to prosecute after a lawyer says we should go forward, that decision goes all the way up to the secretary of the service. When the lawyer and the local commander say no to moving forward in an allegation of sexual assault, it goes up to the next level of command, which I think is a very good signal to take this seriously.

But I would just say to both witnesses, from a military point of view, to tell the commander this is no longer your problem would be an absolute disaster for fixing the problem and, I think, erode what the military is all about. It is the commander's problem. It is their responsibility, and we expect them to do their job.

Thank you both, and thank you, Madam Chairman. I look forward to hearing from the next panel.

Senator GILLIBRAND. Thank you very much for your testimony.

So I want to talk a little bit about the type of mental health services you did receive. Mr. Arbogast, could you talk a little bit about what type of mental health treatment you received through the DOD after your assault and whether you thought it was adequate care, if there are any improvements specifically to that?

And then after separating from the military, what was the mental health treatment like at the VA? Were there any challenges, any inadequacies there? And what recommendations would you make to this committee for the DOD or VA to improve the type of mental health services you receive after a sexual trauma?

Mr. ARBOGAST. Thank you.

After my assault, I was pretty much tossed to a back room, I would say, and, you know, just left floating around a command after I was transferred. As for care, I didn't receive adequate care from the DOD at all for the simple fact is, at my time of my rape, you know, this—you felt like a dirty little secret that they just wanted to do away with.

And the psychologist at Walter Reed Bethesda, you know, didn't—they wanted to either put you in groups that were either combat related or other mental illnesses. And then, you know, when you are in these groups and you are talking about this, you just don't feel comfortable talking about it.

So then they move you to an outpatient care, which, you know, is the same thing. They throw drugs at you, and it could be, you know, four or five different prescription drugs. And the thing is, is they don't want you to commit suicide, but what is the side effects of these medications? A lot of these medications is suicide.

So, you know, as for the DOD, they did absolutely nothing for me but just pretty much, you know, gave me a 30 percent discharge from the DOD for PTSD and sent me on my way. As for the VA, I only seen a counselor, one counselor, through my whole therapy who was not trained in military sexual trauma. He mostly trained Vietnam vets.

I looked for different treatment facilities and different programs at my VA. They were, you know, women oriented, which was fine. But then when I asked about, you know, what can they do for men? And she says, you know, "Well, we don't have a men's group yet. We are still in the process of putting that together." And this is just last year.

So, you know, her recommendation was to go through cognitive therapy, and that is traveling down, you know, every day for, you know, 6 weeks. And that is 90 miles from my home, you know?

Senator GILLIBRAND. After you attempted suicide, what did—what type of treatment did you receive then? Was it a different kind of treatment, or did you receive better care through the VA?

Mr. ARBOGAST. I received—as my spinal cord injury and my paralysis, I receive excellent care regarding that. And I go to Richmond at Hunter Holmes McGuire VA Medical Center down there for their spinal cord clinic, as it is top notch.

Their psychologists there are very well listeners, but again, they are not trained about military sexual trauma. You know, you bring it up, and they are like "oh." You know, that is kind of like their first thing, you know, their first expression. And at that point, you

kind of feel like, oh, you know, I am just this—you know, this dirty thing that they just happened to stumble in.

Not that I am downing any of them, it is just the fact that is a stigma that I feel personally when you get a reply of “oh,” you know, when you say that you are sexually assaulted.

Senator GILLIBRAND. Thank you.

Ms. Kenyon, can you share with us your experience in terms of what type of mental health treatment you received and whether it was better in the VA or whether it was better in active duty under the DOD and whether your records were transferred well, and what impact that treatment had on you?

Ms. KENYON. Yes, thank you.

During my active duty service, the recommendation was to go to mental health, and whenever I did, I would get a counseling statement for not doing my job. So after one or two, I believe, I stopped going because of the repercussions in my command. On—

Senator GILLIBRAND. Did your case go to trial, Ms. Kenyon?

Ms. KENYON. It did not. It went to—basically, the CID investigated, and he denied everything. And then he was caught lying on his sworn statement later, and they gave him a charge of lying on a sworn statement and indecent assault. And basically, he was given an Article 15 and extra duty. So he had no jail time, he lost rank, and that was it.

But my repercussions and the fact that I could not go to treatment, I was punished for going to treatment. So I did not pursue it while I was in the military. However, when I went out, I did. When I was discharged, I did try to go to the VA multiple times and was redirected to other locations, other services, and eventually gave up.

And I restarted recently trying to get more help and get support. And basically, what I have found in helping myself and other veterans, it is good counselors are the stuff of legends. You know, they are always 50 miles away.

They are always, you know, “I heard of this” magical counselor somewhere out of reach, you know? And those types of things happen and are told to other veterans, and they do try and pursue them. But if they are any good, they have a very long list.

Senator GILLIBRAND. Wait list. During your trial, were mental health records used in your trial, your mental health records?

Ms. KENYON. Not to my knowledge, and it was just my commander took it, and he didn’t—it was no formal trial.

Senator GILLIBRAND. Do you know, Mr. Arbogast, if your mental health records were used in your Article 32 hearing or during your trial?

Mr. ARBOGAST. I am not quite sure. But they did use mental instability. You know, the defense tried that approach when they did, when they drilled me on the stand.

Senator GILLIBRAND. But your trial was unique. You had taped evidence—

Mr. ARBOGAST. Correct.

Senator GILLIBRAND.—of your perpetrator admitting the crime of drugging you and then raping you. So you had more of an airtight case. But again, for those who joined our hearing later, your assailant received no jail time.

Mr. ARBOGAST. No. Due to, you know, his 23 years of service, they thought that was, you know, more or less, like I said, you know, it was kudos for him. And you know, to me, it was disgusting because, you know—

Senator GILLIBRAND. Which is one of the reasons why members of this committee are working so hard to remove the good soldier defense.

Mr. ARBOGAST. Right. And I think that is very important because of the simple fact of, you know, when I am brought in and I am told that, you know, oh, well, he is just a lance corporal. I am a staff sergeant. This is how many years I have served. And then you use that good soldier defense, then that weighs upon the jury or the judge, whoever has the case.

And then they are like, oh, well, you know, he has had this one case. But that doesn't mean that he hasn't had cases in the past.

Senator GILLIBRAND. Thank you.

Senator Graham?

Senator GRAHAM. Thank you very much.

Do both of you agree that if you had access to civilian counseling services, that would be beneficial—if the VA would pay for it?

Ms. KENYON. If I had a little more choice outside of where I did not feel I had to go to the VA and possibly endure other male soldiers who are always threatening to me, regardless—it is just a trigger—I do believe that I could see the benefit in not only other outside counselors, but other alternative healthcare, as prescriptions are not.

Senator GRAHAM. Do you know of anything in your local community that you think would be beneficial to you?

Ms. KENYON. I have heard and seen a lot of benefits to things like meditation, to yoga, to—in correlation with a counselor, you know, to push through balance and well-being and taking those triggers and those moments of panic and being able to maintain them much better.

Senator GRAHAM. I don't want to butcher your last name. Lance Corporal?

Mr. ARBOGAST. Arbogast, Senator.

Senator GRAHAM. Arbogast. Do you think that would be helpful to you to have access to civilian counseling if VA is inadequate?

Mr. ARBOGAST. I actually do that. I actually use my TRICARE and Medicare to do that because of the VA counselors not having that expertise.

Senator GRAHAM. Okay. So TRICARE does provide that access to you?

Mr. ARBOGAST. Correct.

Senator GRAHAM. In your case, Ms. Kenyon, that is not the case?

Ms. KENYON. I currently do not receive anything like that, and I pay out-of-pocket for any counseling.

Senator GRAHAM. Okay. But you did not—did you get a disability rating at all?

Ms. KENYON. I have not received a rating. The—

Senator GRAHAM. Is that still ongoing?

Ms. KENYON. It is still ongoing, Senator.

Senator GRAHAM. Okay. What was the date of your assault? Do you recall what time period?

Ms. KENYON. I hate to say this, but which one?

Senator GRAHAM. Well, I mean the one that is the subject of the Article 15.

Ms. KENYON. The one that received the most justice, I suppose, would be in July 2006.

Senator GRAHAM. 2006. Now you said you received letters of counseling going for treatment. Is that correct?

Ms. KENYON. Yes, Senator.

Senator GRAHAM. Would you be willing to make those letters available to the committee?

Ms. KENYON. Absolutely. If I have received a copy of them, I will make sure—

Senator GRAHAM. Okay. I would like to see the letter of counseling, who wrote it, and what they said.

Thank you both. I hope that we can find a way to broaden the treatment options available for those who find themselves in your circumstance. And I think there are a lot of things outside the VA, outside DOD that may be beneficial not just in this situation, but in other situations, but particularly this situation.

Thank you for sharing your testimony with the committee.

Senator GILLIBRAND. Senator Hirono?

Senator HIRONO. Thank you, Madam Chairman.

And thank you both for testifying this morning.

One of the concerns that this committee and the larger committee, the main committee, has is the fact that thousands and thousands of these sexual assaults occur, and they are never reported. Would you share with us particularly from your own experience why this is so and what we can do to enable more of the survivors to report these crimes?

Start with you, Mr. Arbogast.

Mr. ARBOGAST. Senator, could you elaborate that question again?

Senator HIRONO. Well, thousands of—the figures are some 22,000-plus sexual assaults occur in the military in a given year, and only a very insignificant number of these crimes are ever reported to the chain of command. And I wanted to ask for your thoughts on why this is so and what we can do to enable more people to report these crimes, enable more servicemembers to report these crimes.

Mr. ARBOGAST. In the DOD, reporting to the chain of command, it is horrific. You know, it could be a perpetrator in your chain of command. It could be your direct supervisor.

In my case, it was my previous supervisor. He used his influences to try to get to me, torment me over the time that I was, you know, raped and to the time that the investigation was going on.

Then I endure, you know, going to his home wearing a body wire, and then I have to endure the Article 32. Then I have to endure the court martial. So you can see the patterns of different traumas that I was subjected to.

So anybody that would see something like that, any servicemember would be like, you know, I am not going to report this. And thousands of veterans—the VA finds thousands of veterans a year that finally report military sexual trauma, and I don't have the exact numbers, but I know it is alarming.

So, you know, taking it out of the chain of command. You know, I have talked to some active duty commanders, and they have specifically said if I don't have to deal with sexual assault and I can continue going on with what my mission is to, you know, make the unit ready and deal with these everyday problems of what needs done in whatever their command is, whether it be engineering, motor, or transport, they would like to do that, concentrate on that. Because a sexual assault is more or less a burden on the command, and then it creates a morale problem and a cohesion problem.

So, you know, it is just that is the only thing I can think of that would get that, and you know, going back to my testimony where it says, you know, that SAPRO official made the comment that, you know, let us tell them, let us just tell perpetrators "don't rape." Okay. So you get all the perpetrators in a room and tell them don't rape, but you are still going to allow them to serve?

Senator HIRONO. I note in your testimony that one of those observations you made is that there should be some very specific specialized training in working with survivors of military sexual trauma. I do agree with you because on the civilian side, there are many States that require prosecutors, for example, to get very specialized training when they deal with rape victims, for example. And apparently, that is something that you would suggest for the military.

Ms. Kenyon, would you like to give us your thoughts on my question?

Ms. KENYON. Yes, thank you, Senator.

I would add, generally, the attitude—sexual assault is underreported in the civilian world as well and is not to disregard the military environment in which makes it even more hostile.

I would also point out that I can only correlate it with to make an understanding, who would a cop report a rape to within their own that wouldn't cause other police officers to possibly spread a rumor? That is the only civilian thing I could possibly think that would correlate with a perversion of justice this way.

So I would also stop publicly putting posters up with rape myths like "wait until she is sober." These types of things like that, where it is a different type of candy-coated victim blaming.

There is a lot of studies in regards to the perpetrators are repeat offenders. They prey on this. It is not a sexual act. It is a power act. It is not about the sex. It is about usually taking them down a notch.

Senator HIRONO. And would you agree it should also be treated as a crime?

Ms. KENYON. Oh, absolutely.

Senator HIRONO. That is what it is. You work with survivors of military sexual trauma. So during the period when you had to undergo repeated traumas, have there been some positive changes to how the military helps survivors of military sexual trauma?

Ms. KENYON. Well, I do believe the 2004 implementation of the SAPRO office, despite it not having power, the option to report unrestricted and restricted did open a few doors. However, the loopholes are so great that the command can still exploit them regardless.

Because, for example, if you were a survivor of sexual assault and you wanted to go to a counselor, but you reported restricted, which is all within your rights, what would you tell your commander? You know, giving that information to a commander allows them to investigate it and go further with an unrestricted report whether they cooperate or not. This was threatened to me.

And already being ostracized based on a previous investigation, I could not allow the commander who threatened to question everybody in my hangar—that is 260 people—and create that kind of environment which everybody knew what was going on, not just most of them.

Senator HIRONO. So while there have been some improvements, then given the severity of the problem, more can be done?

Ms. KENYON. We have a very long road ahead, and you know, it is an amount of baby steps. And I do hope that we can take it step by step, and public prosecutions will go a long way to showing both victims and survivors or perpetrators as justice can and will be done.

Senator HIRONO. And you, too, support removing the chain of command from the decision to prosecute these crimes?

Ms. KENYON. Absolutely. I believe that there is enough on the commander's plate, and the fact that there is just entirely too many conflicts of interest, as well as just even if they do want to do the right thing, there is pressures from every direction that creates an almost impossible environment in which justice could be served even, and I hate to say this, but even to the perpetrators.

Senator HIRONO. Thank you.

Thank you, Madam Chairman.

Senator GILLIBRAND. Senator Kaine?

Senator KAINE. Thank you, Madam Chairman.

Questions in sort of two areas that have been raised by just listening to your testimony and answers to questions. And first, I will just thank you for being here today. This is hard to do, and I appreciate your courage in coming and letting us ask questions so that we can understand the situation and better decide how to improve it.

Ms. Kenyon, you raised a point in your testimony, and I want to make sure I understood what you meant. You said that you think to some degree, sexual assault in the military gets treated like any other sexual assault, a citizen sexual assault. And you said that you thought the better analogy was an incest analogy, and I just want to make sure I understood kind of what you meant when you said that.

Ms. KENYON. Absolutely. Thank you.

I love talking about this in regards to how I even talk to my survivors who contact me. In doing that, the betrayal aspect that is completely—very uncommon in the civilian sexual assault is one of the feelings that I left the military feeling almost crushingly, the betrayal of my command.

I mean, we are talking at this point an All-Volunteer military. So they go in, and there is an inherent trust. There is a trust in the system. You know, you are fighting next to your brothers, your sisters. You know, these guys are in charge of your well-being, your

food, your exercise, your clothes, everything. Everything in the same psychological aspects as an adult that it would be as a child.

I mean, boot camp is literally there to break you down, to build you back up as a soldier, an airmen, et cetera. And that being said, you know, if, say, you were assaulted by your brother, which in many cases psychologically is quite similar, you go to your father, your commander, and say he didn't want to report it. How would you deal with that?

So it is quite psychologically similar, as well as the fact that it is very easy for victims—and this happens in the civilian world. But it is very easy for victims to start blaming themselves because they don't know the perpetrator. So I teach them about the perpetrator so they can put the blame where it belongs and process that correctly.

Both of those go a long way into getting into the right head space long enough so they can work through this bureaucratic system, which is extremely difficult, and it is like a safe. You know, if you get it wrong, you have to start over.

Senator Kaine. So that is very helpful to understand the analogy, the environment that creates a bond. It is not only a crime of violence, but it is also a betrayal of a relationship. So whether in the civilian context, whether it is incest or whether it is sexual assault by someone you know, which a huge percentage of sexual assaults in the civilian context are by—you know, the survivors know the perpetrator.

Ms. Kenyon. Right.

Senator Kaine. There is an additional betrayal element. That helps me understand what you meant.

Both of you, I think, Ms. Kenyon, in your testimony and, Corporal Arbogast, in one of your answers to the question, you touched upon a topic that I want to have each of you address a little bit. That is the issue of in the treatment phase, concerns that you both have about overmedication.

And I just was curious. Is that a concern that you have about the way PTSD is treated from sexual assaults or a more general concern you are sharing with us about the way the DOD or the VA approaches mental health issues? You know, this is part of a much larger discussion, obviously, about the way we as a society tackle mental health issues. Are we too heavy into just, you know, take this prescription and then take two or three more?

But I am curious as to whether you think that this might be really focused on the PTSD issue, or is it a more general kind of complaint about the way we do mental health in the military context?

Mr. Arbogast. Thank you, Senator.

That context not only goes with combat-related PTSD to military sexual trauma PTSD. You hear from both groups that they are overly medicated, overly medicated, and you have got severe side effects to all these medications.

So you are pretty much, like I said, when, you know, you go to these appointments, and this is a flaw also, is that when you go to get these medications, you have got 6 months gaps before you see a psychologist or psychiatrist. So there is too many long gaps

there. And then when you go there, you know, to spend 5 minutes in their office.

So if you live far away, you travel 90 minutes to spend 5 minutes in an office for them, “Oh, we are going to throw this drug at you,” or “We are going to throw that one at you.” And like I said before, it is these side effects are just astronomical of what they can cause.

Ms. KENYON. Thank you, Senator.

Definitely I can speak personally in the PTSD realm. However, in the survivors that I have dealt with, it does bleed over into other—when it comes to like TBI, to any sort of personality disorders, any diagnosed depression, all of these just get—any sort of pain even. Even if you say, “Oh, I hurt my foot,” they will throw a pill at you, at least one.

What happens is it usually starts with one or two, “Oh, let us try this out.” And like Jeremiah pointed out, there is long spans in getting back in to get—you know, to take yourself off of some of these drugs is extremely dangerous, and to mix and match is also even worse.

And then you come up with new symptoms, saying, “Well, I dealt with this, but I still—now I feel like I am under water all the time.” And they will throw another pill at you instead of fixing the one that they previously gave you.

Senator KAINE. We are seeing—obviously, I know you follow this, too—a huge epidemic of things like heroin addiction these days in the broader society that often begins with prescription drug addiction. And then prescription drugs are more expensive than heroin now, and so this prescription drug thing is a significant issue.

And if I hear you correctly, as you describe it, you worry a little bit that this overmedication is driven by, well, we don’t have enough counselors to meet with you enough, and so if it is going to be 6 months until you have an appointment, we have got to do something. So, here, try this.

It is kind of a stopgap. Probably isn’t the best diagnosis, probably isn’t the best strategy, but we have got to do something because there are not enough counselors to deal with your mental health needs. So there is an issue of probably the number of counselors, the kind of training they get, and you worry that the medications are just being, you know, kind of “Here is something to get you by for a while.”

Ms. KENYON. Yes, a band-aid, basically. And even then, it is a band-aid that could kill you.

Senator KAINE. Yes.

Ms. KENYON. And some of them are just—the medications snowball, and I don’t—I personally have looked this up, but I can’t find accurate like correlations with civilian versus military treatment in medications and how they are doled out. And I think that would be important to study—

Senator KAINE. Yes.

Ms. KENYON.—as well as just the survivors that have contacted me, out of curiosity, the ones who would volunteer their list of medications, and my husband being a neuroscientist, I hand them over. And he says, “How are they still alive?” You know, and it is amazing to read just the side effects and some of these things.

Senator KAINE. Well, my time is up, but I think that this raises an interesting area that we probably should explore. If we were able to determine, for example, that folks in the military who are seeking treatment for mental health issues, PTSD or other, were dramatically more medicated than those who were seeking mental health services in the civilian world, that would really strike a big alarm.

That would suggest to us that maybe something is not being done right, and the way you have made that testimony, you have pointed at a potential problem that we ought to explore further.

Thank you for your testimony today.

Senator GILLIBRAND. Thank you, Senator.

Senator McCaskill?

Senator MCCASKILL. Thank you. First and most importantly, I always stand in awe of those of you who have been victimized by this horrific crime and step out of the shadows and not only try to see justice, but then go on and try to do even more. And I think while there are some policy differences in the U.S. Senate, I think we all are such fans of your courage and your tenacity. So I want to thank you very much for that.

You know, as somebody who spent years as a sex crimes prosecutor and walked into the courtroom hand in hand with hundreds of victims, I am painfully aware of the shortcomings of victim services for this crime no matter where it occurs.

And one of the things I wanted to visit briefly with both of you about is, first, I want to thank the military because I think it is the research and the recognition of PTSD that has allowed the civilian criminal justice system to begin to get their arms around the fact I think most of the victims I worked with in the late 1970s and 1980s and 1990s were suffering from PTSD, and those that were victims of domestic violence were suffering from PTSD. And our ability to treat this and prevent suicide as a result of this absolutely insidious illness should be at the top of all of our lists.

And so, I think that at least now we are beginning to recognize the problem. We have got a ways to go, obviously, with having the services tailored to the type of stress and trauma that has brought about this illness, and I think that is what we are all focused on trying to do now.

If either one of you at the moment you reported, whether it was to a social worker or at a hospital or wherever, whether restricted or unrestricted, if at that moment you had gotten your own lawyer whose only job was to look out for you, do you think it could have made a difference in terms of how you were treated as you navigated this difficult process and the services that you might have been provided?

Ms. KENYON. Thank you, Senator.

I do believe a lawyer would be helpful, especially one that is impartial and not in my command or any way related. I have also—I have personally been working on almost a type of Miranda rights where you can go to anybody as a survivor of sexual assault, and they have to tell you what your rights are before you move forward.

That way, you knew—I mean, you didn't accidentally go to your commander, and then now you can't report restricted. I mean, that was something that happened to me and that my commander then

later made promises that made me confident in the fact that he would lie to me.

That being said, between the lawyer as well as like just being very upfront, commanders, priests, clergy, lawyers, anybody involved in that system should be upfront with what a survivor is allowed to do at that point before he or she can make a decision in that regard.

Senator MCCASKILL. Do you think it would have helped you, Lieutenant Corporal?

Mr. ARBOGAST. Senator, I really don't know because I was young at the time. I can't say because everything was kind of fast paced.

Senator MCCASKILL. Right. Right.

Mr. ARBOGAST. You know, I went from falling apart to where do I go and going to a social worker and everything just trickling down from there. And was I told about anything about, hey, these are your rights, and you could have your own attorney, I think that would have helped as being somebody that was advocated that was not biased within the chain of command for the simple fact is, is because you don't know if that person that may be advocating for you, or your so-called lawyer—I don't know if you are referring to a civilian lawyer or a military lawyer. But you don't know if that is a golfing buddy or somewhere down the line that they know each other, and they go back and tell your personal information.

And then where I have had this happen is like people found out about my situation from being talked about, and it is like how did they find out? So—

Senator MCCASKILL. Right. Just I know that when I was a prosecutor, there were sometimes victims that declined to go forward even after we had gone through a lot of the process and I felt very strongly that the case could be successfully prosecuted. And the victim, for a lot of reasons, including mental health issues, PTSD issues, said, "No, I am done."

And at that moment in time, the lack of trust that victim may have had in me because I was part of a system. You know, I was associated with the police, and you know, I was—if they had had their own independent lawyer that would have been giving them advice just for them, a little bit like we do with court-appointed special advocates for children in the juvenile system in the civilian cases, where there is a lawyer, an advocate for the child that is not associated with any of the other parties in the conflict.

I am hoping that what we have done, which is remarkable that we are going to require this for all victims, is going to set a standard. First of all, this has never been done anywhere in the world has this occurred. I am really hopeful that it will once again show the way to the civilian system that we have got to find the resources. Because in the civilian system, the victims have no guarantee of any mental health services. None, zip, nada.

There is nothing there. A lot of them don't have insurance. So you have to kind of try to coddle together.

Finally, I want to say we are determined to get rid of the good soldier defense. I am confident that is going to happen if not within the next month, then certainly with the next NDAA. I have not encountered opposition to this idea. So I want you to know that before you go.

And finally, we are going to work on this overmedication thing. When I went to Walter Reed after the big scandal there, and I went from room to room in Fisher House and other places over there, every single room, the dresser was all alcohol bottles and pill bottles, and I didn't see one sign for group therapy for addiction treatment. And I began then realizing we have a huge overmedication problem when it comes to mental health in the military.

Mr. ARBOGAST. If I could ask you about your question about the attorney. You have my testimony about, you know, how like I said before, how—what I went through, you know, going from reporting to the Article 32. I had nobody, nobody at all.

And you know, the thing is, is that when it came to court martial time, I was drilled. I mean, I am being traumatized so many and being revictimized so many times. And nobody—you know, I had the prosecutor, but, you know, he can only do so much.

But you know, when you are up there and you are getting drilled by this perpetrator's defense attorney, and they are playing the recorded tape that I got on him and saying, "Listen to this. Did you ask for this? You wanted this." You know? And the judge not to intervene, it was disgusting.

Senator MCCASKILL. Well, there, believe me, I have been in a courtroom as a prosecutor when a judge didn't intervene when there was inappropriate questions, when I have made the objection on rape shield statute and others. And the judge just completely did not make the right ruling.

And you know, I think judges are better today than they were 20 years ago. And we are working now to make sure that the victims today and going forward have that independent lawyer that can be there for them and advise them, and I am very excited about that reform. We all worked very hard on it together. I am really proud of it.

I don't think that how big it is actually has been comprehended by most people because we have been focused on a policy difference rather than on the monumental historic changes that we just got signed into law.

Mr. ARBOGAST. I believe it would really—it would help tremendously, you know, to have somebody there along supporting you because I had nobody.

Senator MCCASKILL. Right.

Ms. KENYON. May I say to have that as well, that person not be subject to rank. That is very important. Because I had lawyers who were captains or lieutenants, and they were unable to confront my commander because they outranked. Or even the SAPRO office, who had no rank and were civilian, cowered under anyone with any bars on them. So to have that independence somehow.

Senator MCCASKILL. We have got to make sure that happens. You are absolutely right, Ms. Kenyon.

Thank you both very much.

Ms. KENYON. Thank you.

Senator GILLIBRAND. Thank you, Senator.

Interestingly, we have heard incidents where the special victims' counsels have been put in very difficult positions for that reason. So that is something many of us are going to look into for the next NDAA. Because I have heard of cases where special victims' coun-

sels have advised not to seek mental health because of the concern it would be used in the Article 32 against them or at least advised you need to be aware that it could be used against you.

And I have heard of cases where the question of whether one would report or not was debated because of fear of how they would be treated. So I think we have to really look into empowerment of that specific person to make sure they can't be bullied. They can't be retaliated against themselves.

So I think that is something Senator McCaskill and other Senators and I are going to work on for the next round. I think it is really important.

Senator Ayotte?

Senator AYOTTE. I want to thank you, Madam Chair, for holding this hearing.

I want to thank both of you for being here and for your courage in coming forward before us. And so sorry for everything that you have been through, but to come here before us, it is really important because this issue, obviously, is one that we want to work together to stop the occurrence of military—sexual assaults in the military, but also to make sure the victims get the full support that they need.

And I think this issue of special victims' counsel that Senator McCaskill and I and Senator Gillibrand and others on the committee have worked on is going to be a very important reform. You know, one of the things that the reforms have, too, as well is making retaliation a crime under the UCMJ. And I think, as we go forward with implementing the special victims' counsel, this is something we should look at to make sure that it is clear that any kind of action against a victims' counsel that is helping a sexual assault victim should also be actionable.

And so, I think that is an important thing so that everyone understands that retaliation against a victim is a crime under the UCMJ because we have just made it so. But also any retaliation against someone acting on his or her behalf should be as well, and I think that is something we can make sure as we look at this going forward.

You know, the other issue that Senator McCaskill and I have and others on the committee have thought is really important is this idea of eliminating the good soldier defense. So I am hoping we do that this year. We have done a whole host of reforms, including the special victims' counsel. But this good soldier defense has no place in determining, you know, the outcome of these cases in the sense that your conduct should determine the outcome.

And if you have committed a crime and have committed these horrible acts, then just because you were a good soldier doesn't mean you shouldn't be held accountable and fully accountable and have the appropriate sentence to go with the crime that you committed. And I think that, you know, in the civilian system, we have eliminated a lot of those things, and those reforms now I am hoping we will have some agreement on that. And I think there is a lot of agreement to get that passed this year as well.

Finally, I just wanted to understand that as you talk about the overmedication issue and the transitions that you have made, you know, outside the military, so is there—how is that—how do we

improve that transition process? What can DOD and the VA do to improve that transition process from your perspective and to make sure that you have the support system in place if you choose to leave the military and have been a victim of sexual assault?

Last week, I was up in New Hampshire visiting one of our veterans centers, and one their charges is to treat victims of sexual assault. And I think it is obviously how do we make sure that that care is there?

And I just wanted to get your thoughts on what can we do better on even the transition from DOD, those who are leaving out to the VA. And obviously, I have heard what you said about the overmedication issue within the VA system so that we are working, even though the Veterans Committee will work on that, we can work on this, I think, in this committee, too. So just wanted to get your thoughts on how we could do a better job.

Mr. ARBOGAST. Thank you, Senator.

I have worked—you know, I worked closely with and do adaptive sports with the Wounded Warrior regiment for the Marine Corps. They have district injured support coordinators. I think the Marine Corps has made a huge step when it comes to that because not only do they follow from the time that they are in the Wounded Warrior regiment there, you know, to civilian world, these district injured support coordinators that are still active duty check in on the veterans.

And I think that is crucial, and it is also an awesome concept, you know, when it comes to that. So that way, the veteran can pick up the phone and say, “Hey, look, this is going on.” That desk officer or enlisted, whatever it may be, can contact their resources and make things move along.

So the Marine Corps has done tremendously when it comes to taking care of their wounded. So—

Senator AYOTTE. So maybe that is a model that we can look at also to make sure that is across Services?

Mr. ARBOGAST. I believe so, ma’am. I mean, like I said, it has been pretty effective.

Ms. KENYON. I would say holding the ability for the VA to talk to the DOD. That is something that is very broken right now. The records and the database in which they both work do not communicate at all, and that will go a long way to just even simple as a records transfer. That will help, as well as affording opportunities outside the VA, and I would almost even say a grace period in which PTSD sufferers could have proper assistance in getting themselves to a well-being and to navigate that complex system.

There is—as I said, there is no right way to have PTSD, and so there is no real here is my recommendations, and it will work for everybody. However, I think catering and having enough support, even if it was just a single counselor for one individual to help with paperwork to see that he or she receives the proper medications, that they are able to make appointments with one phone number and not sit on hold as opposed for days because—

Senator AYOTTE. For days, really?

Ms. KENYON. I mean for hours and hours, and most of the time you give up, and then you try again tomorrow.

Senator AYOTTE. Wow.

Ms. KENYON. And so, that does happen quite a bit. If it is okay, I would like to make a comment on the retaliation? You guys—
 Senator AYOTTE. Whatever you would like to—

Ms. KENYON. You said you want to make retaliation a crime, and currently in regulations, it is. But, however, it is usually the command who does it. And as it currently stands, it is the command who would prosecute themselves.

So that is a clear conflict of interest. And how would you pursue that? How are you proposing that, you know, say I was retaliated against, who do I go to, and who would handle that case? As well as who would be in charge of making that charge and deciding what was really retaliation and what might have just been a bad, you know, night out or any other number of things that the command could downplay it as.

Senator AYOTTE. I think that we have further—with what we passed in the legislation further emphasized that retaliation, in particular for these types of crimes, is a clear crime under the UCMJ to further give teeth to that crime under the UCMJ. And you know, the proposed—one of the proposals that is on the table allows a really going beyond the chain of command, up the chain beyond if there is a conflict at the level of the chain of command.

So I think that is one way to deal with it, where you are taking it up beyond that person and really upping the issue within so that there is a huge emphasis on it. But obviously, one of the things we want to get with everything we are doing is that we continue to have oversight over this.

I mean, I think what you are you hearing from everyone here is that whatever we pass, I mean—and we have passed some incredibly important reforms in the defense authorization, and we may pass further reforms—that we are going to continue not just to have this be the year where we are emphasizing it, but that we have regular oversight over this. So I think that is an important aspect, too, so that we can further pass whatever needs to be done and also hold people publicly accountable, particularly for those who are leaders to understand that this is part of their responsibility to have a zero tolerance policy and to support victims.

And that if a leader in our military is found to be retaliating against someone who is a victim or someone helping a victim, that they are going to have a lot of problems, and we will hold them publicly accountable here, too. So I want you both to know this isn't you come here once, and we are just going to have this year of issues because I think all of us around this table are committed to a continuing oversight function next year and each month.

Because I think that is what in the past we have sort of had this issue where we are all focusing on it and then it goes away, but you all are dealing with the problem still. And so, we, I think, are committed to remaining continuously engaged on this issue on a bipartisan basis.

So thank you for raising the issue on the retaliation.

Senator GILLIBRAND. Thank you.

Senator King?

Senator KING. Thank you, Madam Chairman.

Like my colleagues, I want to thank you. I wouldn't want to appear before a Senate committee under any circumstances, and you

are doing it under particularly difficult circumstances. You are truly serving your country today and honoring the oath that you took when you joined the service, and I deeply appreciate it.

I want to focus on the issue of command and chain of command because that term has been used repeatedly. Ms. Kenyon, you said something about it is the command who retaliates. How can they prosecute themselves? My commander lied to me.

I don't need a name, but what rank person are you referring to when you say that?

Ms. KENYON. I actually had multiple ranks retaliate as well as lie to me and make false promises and things of those nature, everyone from my squad leader up to my command sergeant major and my lieutenant colonel. I mean, everyone in that rank who I came in contact with regarding my sexual assault somehow, some more severe than others, let me down or made false promises or made it—outright made my life a living hell.

Senator KING. I understand that. But I think one of the ways that this discussion that we have been having has been somewhat confusing is that we are using the term “chain of command” as if it is multiple people. In reality, as I understand it, under Department of Defense policy, nobody below O-6 makes the decision whether or not go to forward with a prosecution, and those people you just mentioned all are below the O-6 level.

In other words, when you say your commander, you are not talking about a Navy captain or a colonel or above. Is that correct?

Ms. KENYON. Yes, Senator. That is correct. I—my—excuse me. At that time that I served, it was the commander's ability to lessen the charge so an O-6 never—it never came across it, their desk.

Senator KING. Okay. Well, now that is an issue we have to be sure that the facts get to the O-6 level because they are the people making the decision. But I think it is important to inform our discussion that when people talk about taking the decision out of the chain of command, you are not taking away from sergeants and majors. You are taking it away from colonels and naval captains. That is a higher level.

Let me change the subject for a moment. You have talked eloquently about the deficiencies of the treatment system. Would one solution be to allow military personnel to use their benefits in a civilian system? In other words, to go outside the military system to get the counseling and those, if there is more availability in the area that—wherever you live?

For example, we have a program in northern Maine under the VA. It is a pilot program where veterans are able to get their services not by going 4 hours to the VA hospital, but by accessing local civilian services. Would that be something that might be helpful in this situation by broadening the field of available treatment possibilities, Mr. Arbogast?

Mr. ARBOGAST. Thank you, Senator.

Like I stated before, I already use my TRICARE and Medicare for that purpose because where the VA lacks. I think the VA veterans would not have a problem traveling for good care.

It is the fact that they need to—you know, I emphasized on how good I get my spinal cord injury care in Richmond, Virginia, now.

So that is a 4-hour drive for us. So, you know, I would go there every day—

Senator KING. If you were getting adequate care?

Mr. ARBOGAST.—if I was getting—well, I mean, I get adequate care there. I get superior care there.

Senator KING. But you mentioned the 90-mile drive for 5 minutes.

Mr. ARBOGAST. Oh, that would be within my VA medical center, which I try to avoid at all costs because they are just—they are out of the loop. They don't have the resources. You know, they don't even have a doctor that specializes in spinal cord injury care. He is just an M.D. who thinks he just knows about it but really doesn't.

But the thing is, is if every VA had the resources to deal with every type of injury, illness, whatever, then it wouldn't be a problem to use the VA system. It is the problem that each VA medical center is different in what their care is, and I think it is because they are not being held accountable. So—

Senator KING. Ms. Kenyon, do you have thoughts about that?

Ms. KENYON. I believe there are a lot of benefits especially in the ability to test drive basically other counselors and caregivers to whom you feel comfortable, as well as being able to better specialize in what is actually affecting you, such as well as, you know, there is the PTSD, the prescription and overprescribing problems.

But then there is also identity issues and other addictions that don't fall under narcotics or alcohol, like even like shopping addictions and things like that that are not treated in the VA. But if you went and sought outside help, I think there is a lot of benefit to getting more specialized treatment.

And I think it is I would say almost impossible for every VA to have every service. And so, with that knowledge, to have the ability to go outside of that would benefit them.

Senator KING. But given the rise of this—I don't want to imply that it hasn't existed before. I am sure PTSD goes back to the beginning of time. But the increasing awareness of it, the volume of it that we are seeing in recent years, I suspect you would agree that this is something the VA should be gearing up for in a very serious way. And I am gathering from your testimony that you don't believe that they are?

Ms. KENYON. I don't believe the VA has the ability to move three moves ahead or to see that where the need is coming until they have the problem. Then they approach whomever, and then the money comes in for the problem. But by then, it is 2 years down the road, and the problem is even bigger.

And so, I don't see that there is an adequate system for the VA to apply certain foresight in seeing where they need help and being able to justify it effectively to whomever they have to, to get the proper funding to get it. So you might want—I would consider looking into that system where you could encourage the individuals, the directors to think three moves ahead and say, you know—

Senator KING. What is coming.

Ms. KENYON. Right. Look what is coming. You don't necessarily have to obviously prove it with, you know, the numbers in regards

to you already have these, and this is what you are funded for. You don't have to have them on backup to justify the need. So—

Senator KING. Well, the VA isn't within the purview of this committee, but clearly, it is a continuum of concern that we have about our military people, whether they are in service or veterans.

Thank you very much for your testimony. Thanks again for taking the time.

Mr. ARBOGAST. If I may?

Senator KING. Yes, sir.

Mr. ARBOGAST. There is a very big problem with the VA's retention rate, too, with providers.

Senator KING. Retention rate?

Mr. ARBOGAST. They can't keep doctors, especially where I am at. Their VBOC or CBOC, excuse me. You know, I went through seeing a doctor who I seen for years, we are talking about like medical doctor. You know, I seen for years, and then I come back in and find out he quits.

Well, then it takes them 6 months to get a new doctor. So I am left without care for 6 months. They finally get a new doctor. I have to explain everything all over again. Then come to find out, oh, well, I will see you in a month or 2 weeks or whatever it may be. Well, come to find out he quits. So then I am left without care for 8 months.

Senator KING. Now do you have a choice in all this? Do you have to go to the VA hospital, or could you use TRICARE to go anywhere?

Mr. ARBOGAST. I could use TRICARE to go anywhere, but the fact is, is some civilian providers are just as bad as the VA providers. It is the way—

Senator KING. Are you suggesting our healthcare system in this country is screwed up? [Laughter.]

Mr. ARBOGAST. It is.

Senator KING. I am shocked.

Mr. ARBOGAST. It is truly. It is, and you know, it is quite disturbing that, you know, we more or less veterans have to go around and shop for, you know, is this doctor specialized in this care, you know? What do they know? So I mean, it is a very disturbing problem.

Senator KING. Well, thank you.

Thank you, Madam Chairman.

Senator GILLIBRAND. Thank you.

I want to thank this panel for their testimony. This is extremely helpful in our deliberation to understanding these issues, and we are grateful for your service.

Thank you very much.

Ms. KENYON. Thank you, Senator.

Senator GILLIBRAND. We will now welcome the next panel to join us. On our second panel will be Dr. Karen S. Guice, M.D., M.P.P., Principal Deputy assistant Secretary of Defense for Health Affairs; Ms. Jacqueline Garrick, LCSW, BCETS, Director, Department of Defense Suicide Prevention; Dr. Nathan Galbreath, senior executive adviser, Department of Defense Sexual Assault Prevention and Response Office; Susan McCutcheon, R.N., National Mental Health Director, Family Services, Women's Mental Health, and Military

Sexual Trauma; and Dr. Margret E. Bell, Director of Education and Training, National Military Sexual Trauma Support Team, Department of VA. [Pause.]

For those of you who—I have handed out some data that we can have for the benefit of the expert panel we are about to have. The first chart shows the likelihood of having PTSD as a result of each action.

So, for example, placement in the U.S. Army, it is 1 out of 10. It is 10 percent. Enlisted at 1 out of 10, active duty 1 out of 10, multiple deployments slightly higher. But if you have military sexual trauma, your likelihood of PTSD is 4 out of 10.

So that is just the first chart. The second chart shows the number of people who screen positive for military sexual trauma, the incidence of PTSD is higher for both men and women. So if you have experienced military sexual trauma, it is 52 percent of the time you are going to get PTSD if a man, and 51 percent of the time you are going to get PTSD if you are a woman.

And then the last two charts that if you screen positive for military sexual trauma, you have a higher incidence rate of mental health conditions. Meaning if you have been sexually assaulted, you are 75 percent likely to have a mental health condition as a man. Slightly higher for a woman. Same for depressive disorders, post-traumatic stress disorder, and other anxiety disorders. And that is the last two charts.

So our experts can refer to these charts if you need to. It is just the currently available data for veterans from Iraq and Afghanistan from April 1, 2002, through October 1, 2008. Do you want to put the charts up so people can see them? [Pause.]

We also have a statement that we are going to add to the record from Brian Lewis from Protect Our Defenders. Without objection, I will enter it into the record.

Is there an objection? Without objection, it is entered into the record.

[The prepared statement of Mr. Lewis follows:]

[SUBCOMMITTEE INSERT]

Senator GILLIBRAND. Thank you to each of you who have joined us on our second panel. I appreciate your expertise that you are going to bring to this discussion, and I invite you each to give a personal statement of up to 7 minutes, and your full statement will be submitted for the record.

Dr. Bell, if you would like to start?

STATEMENT OF MARGRET E. BELL, PH.D., DIRECTOR FOR EDUCATION AND TRAINING, NATIONAL MILITARY SEXUAL TRAUMA SUPPORT TEAM, DEPARTMENT OF VETERANS AFFAIRS

Dr. BELL. Good morning, Chairman Gillibrand, Ranking Member Graham, and members of the subcommittee.

Thank you for the opportunity to discuss the intersection of two very important issues involving our servicemembers and veterans, namely military sexual trauma and suicide.

We just heard the incredibly moving stories of the two veterans that testified who have struggled very much with the issues that we are discussing today, and I very much appreciate their willing-

ness to come today and really bring some of the data that I am about to speak about to life and make it more real for us today.

The stories they have shared really underscore the importance of the issues I would like to review in my comments, which is what research and empirical literature tell us about the health impact of military sexual trauma, as well as the relationship between trauma, military sexual trauma, and suicide specifically.

Military sexual trauma, also known as MST, is an experience, not a diagnosis or a mental health condition. And as with other forms of trauma, there are a variety of reactions that veterans can have after experiencing MST. The type, severity, and duration of a veteran's difficulties will all vary based on factors like the nature of the MST experienced, the reactions of others at the time and afterwards, and whether the veteran had a prior history of trauma.

Although the struggles that men and women have after MST are similar and may overlap in some ways, there can also be gender-specific issues that they may deal with. The impact of MST can also be affected by race, ethnicity, religion, sexual orientation, and other cultural variables.

Our veterans are remarkably resilient after experiencing trauma. But unfortunately, some do go on to experience long-term difficulties after experiencing MST. VA medical record data indicate that in fiscal year 2012, post-traumatic stress disorder and depressive disorders were the mental health diagnoses most commonly associated with MST.

Other common diagnoses were other anxiety disorders, bipolar disorders, substance use disorders, and schizophrenia and psychotic disorders. Veterans who experienced MST often also struggle with physical health conditions and other problems, such as homelessness.

With regard to suicide, research has shown that trauma in general is associated with suicide and suicidal behavior. This is true for both civilian and military populations. But if we focus on sexual trauma specifically, data from civilian studies have found an association between sexual victimization and suicidal ideation, attempted suicide, and death by suicide. These relationships remain even after you control for mental health conditions like depression or PTSD.

Although less work has been done examining the link between sexual trauma and suicide among veterans specifically, the data that exist show a pattern similar to the studies of civilians that I just reviewed. That is, studies and VA administrative data show that sexual trauma during military service is associated with suicide attempts as well as death by suicide, and this association also holds even after accounting for mental health symptomatology.

Treatment approaches always need to be tailored to the specific needs of the individual veteran and take into account not only comorbid health conditions, but also the veteran's treatment and broader psychosocial history, his or her current life context, and his or her individual preferences.

Regarding treatment for veterans with PTSD specifically, a significant research base has accumulated identifying exposure-based cognitive behavioral therapies, such as cognitive processing therapy and prolonged exposure, as effective treatments for post-traumatic

stress disorder. Cognitive processing therapy and prolonged exposure in particular were originally developed for the treatment of sexual assault survivors with PTSD, and they have a particularly strong evidence base in this area.

Although these therapies should be considered a first-choice approach to treatment of sexual assault survivors with PTSD, some veterans may benefit from an initial focus on coping skills development before beginning these emotionally demanding treatments. This sort of phase-based approach can help augment their strategies for managing the emotional distress that may be brought up during completion of the cognitive behavioral treatment.

Psychoeducation about PTSD and the impact of sexual assault can also be an important component of treatment.

Madam Chairman, VA is committed to ensuring that our veterans get the help that they need to recover from experiences of MST. I really appreciate having the opportunity to speak about some of the research in this area today, as well as thank you for your support of these important issues and am prepared to respond to any questions you may have.

[The prepared joint statement of Dr. Bell and Dr. McCutcheon follows:]

Senator GILLIBRAND. Thank you.
Dr. McCutcheon?

STATEMENT OF SUSAN J. McCUTCHEON, R.N., ED.D., NATIONAL MENTAL HEALTH DIRECTOR, FAMILY SERVICES, WOMEN'S MENTAL HEALTH, AND MILITARY SEXUAL TRAUMA, DEPARTMENT OF VETERANS AFFAIRS

Dr. McCUTCHEON. Good morning, Chairman Gillibrand, Ranking Member Graham, and members of the subcommittee.

Thank you for the opportunity to discuss the Department of Veterans Affairs healthcare services for veterans who have experienced sexual trauma while serving on active duty or active duty for training, which is known as military sexual trauma, or MST.

I would also like to thank the veteran panel for their detailed testimony of their struggles and the courage to share their stories with us today.

VA is committed to ensuring that eligible veterans have access to the healthcare services that they need to recover from MST. To this end, VA has been developing and executing initiatives to provide counseling and care to veterans who have experienced MST, monitor MST-related screening and treatment, provide VA staff with training, and inform veterans about our available services.

Fortunately, recovery is possible after experiences of MST, and the Veterans Health Administration has services spanning the full continuum of care to assist veterans in these efforts. Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all veterans seen for healthcare are screened for experiences of MST.

Veterans who screen positive are offered a referral for mental health services. All VHA healthcare for physical and mental health conditions related to MST is provided free of charge. Receipt of free MST-related services is entirely separate from the disability com-

pensation process through the Veterans Benefit Administration, and service connection is not required for this free treatment.

Every VA medical center provides MST-related outpatient care for both mental and physical health conditions. Complementing these outpatient services, VA has mental health residential rehabilitation and treatment programs and inpatient mental health programs to assist our veterans who need more intense treatment or support.

We have MST coordinators at every VA medical center, who will assist veterans in accessing these services. It can take tremendous courage for veterans to seek out help after experiencing MST. Fortunately, VHA data shows continually increasing rates of veterans seeking care.

Ensuring staff have the training they need to work sensitively and effectively with veterans who have experienced MST is a priority for VA. All VA mental health and primary care providers are required to complete a mandatory training on MST.

The VA's National MST Support Team hosts monthly teleconference training calls open to all VA staff on topics related to MST. Content on suicide and sexual trauma has also been included in other MST-specific training efforts.

In addition, as part of its strong commitment to provide high-quality mental healthcare, VA has nationally disseminated and implemented specific evidence-based psychotherapies for PTSD and other mental health conditions. Because PTSD, depression, and anxiety are commonly associated with MST, these initiatives are very important means of expanding MST survivors' access to evidence-based treatments.

Recognizing the strong link between sexual trauma and risk for suicide, VA's National MST Support Team has an ongoing collaboration with the VA's Veterans Crisis Line. Current efforts include the development of specialized materials to further enhance all Veterans Crisis Line staff's knowledge of MST-specific issues and facilitate sensitive and effective handling of calls from veterans who have experienced MST.

Complementing these efforts at the local level, MST coordinators have been encouraged to develop working relationships with the facilities' suicide prevention coordinators. These relationships will allow MST coordinators to ensure local suicide prevention initiatives incorporate information about MST and target the unique needs of these survivors. This close collaboration will also facilitate addressing the treatment needs of specific veterans at their facilities who have experienced MST.

Madam Chairman, the Department of Veterans Affairs is committed to providing the highest quality care that our veterans have earned and deserve. Our work to effectively treat veterans who have experienced MST and ensure eligible veterans have access to the counseling and care they need to recover from MST continues to be a top priority.

I appreciate your support and am prepared to respond to any questions you may have.

Thank you.

Senator GILLIBRAND. Thank you.

Dr. Galbreath?

Dr. GALBREATH. Dr. Guice is going to be presenting for us.

Senator GILLIBRAND. Dr. Guice?

Dr. GUICE. We sort of bundled today.

Senator GILLIBRAND. That is fine.

STATEMENT OF KAREN S. GUICE, M.D., M.P.P., PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS; NATHAN W. GALBREATH, PH.D., M.F.S., SENIOR EXECUTIVE ADVISER, DEPARTMENT OF DEFENSE SEXUAL ASSAULT PREVENTION AND RESPONSE OFFICE; AND JACQUELINE GARRICK, LCSW-C, BCETS, DIRECTOR, DEPARTMENT OF DEFENSE SUICIDE PREVENTION OFFICE

Dr. GUICE. Madam Chairman, members of the committee, thank you for the opportunity to assess the Department of Defense's support for sexual assault survivors and the relationship between sexual assault, the subsequent development of PTSD, and suicide.

Sexual assault survivors are at an increased risk for developing sexually transmitted infections, depression, anxiety, and PTSD, conditions that can have a long-lasting effect on well-being and future functioning and can precipitate suicidal thought.

To address these and other potential risks and regardless of whether the survivor is male or female, whether the sexual assault occurred prior to joining the military or during service, or whether the manifestations are physical or emotional, the Department of Defense has policy, guidelines, and procedures in place to provide access to a structured, competent, and coordinated continuum of care and support for survivors of sexual trauma. This continuum begins when the individual seeks care and extends through their transition from military service to the VA or care in their communities.

DOD has issued comprehensive guidance on medical management for survivors of sexual assault for all military treatment facilities and service personnel who provide or coordinate medical care for sexual assault survivors. Included in this guidance is the requirement that the care is gender responsive, culturally competent, and recovery oriented.

Any sexual assault survivor who presents to one of our military treatment facilities is treated as a medical emergency. Treatment of any and all immediate life-threatening conditions takes priority. Survivors are offered testing and prophylactic treatment options for sexually transmitted illnesses. Women are advised of the risk for pregnancy and counseled with regards to emergency contraception.

Prior to release from the emergency department, survivors are provided with referrals for additional medical services, behavioral health evaluation, and counseling in keeping with the patient's preferences for care. In locations where DOD does not have the needed specialized care, including emergency care within a given military treatment facility, patients are referred to providers in the local community.

Last spring, the Assistant Secretary of Defense for Health Affairs issued a memorandum to the services regarding reporting compliance with these standards. The Services returned detailed implementation plans, and the first of a yearly reporting requirement is due this summer from each of them.

The long-term needs of the survivors of sexual assault often extend beyond the period which a servicemember remains on active duty. To support individuals with mental healthcare needs, DOD provides the inTransition program. This program assigns servicemembers to a support coach to bridge between healthcare systems and providers.

You asked about the relationship between suicide, PTSD, and sexual abuse. We know from civilian population research that sexual assault is associated with an increased risk of suicidal ideation, attempts, and completions. Furthermore, this association appears to be independent of gender.

Sexual assault is also associated with mental health conditions such as depression, anxiety, and PTSD. Likewise, these mental health conditions are associated with suicidal ideation, attempts, and completions.

For military populations, the evidence associating sexual assault and subsequent suicidal ideation, attempt, or completion is less well defined for that of the civilian population. Between 2008 and 2011, the number of individuals who attempted or completed suicide and reported either sexual abuse or harassment in DOD ranged from 6 to 14 per year, or 45 in total. Only nine of those individuals also had a diagnosis of PTSD.

These data show an association that is similar with clinical experience and prior studies in civilians. The data do not, however, describe causation, the nature of the association, its directionality, or potential influence of additional comorbidity factors.

The department has a variety of research initiatives directed to better understand the variety of issues associated with suicide, including risk factors, the impact of deployment, and possible precursors.

Madam Chairman, members of the committee, thank you for the opportunity to discuss these very important issues. Our policies within DOD are designed to ensure that all trauma survivors, and particularly those subjected to sexual assault, have access to a full range of medical and behavioral health programs to optimize recovery and that their transition from military service back to civilian life is supported.

I also would like to add my thanks to the witnesses today. It is compelling testimony that makes us see ourselves in a better light.

Thank you.

[The prepared statement of Dr. Guice, Dr. Galbreath, and Ms. Garrick follows:]

Senator GILLIBRAND. Thank you all for being here today.

For the DOD witnesses, I don't know who is appropriate, but I think it is perhaps Dr. Galbreath. I have heard from survivors and others that some are stopping therapy because they are afraid that their mental health records will be used against them during the court martial.

For example, the alleged victim in the Navy Academy case stopped going to therapy once she learned her records could be reviewed by a military judge and possibly provided to the accused and his attorneys. I understand that this comes under the constitutional exception to the psychotherapist-patient privilege. But I am

concerned about the negative impact on survivors' mental health if they feel like there is no confidentiality for their treatments.

As practitioners, what might be the impact on survivors if they choose not to seek care because they are worried about therapy being made public? Are you seeing this happening? What do you think the risk is?

Related, when a victim and a survivor doesn't report the case, they might not have access to those mental health services because they have not been willing to come forward. And so, again, the risk of PTSD or suicide may be higher than it should. I would love your thoughts on that.

Dr. GALBREATH. Thank you, ma'am.

Just to start out, as a psychologist, I am required to inform all of patients seeking care with me that there are limitations to privacy and confidentiality in the military. That is part of the informed consent document that everybody that wants to come to see me as a provider has to understand.

Not only do I work through them with those limitations to privacy, and one of those issues is if an administrative or a court proceedings, there might be a situation where those records might become available. I also give them a verbal counseling as well to document that.

That is a concern that I think all therapy providers in the Department of Defense have. I haven't seen it happen very often, but it does happen. And I do—I am concerned. I have never had anyone quit treatment with me because of that concern, but I have seen other situations where that occurs.

So one of the things that I do, given my law enforcement background, is I am very careful about how I document care, and I also teach others at the Center for Deployment Psychology up at the Uniformed Services University. I see—about every 2 months, I treat anywhere from 60 to 70 different providers, and we talk about these issues and how to best protect our patients' care.

So that is something that we are very concerned. You asked about what the chances are of a person's condition worsening if they don't get care, and that is definitely a possibility. Most people do tend to get better, and I think what our research shows is that what we can do for most people is help them get better sooner with our therapy and our care.

However, for some people, they don't get better, and they do—without care, and we do want to have a number of different ways to provide them treatment. So given those concerns, the DOD has looked at a number of different ways to kind of help people sample what is right for them.

As you know, any victim of sexual assault has had a number of different things taken away—their health, their privacy, their sense of being. We want them to be able to sample at the rate that they would like to. So from the very—the most anonymous way of doing that is through our DOD Safe Helpline.

That is run for us by the Rape, Abuse, and Incest National Network (RAINN). It is completely anonymous. Victims can call in from any area, and they can get care and services that they need through there.

Senator GILLIBRAND. Thank you. Thank you. Thank you, Dr. Galbreath.

We have some information. I think this is for Dr. Guice. So SAPRO gave us some new numbers, and we have raw numbers about restricted and unrestricted reports that have been made. And we have a number, about 5,400 reports. Do we have the number of incidents so we can assess whether reporting has gone up or not?

Because when we compared the earlier reports when we had the benefit of looking at 2012 and 2011, the number of reported rapes went up, but the incidence rate went up higher. So, actually, there was a decrease in reporting from 13 percent to 9 percent. Do we know if there is higher incident rate or if we really are—have a higher reporting rate?

Dr. GUICE. I believe that is Dr. Galbreath.

Dr. GALBREATH. Okay. Ma'am, we don't have a survey this year for that. But what I would offer to you is we know that even in 2006, when we had the highest rates of unwanted sexual contact reported, we only got about 2,900 military servicemembers coming forward to make a report.

This year, with the 5,400, we really do assess that this is due to increased victim confidence and more people hearing our message and understanding that we are going to take care of them. One piece of that that I would offer to you to consider is there are a portion of reports every year that come to us that occurred prior to military service. And this year, that percentage increased from 4 percent in 2012 to 11.5 percent in 2013.

Those—all the offenders in those cases are outside the military justice system. So the only real reason for our survivors to come forward in that situation is to get care and services that we offer through the Sexual Assault Prevention and Response Program. We feel that that is a real—

Senator GILLIBRAND. So we have seen an uptick in reporting before prior to service?

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. And is that the difference between the two numbers?

Dr. GALBREATH. It is not the entire difference. Last year, we had a total of about 132 reports that were for incidents that occurred prior to service. This year, the number is 621.

Senator GILLIBRAND. So that is a huge increase for people who were assaulted before they joined the military.

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. And they are eligible for mental health—

Dr. GALBREATH. Care and services.

Senator GILLIBRAND. A related question. We have heard from survivors that after they report the assault and they attempt to seek mental health treatment, they were diagnosed with a personality disorder and are medically discharged. So this diagnosis is labeled as a preexisting condition and, therefore, effectively cuts off services for the survivor.

Many of these same survivors have said that after the assault, they still wanted to stay in the military and were planning on doing so. But because of the diagnosis of personality disorder, they

were kicked out. What has your experience been with that issue, and what is the best way to address it?

And I don't know if VA wants to address that or Dr. Galbreath.

Dr. GALBREATH. Do you want to—

Dr. GUICE. So what we have done is that no one can leave the military, be separated for a personality disorder without a complete medical review so that we make sure that there is no underlying TBI that is causing the action or the behavior or psychological health issue that needs to be addressed. So I think we have actually put a mechanism in place to make sure that we have safeguarded and that people are not leaving without a second look by medical professionals.

Dr. GALBREATH. If I could add to that, ma'am? Section 578 of the NDAA for Fiscal Year 2013, you all helped us out with that, and we took your advice and we kind of expanded on it a little bit. You asked us to—for any separation due to retaliation, within a year of the report, it had to be reviewed by a general officer. That was the nature of the law.

I checked in our military instructions, and that has been incorporated into the administrative separation instruction. But we have expanded it just a little. So instead of just a year from the date of report, we took it from a year from the date that the case disposition was made. So it is a much longer period.

And instead of just retaliation, admin separation, we have any separation administratively can be heard in this process and be reviewed. And in addition to that, instead of the first general officer, flag officer in the chain, we took it to the first general officer, flag officer in the chain of that administrative separation authority's chain of command. So it goes beyond that one person.

So we took your good idea and put it into our instructions.

Senator GILLIBRAND. Thank you.

Senator Graham?

Senator GRAHAM. Kind of follow up on that. A personality disorder would make one subject to involuntary discharge. Is that right, Dr. Galbreath?

Dr. GALBREATH. Yes, sir.

Senator GRAHAM. And the point we are trying to make is if you are a victim of an assault, one of the consequences, obviously, would be people would be disturbed, and it would show. That we don't want to cut off treatment. We don't want it to be anything other than an honorable discharge. We want to make sure that the person may no longer be able to serve in the military, but they are not denied treatment for what happened to them in the military. Is that correct?

Dr. GALBREATH. That is correct.

Senator GRAHAM. Okay. Now having said that, personality disorder is often used as a way to separate, and we want to make sure that we don't deny people treatment but, at the same time, not deny the military the ability to separate somebody from a unit for a cause.

As to this chart, it makes perfect sense to me that PTSD candidates from the sexual—a person who has experienced sexual assault would have a higher propensity to have post-traumatic stress syndrome simply because of the nature of the attack, compared to

anything else. The one category that we left out is combat-related action.

Most of the PTSD cases that I am familiar with come from people who have been involved in a combat-related experience. And I would argue that a sexual assault is every bit as traumatic, if not more. So that makes perfect sense to me that that would occur.

Now about two things. The military system is being scrutinized, and that is fair. That is appropriate. We have a problem. You have to admit your problem before you can fix it. The question is how to fix it. That is what the whole debate is about.

But I want to also highlight some of the things about the military that are worth noting. I asked the question if one of our staff members were assaulted at work, would they be entitled to medical disability as a result of that assault? I have been told that is not the case.

I just want people to understand that in the workplace in the civilian world, sexual assaults occur. Most employers are not going to be held liable for worker compensation claims based on the criminal acts of a third party. That is a general proposition of law.

In the military, when the assault occurs during employment, you are treated quite differently. I think that is a positive thing. Just realize that if somebody in your own office were assaulted, they are a Federal employee, under the law that exists to now, all the things available to a military member would not be available to your staff. That is probably true in the civilian population.

So let us focus on the fact that if you get assaulted in the military sexually, there is an array of benefits and counseling available to you unlike anything that I know of in the private sector, and I think that is very much appropriate because of your willingness to serve your country.

So how we make that better is the subject of the discussion, but we need to realize that our military members are not—they have access to healthcare, to treatment not available to the average person who goes through the similar experience in the workplace. And we want to make it better, but we should be proud of the fact, quite frankly, that occurs in our military. We want to make it better.

Now about expanding treatment options. Both witnesses testified that they believe that services available in the civilian sector could supplement or greatly increase the likelihood of a better outcome. The one gentleman, the lance corporal, is TRICARE eligible. The other lady is not.

How do we deal with that dilemma? What do we do as a Congress to make sure that someone who goes through the disability evaluation process—you make a claim. “This happened to me in the military. I was sexually assaulted. As a result, I am having these problems.” Once the medical board evaluates in the VA or Department of Defense, you are eligible for compensation based on your evaluation.

This gentleman is eligible for TRICARE because of his disability rating. The other lady—the lady was not. How do we correct that problem?

Dr. McCUTCHEON. Senator, I certainly can't speak to the compensation process because that falls under the Veterans Benefit Administration. But for our veterans who screen positive for mili-

tary sexual trauma, and every veteran who comes to the VA is screened for these experiences, these are two questions. One question addresses sexual assault that occurred while you were on active duty or active duty for training, and the second question is sexual harassment.

If you answer yes to one or both of the questions, you are considered to have screened positive for military sexual trauma.

Senator GRAHAM. Are you eligible then for civilian treatment outside the VA?

Dr. MCCUTCHEON. Non-VA care is always an option.

Senator GRAHAM. So these two witnesses, has anyone ever told them that? She is shaking her head no. How can that be?

Dr. MCCUTCHEON. What we do do, Senator, is that we have an MST coordinator at every VA facility, and we—

Senator GRAHAM. Is part of the screening process making you aware that you are available for treatment outside the VA?

Dr. MCCUTCHEON. If you screen positive, you are given a referral to mental health. And we can always connect you with the MST coordinator, and that person can explore options for you if, for some reason, there is an access issue for you, like the gentleman spoke, as far as like 90 miles to get to treatment or various things.

Senator GRAHAM. Well, both of the witnesses seem to indicate that while they appreciate the services, they were limited and I understand overmedication. Every problem you have in the military, you have in the civilian world when you deal with these issues. People afraid to report, intimidated. The defense attorneys have to do their job. The rape shield law exists in the military, exists in the civilian community.

Some of these problems we are never going to solve because somebody accused of a crime has a right to defend themselves, and where that right starts and stops is always subject to debate. But both witnesses seem to be very much unaware that they were—they had access to healthcare outside of the traditional VA system.

How can we—do you agree with that statement by me? And if so, how can we improve that?

Dr. MCCUTCHEON. I think, Senator, in all of our outreach materials, we encourage veterans to contact the MST coordinator at the facility, and that person is in a perfect position to help them as far as coordinating care within the facility or applying for nonveteran care.

What we are finding, Senator, is that every year we have been tracking MST-related treatment is our numbers are increasing every year. And so, we are seeing more and more veterans, after they have screened positive, coming to the VA for services.

Senator GRAHAM. And I would just conclude, I want to end on a positive note, I appreciate the gains made and the focus and the attention. This is a very real problem for the military, and I think we are on the right track, but we can learn from these experiences. This has been a good hearing in that regard.

So I really appreciate the additional scrutiny and the Congress' interest. But for the two witnesses, I do think there is a gap. I think the average—at least these two, if they are representative, there seems to be a disconnect between what is actually available

to them and what they perceive to be available to them. So let us try to fix that.

Thank you.

Senator GILLIBRAND. Dr. McCutcheon, I just want to follow up on Senator Graham's question.

Dr. MCCUTCHEON. Yes.

Senator GILLIBRAND. When did the military sexual trauma coordinators get placed in every VA in the country?

Dr. MCCUTCHEON. 2002?

Senator GILLIBRAND. Was that in the last year, last 6 months?

Dr. MCCUTCHEON. In 2000, ma'am.

Senator GILLIBRAND. So there has been a military sexual trauma coordinator at every VA in the United States since then?

Dr. MCCUTCHEON. Yes.

Senator GILLIBRAND. Is that person busy?

[Laughter.]

Dr. MCCUTCHEON. Yes, ma'am. It is a position where there is a great focus on looking at our screening data, our treatment data, educating staff.

Senator GILLIBRAND. Do they meet with trauma survivors?

Dr. MCCUTCHEON. As part of their clinical work, yes. A majority of them do also provide treatment. The MST coordinators are predominantly either a psychologist or a social worker, and so as part of their clinical workload, they would be giving therapy, administering therapy as well as, you know, looking and monitoring their screening, treatment rates, other rates of the reports we provide.

Senator GILLIBRAND. Okay. I am going to make a formal request afterwards to get data on all the military sexual trauma coordinators in every VA, how many patients they see a year, what their workload is. And because maybe they are just not even known that they exist.

So I would like to know actually what is their—what do they actually do. So we can work on that later.

Dr. MCCUTCHEON. Thank you, Ma'am.

Senator KAINE?

Senator KAINE. Great. Thank you, Madam Chairman.

And thank you all for the work that you do on this important area.

I want to start with a concern that was raised by Corporal Arbogast and directing it to the VA, and that was the concern that he raised about as a man being told, well, we don't really have a group for men and, you know, feeling like the Services weren't maybe at the same level.

And I was just curious, Dr. McCutcheon, as I was looking at your title, you are the National Mental Health Director, and it says family services, women's mental health, and military sexual trauma. Is that the name of like a department or division or program? Family services, women's mental health, and military sexual trauma.

Dr. MCCUTCHEON. Senator, that is a good question. It is actually three areas of responsibility I hold in my position.

Senator KAINE. I see.

Dr. MCCUTCHEON. I have a colleague who is the National Director for Evidence-Based Treatment and Psychogeriatrics.

Senator KAINE. Okay.

Dr. McCUTCHEON. It just happened to be that those were the special areas. But my title in no way implies that we see MST as a women's issue. We have worked very hard to show it as a gender neutral disorder, and actually, the program responsibility for military sexual trauma was removed from women's health services to be placed in mental health services in 2006.

Senator KAINE. Good. Good. That is helpful.

Let me ask your reactions, each from the VA and the DOD side, about the discussion in both of our earlier witnesses, their concerns about this overmedication phenomenon. What could you tell me about that?

Dr. McCUTCHEON. Senator, I will start from the VA. I really can't speak to that because I have no firsthand knowledge of what the VA is doing as far as analyzing the use of medication. So I would need to take that for the record. I am sorry.

Dr. GUICE. I don't know with the degree of specificity that I think really you need to have for this answer. So we would like to take it for the record, too.

Senator KAINE. Then what I will do is we will try to submit a precise question in writing rather than have you have to kind of guess what we mean. That might be a little bit easier, and we will just take that one under advisement.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator KAINE. One concern, just to share a concern that I have heard and I don't know whether it is region or more general, is in the suicide prevention area. I think you guys do a good job of trying to publicize to active duty and veterans suicide prevention hotlines within DOD and VA.

I had an experience in the last year in the Hampton Roads area of Virginia, where there are a lot of veterans, of somebody saying they were doing a great job of putting out there is a suicide prevention hotline and there will always be somebody there to take your question and deal with you. And he said, "But they didn't deal with me right away." And I said, "Why not?" He said, "I contacted them right away."

Well, we dug into it, and it was an individual who had emailed the email address. And it turned out that the hotline really was a 24-hour hotline if you called on the phone. But if you emailed, it was kind of a cold line, and he made the point to me that if you are in extremis in a mental health area, it might—even the act of talking to someone can be a little bit tough, and it can be a little bit easier just to write an email and send that "I need help."

And he felt like his cry for help was kind of ignored, and as we got to the bottom of it, it turned out that maybe it was treated differently because it was an email. I would just recommend that to your attention that might be fixed or might have been aberration, might have just been one VA hospital. But I can see why somebody in an extreme situation might feel more comfortable reaching out for help via an email than a phone call.

Ms. GARRICK. And Senator, you raise a good point in that we know suicide is complex, and so we like to think that the way in which we deal with suicide also takes a multifaceted approach. So

that when somebody reaches out for help that there are options in how they even initiate that contact.

So, and what the Department of Veterans Affairs has as the Veterans Crisis Line, the DOD uses it as well, and we brand it as the “military crisis line.” It is the same crisis line.

We also have a Vets4Warriors program that we have funded in the Department of Defense that is a peer support program. So it gives you an option of if you just want to talk to a peer and do some problem solving, get a referral, and the peers also provide what we call resilience case management so that they can track and stay with you over the course of your military career.

The goal, though, is to make sure that regardless of whether you do a phone call, an email, a text, a chat, that when you look for help, there are different options and ways for you to find that help.

Dr. GALBREATH. And sir, I would offer that at the DOD Safe Helpline as well, you can click, call, or text 24/7, and there is somebody there live to answer any kind of a reach-out from the individual.

Senator KAINE. Finally, I would like to go back to Ms. Kenyon’s testimony. When I asked her that question about her analogy between incest and military sexual assault because of the betrayal factor, I was curious. In some full hearings before the Armed Services Committee, we have tackled, to some degree, the issue of suicide of active duty and veterans. Senator Donnelly in our committee has been really focused on this.

And I recall some testimony about sort of while it is a complex phenomenon, a number of military witnesses in the past talking about and sort of enlightening me a little bit about it, that it is less people have come back, seen horrible things and the horrible things are weighing on them and driving them to suicide, and more that people were involved in such a close support network and then came back, and that network, that band of brothers and sisters kind of was no more. And even if they had networks of people around them, they didn’t understand what they had been through.

And that experience of going from a close support network of colleagues to a feeling of disconnection, that that has been a factor in testimony earlier before the full committee that has kind of been suggested that there is some research that really ties that into this problem of military suicide.

Am I remembering it or basically describing it correctly? I mean, is that one of the factors?

Ms. GARRICK. So, again, so the causes and associated factors with suicide do tend to be very complex. And we know that the primary factors associated with suicide are relationship issues, financial issues, and legal issues.

So when we look at relationship issues, I think what you are describing is the loss of a relationship issue. We tend to think about that as an intimate relationship issue, but that does certainly extend beyond, and we know that this is—on the active duty side, this is mostly young white male who have died by or attempted suicide.

So that when they come and go from active duty or change units, we have seen the majority of our suicides are among those that in their first year of enlistment and who have never deployed and

have not been in combat. Eighty-nine percent have not seen combat.

So there is some serious issues that we feel we try to look at, and that is why, again, the peer support and providing community-based care is so important is because we really see that those relationship issues are such a driving factor in relationship to suicide and self-harm.

Senator KAINE. Madam Chair, just to close the loop with one last question. That would then loop back to Ms. Kenyon's point about the betrayal phenomenon.

In a sexual assault within the military, if there is a close connection between colleagues, your superior, a sexual assault within your unit is the sundering of a relationship that you had an expectation that was a relationship based on trust. And that suggests a little bit of the connection between sexual trauma in the military and this risk of suicide.

Ms. GARRICK. And the Defense Suicide Prevention Office and Dr. Galbreath's office, we are working on a study right now looking at some of those intersections between suicide prevention and sexual assault response so that we can get a better understanding of how we can move forward on providing support and services to this population.

Senator KAINE. Thank you. Oh, do you want to say something?

Dr. GALBREATH. I was just going to say I couldn't agree with Ms. Kenyon more. I mean, it really is tantamount to an incest type of situation, and I think that is a very adequate description.

Senator KAINE. Thank you.

Thank you, Madam Chairman.

Senator GILLIBRAND. But to follow on, isn't the betrayal also that they have to tell their dad, or their dad is the decision maker. It is not just the betrayal that you are being raped by your brother. It is that second betrayal that makes it intense.

Dr. GALBREATH. It is depending on who the perpetrator is, ma'am, yes.

Senator GILLIBRAND. No. What I am saying is the second thing about reporting. The decision maker is, I have just heard one victim say it is like being raped by your brother, and your father decides the case. So the reference to incest goes beyond who the rapist is. It is also that it is decided as a family matter, and the person deciding has to decide between two children that they both deeply love.

And so, that lack of objectivity to just look at the facts, look at the record, knowing the victim, knowing the perpetrator, according to this one victim, was just—that was the second betrayal. It is not just one betrayal.

Dr. GALBREATH. And so, so important now to have so many different ways to report so we can get it outside of that system that you can report to a sexual assault response coordinator—

Senator GILLIBRAND. Well, we are just talking about the decision maker. Your dad decides. There is no question. I was just trying to clarify the—

Dr. GALBREATH. Oh, okay.

Senator GILLIBRAND. No question.

Dr. GALBREATH. I am waiting, ma'am.

Senator GILLIBRAND. I was just clarifying what I understood the testimony to be, based on other conversations I have had with survivors and how they perceived it. That the incestuous reference is not just about who rapes you, it is also about who decides your future, your fate.

Dr. GALBREATH. That is not one that I had heard from my victims, but I understand what she said.

Senator GILLIBRAND. Senator Ayotte?

Senator AYOTTE. Thank you very much.

I want to thank the witnesses for being here.

I wanted to follow up, Dr. McCutcheon, just to clarify one point that I think it is important for people listening at home to understand is that in terms of sheer numbers, there are actually more male victims in the military of sexual assault than female victims. Isn't that right, just in terms of sheer numbers?

Dr. MCCUTCHEON. Senator, that was correct maybe about 3 or 4 years ago, but what we are seeing right now is there is actually more women who screen positive for military sexual trauma who choose to come to the VA, who are part of our VA healthcare system.

Senator AYOTTE. So we now—

Dr. MCCUTCHEON. But the numbers are pretty close.

Senator AYOTTE. So we now have more women victims, with the recent numbers, that have come forward?

Dr. MCCUTCHEON. So in our last fiscal year, ma'am, we have within our system about a little over 77,000 women who have screened positive for military sexual trauma, and for the men, it is over 57,000.

Senator AYOTTE. Because the one point I wanted to make is that this isn't a male or a female victim situation. And so, as this issue has come up in our committee and people talk to me about it, they make it an issue of this is an issue of women, and certainly women, there are fewer women in the military, and thankfully, they are taking on greater roles, which is a wonderful thing. But I just want people to understand that are home right now that there are a lot of men who are victims as well and who are watching this.

Because this isn't a male or a female crime. This is a crime committed against anyone could be the victim of this in the military. So I think that is important because people need to understand that as we get at this issue that it needs to be addressed for everyone.

And one of the questions that I wanted to follow up with you, how long on average does it take for once the referral is entered, for someone actually to see a mental health provider?

Dr. MCCUTCHEON. I am sorry, ma'am. I don't have that data with me as far as from screen to treatment. So I will have to take that for the record.

Senator AYOTTE. I would appreciate that because I think that is an important question because immediacy is really important, that people are waiting too long to see mental health providers. I hear this from people at home, and I can only imagine that this could be even exacerbated for someone who is a victim of sexual assault.

And one I would also love for you to take for the record, is that period getting shorter or longer? And I think the other challenge

we face is what is the situation in terms of providers? Are we facing a shortage of providers?

You know, we have—one of the things I was certainly glad to hear the report of is that more people are coming forward. That is what we wanted. We wanted to feel that people would be able to come forward, and we want more to come forward. And so, also that will mean that we will need to make sure that we have the providers to give treatment and to give support.

So I wanted to get your answer on that one, too, is what is our situation on having enough providers in the mental health area? Because my experience has been that even at my State, for example, taking it outside of the military context, we have a shortage of mental health providers within our State. So I would imagine that you may have similar challenges. Wanted to get your thoughts of whether we needed to put more of an emphasis on that.

Dr. MCCUTCHEON. Senator, we are required to produce a report on capacity to provide MST-related mental healthcare, and virtually all medical centers within the VA system do have that capacity. So that is something that we do track.

Senator AYOTTE. Okay. So, if on the follow-up if you can let me know just sort of how long does an average person wait, I mean, once the referral is made? And also just what, if you can answer to me what you think the provider challenges are in terms of going forward, as we are going to have more people report, to make sure that we have adequacy of support system there. I would appreciate an answer to that as well.

[The information referred to follows:]

[SUBCOMMITTEE INSERT]

Senator AYOTTE. And Dr. Galbreath, I wanted to follow up on this issue of where we are with regard to the reports and the increase that we have seen in the reports. What do you think that that says in terms of you have talked, I think, fairly positively about that as an indicator that we are certainly glad that more people are feeling that they can come forward.

What do you think in terms of the role of the commander? Here, one of the pieces of legislation that we are going to be looking at is how do we—within the system, who keeps the decision in terms of whether the charge will go forward?

And also, you know, the proposal, for example, that Senator McCaskill and I have is one that would go if there is a difference of opinion between the JAG lawyer and the commander, it would go up all the way to the civilian secretary in instances where the decision is not to bring a case. And in instances where both are in line that a case should not be brought, then it still goes up for another level of review.

So if we were to, what effect do you see or what role do you believe the commander should have in terms of involvement in addressing this issue, if you have thoughts on this?

Dr. GALBREATH. I will offer, ma'am, I am clinical psychologist. And clearly, my perspective would come from treating victims. So I know that any—

Senator AYOTTE. Well, yes, and I am only asking you from your own background and perspective.

Dr. GALBREATH. You bet. I would offer to you that we believe that commanders really do need to be more involved, not less involved in this process because we know that they are going to be critical to setting that climate of dignity and respect in a unit. And that is a kind of unit environment where we know that victims can heal and flourish.

And every single victim who comes forward is influencing, their experience influences other victims that are deciding whether or not to report. And until we get this right and we make sure that commanders are held appropriately accountable to set that climate of dignity and respect and have those tools with them that would allow them to enforce that climate, we are—we really do believe that that is going to allow us to move forward on this and increase even more reports of sexual assault every year.

Senator AYOTTE. Thank you. Appreciate that.

And could you also give us an update, my time is almost gone here. Just we have talked a lot about the special victims' counsel today, and I think all of us are very supportive of this. This has been legislation that I worked on with also Senator Murray, who is the chair—was the chair of the Veterans Committee, now the chair of the Budget Committee, but very involved in these issues.

Just how are things going? I know this is a very important undertaking and large undertaking. And so, just as an initial report of what your thoughts are of implementing this important initiative that is going to give every victim counsel that is their—really their counsel, that is there to advocate for them and no one else.

Dr. GALBREATH. Yes, ma'am. Very briefly, everyone, all the services were supposed to have initial operating capability last October. They all stood up their full capability in January.

The Air Force, as you know, has the greatest number—had this program going for about a year now.

Senator AYOTTE. They started it as a pilot, and we extended it.

Dr. GALBREATH. They did.

Senator AYOTTE. Yes, that is right.

Dr. GALBREATH. Absolutely. Yes, ma'am.

And the information that we have gotten back from the survivors that have used the special counsel is overwhelmingly favorable. I do believe that this is a deal changer for victims of sexual assault in the military. Having that person to represent you increases their confidence. It allows them to kind of understand what their options are even more from a legal perspective.

And although it is a small number, I would offer to you that what we have heard is of the restricted reporters that have engaged a special victim counsel, their conversion rate from restricted to unrestricted cases that would then bring them into the justice system and participate in a prosecution, their conversion rate is at about 50 percent, 5–0.

Senator AYOTTE. Wow.

Dr. GALBREATH. On average across the DOD, we are about 14 to 15 percent conversion rate. Now once again, small numbers, but initial data. But we do think that this is very promising, and from a psychologist's perspective, I think it is great because it builds victim confidence and boosts their abilities and gives them a greater understand of the legal system.

Senator AYOTTE. Well, thank you. And I think one of the things we will be watching carefully is just making sure that we are updated on how it is being implemented so that every victim can have access to a special victims' counsel.

Dr. GALBREATH. Thank you, ma'am.

Senator GILLIBRAND. Senator King?

Senator KING. Madam Chair, I am going to be very brief. First, I want to associate myself with your request for the data on the backlog. That is really important, and don't—don't candy, don't sugarcoat it. We want the straight data on from the day somebody on the average applies to the time they get accepted. Because this is, you know, treatment—treatment delayed is treatment denied in many of these cases. That is number one.

Number two, Madam Chair, I think there is a gap here in coverage in the sense that TRICARE is only available to retirees 20 years or more. So if you can't get service at the VA for your service-related trauma, you don't have any other choices. So I think that is something we need to be thinking about that is not like they can turn around and to go TRICARE and use their local provider.

Finally, Dr. Galbreath, this isn't really a question. I am—but I just want to make a statement. I don't understand why anybody would go to you for counseling if they understand that that record of that counseling can be made available in a later proceeding.

That just—that just makes no sense whatsoever, and I want to visit that one, Madam Chairman.

Senator GILLIBRAND. Absolutely.

Senator KING. Thank you.

Senator GILLIBRAND. Thank you, Senator.

Dr. Galbreath, I just want to go back over a little bit of your testimony. I agree that we have to set a climate of dignity and be more involved, not less involved for commanders. I agree that commanders need to actually be taking responsibility for setting command climate, making sure there is no retaliation, making sure the victim feels safe to come forward and report the crime, making sure he or she gets the mental health services and the support they need.

So no one is actually suggesting they become less involved, and in fact, when they do so, they actually distort the debate because the only commanders today who have the authority to be the convening authority to make a decision about whether to go to trial are very senior-level commanders. It is less than 3 percent of commanders.

So the 97 percent of commanders are as involved as they have ever been involved, and what we have been trying to do in the underlying bill is to make them more responsible by actually reviewing their record on creating a command climate that is consistent with no rape, no assault, that is conducive for victims to come forward.

Those commanders will never have the right to make the legal decision. So whether or not we take that right away from that 3 percent of top-level commanders, the purpose is to instill confidence by the victims.

If you listen to our victims panel and you listened to what they said, one of our victims was retaliated against by all these junior-

level commanders. And so, her hope that a senior-level commander would have her back doesn't exist because her perception is that all the other in the chain of command are going to retaliate against me so they will believe those commanders over me every time.

So I really want you to focus on that because when you say I don't think they should be less involved. I don't think they should be less responsible. No one is arguing them to be less involved or less responsible. In fact, everything we have done in the NDAA is making them more responsible and more involved.

I just want to remove that appearance, and the VA's Web site specifically says that the current system is undermining recovery and is actually creating greater PTSD and undermining the patients. And I can—I read it when I did my opening statement. I don't know if you heard it, if you were all here, but you can give me the VA Web site thing.

It says here, "Many victims are reluctant to report sexual trauma, and many victims say that there were no available methods for reporting their experiences to those in authority. Many indicate—" And that is a perfect example of what our first witness, Ms. Kenyon, said. She didn't feel like she could tell anybody because everyone in her chain was retaliating against her.

"Many victims are reluctant to report sexual trauma, and many victims say that there were no available methods for reporting their experiences to those in authority. Many indicate that if they did report the harassment, they were not believed—" perfect example with Ms. Kenyon. "They were not believed or encouraged to keep silent about the experience. They may have had their reports ignored or, even worse, have been themselves blamed for the experience. Having this type of invalidating experience following a sexual trauma is likely to have a significant negative impact on the victim's post-trauma adjustment."

How do you review that VA Web site's analysis?

Dr. GALBREATH. Ma'am, I would offer to you the—I would offer to you that the system that we have in place today is not the system that we had in place even a few years ago. When Mr. Panetta took the stand in January 2012 and he said we have a problem and he cited numbers associated with that, he put a chain of events in motion that I would offer to you have really substantively changed the landscape of the current military system.

What you see in our numbers this year, this is the—this is the system that we have now. This is the system that we have today. I believe that the increase in the number of reports have come from people that believe what our commanders are doing is correct and supporting them, that the—

Senator GILLIBRAND. Dr. Galbreath?

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. Two out of 10 rape victims are reporting today. I would not pat yourself on the back for 2 out of 10. Granted, according to your number, we know that there is more reports.

Dr. GALBREATH. Yes, ma'am.

Senator GILLIBRAND. But we don't have the base number. So we don't know if it is the same thing that happened between 2011 and 2012 where total reports are up, but the incident rate skyrocketed. So, in fact, reporting by a percentage went down.

So please, before we have the evidence and data, we should not be patting ourselves on the back—

Dr. GALBREATH. Ma'am, I—

Senator GILLIBRAND.—on any level. And having 2 out of 10 report is insufficient and is still a significant failure. So please do not say we are succeeding. Because if 8 out of 10 victims stay mum because they don't believe justice is possible or they fear retaliation, we are failing 8 out of 10, clearly.

Dr. GALBREATH. We have a long way to go. You are absolutely correct. But I would offer to you is that this is evidence of change in the system, and—

Senator GILLIBRAND. We don't know that. If we don't have the raw numbers, we don't know. We know that if you have been raped before you get in the military, there has been an increase in reporting. We don't know what the raw numbers of total rapes within the military were this year. We just know the number of brave individuals who came forward and actually signed their name to a real report.

But if the number of actual rapes went up, well, we are not doing any better. If it is still 1 out of 10 cases, we are still where we were last year.

Dr. GALBREATH. I don't see the data that way, ma'am.

Senator GILLIBRAND. Well, you don't know the raw numbers. You can't see the data any way.

Dr. GALBREATH. We have had—we have had very consistent reporting of unwanted sexual contact since 2006. It is somewhere between 4 percent for women and 7 percent. And for men, it is between 1 and 2 percent.

In that historical context, I judge that this increase in reporting is progress.

Senator GILLIBRAND. Unless there is an increase in rape, like what we saw between '11 and '12.

Dr. GALBREATH. But even so, ma'am, that was just in two instances in two Services. That wasn't across the board.

Senator GILLIBRAND. That is the DOD's report.

Dr. GALBREATH. Yes, ma'am. I was involved in that.

Senator GILLIBRAND. So—

Dr. GALBREATH. I would offer to you, ma'am, that you are exactly right. Next year, when we have a prevalence survey that we are able to judge in better context what this increase in reporting means, we will have a better picture. But given historical data and confirmation from other independent surveys that we have that have been conducted in the last 5 years, that this increase in reporting is a positive sign.

We are not done by any means. We are—we are very cognizant that we have a lot more work to do, and it is not a pat on the back by any means. But I just want to make you understand that we do take this very seriously, and we are doing everything we can to bring more victims forward so they can get the help and care that they need so that they can restore their lives.

Senator GILLIBRAND. So can we go back to the issue of the VA's Web site? What is your impression of that?

Dr. GALBREATH. Ma'am, I would offer to you that was probably a snapshot of time of things in the past history. I don't know

about—I don't know this article. I don't know what they are talking about as far as the time aspect goes.

But like I said, since 2012, we have had a number of reforms helped by you and the members of this body, as well as a number of other things that we have done to bring more victims forward.

Senator GILLIBRAND. Dr. Bell?

Dr. BELL. Well, this is—I am really best positioned to speak to research, but it looks like this is coming from the National Center for PTSD's Web site, which is, of course, a VA entity.

I mean, what I would turn to, thinking research wise, is we certainly know that the types of support, the types of reactions that people get after experiences of sexual assault are really pivotal in their recovery. In fact, we know that it is the biggest and strongest predictor of their recovery afterwards and the biggest and strongest predictor of developing PTSD.

So I think the systemic responses, I think the support from family and friends, I think the societal response more generally is really going to strongly shape the course of someone's recovery after an experience like this.

Senator GILLIBRAND. Well, thank you all for testifying. I am extremely grateful for the hard work you are doing. I am extremely grateful that you have taken it upon yourself with both the DOD and the VA to meet the needs of these survivors.

I know this is a very, very hard, hard and difficult road ahead of us. But I trust your commitment, and I am grateful for that commitment because you are the difference between men and women receiving the care they need and not.

Thank you so much for your service, and thank you for being here today.

Dr. GALBREATH. Thank you, ma'am.

[Whereupon, at 12:33 p.m., the subcommittee adjourned.]