MAXIMIZING VA BENEFITS FOR SURVIVORS OF MILITARY SEXUAL TRAUMA: A PRACTICAL GUIDE FOR SURVIVORS AND THEIR ADVOCATES

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INTRODUCTION

Military Sexual Trauma (MST) is an imprecise term that basically relates to "sexual assault or repeated, unsolicited, threatening acts of sexual harassment that occurs during military service."[1] Despite a variety of definitions for "sexual assault" and "sexual trauma" (e.g., some including verbal harassment),[2] and differences in populations sampled (e.g., active duty members versus treatment-seeking veterans),[3] estimates consistently indicate

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1 Erin L. Rowe, *Military Sexual Trauma in Treatment-Seeking Women Veterans*, 21 MIL. PSYCHOL. 387, 388 (2009); *see also infra* Part II (describing nuances of the VA's definition in various statutory and regulatory sources and the appellate cases which interpret them).

2 *See, e.g.*, Michelle Davies & Paul Rogers, *Perceptions of Male Victims in Depicted Sexual Assaults: A Review of the Literature*, 11 AGGRESSION & VIOLENT BEHAV. 367, 368 (2006) (discussing how prevalence estimates for sexual assault dramatically change for both males and females based on broader definitions which include "non-contact abuse," and narrow definitions, which only consider "penetration").

3 *See, e.g.*, Naomi Himmelfarb et al., *Posttraumatic Stress Disorder in Female Veterans with Military and Civilian Sexual Trauma*, 19 J. TRAUMATIC STRESS 837, 838 (2006) (discussing how clinical samples of veterans

that that just over 20% of females and 1% of males are sexually assaulted in a physical manner during their service.[4] The numbers rise substantially to 20% of males and 70% of females in studies where verbal trauma is included in the definition.[5] Importantly, the term MST was "created to capture the different forms of sexual maltreatment reported by military personnel."[6] Thus, MST "is not a syndrome, diagnosis, or construct associated with clear treatment indications."[7] Instead, it represents a type of stressor that can result in such maladies.[8] Recent and renewed interest in the MST epidemic has resulted in legislative proposals to revamp the entire military justice system to hold perpetrators accountable and encourage survivors to report their abuse,[9] as well as ongoing efforts within the Department

obtaining VA treatment will lead to higher MST prevalence rates than samples of active duty members); *id.* at 843 (suggesting further that the increased MST prevalence indications from VA samples is attributable to the VA's targeted outreach to MST survivors); Lori S. Katz, *Military Sexual Trauma During Deployment to Iraq and Afghanistan: Prevalence, Readjustment, and Gender Differences*, 27 VIOLENCE & VICTIMS 487, 488–89 (2012) (describing a host of factors that account for variance in prevalence of MST based on specific subpopulation attributes).

4 Himmelfarb et al., *supra* note 3, at 837 (observing that female in-service sexual assault "estimates tend to cluster in the 23% to 33% range"); Tim Hoyt et al., *Military Sexual Trauma in Men: A Review of Reported Rates*, *in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 244, 253 (Carolyn B. Allard & Melissa Platt eds., 2012) (noting a "weighted average" for male MST of "0.09% for twelve-month incidence and 1.1% for lifetime prevalence," even accounting for a high of 12% in one study); Ursula A. Kelly et al., *More Than Military Sexual Trauma: Interpersonal Violence, PTSD, and Mental Health in Women Veterans*, 34 RES. IN NURSING & HEALTH 457, 457 (2011) ("Researchers have consistently reported prevalence rates of sexual assault of women during military service of 21–25% or higher."); Rachel Kimerling et al., *Military Sexual Trauma and Patient Perceptions of Veteran Health Administration Health Care Quality*, 21 WOMEN'S HEALTH ISSUES S145, S145 (2011) (reporting MST rates of 22% for female and 1% for male veterans using Veterans Health Administration (VHA) services).

5 For example, while approximately 1.2% of active service men have reported sexual assault, when cognized as attempted or completed rape, 36% to 74% have reported experiencing sexual harassment. Jessica A. Turchik & Susan M. Wilson, *Sexual Assault in the U.S. Military: A Review of the Literature and Recommendations for the Future*, 15 AGGRESSION & VIOLENT BEHAV. 267, 268 (2010). Moreover, a study that included "sexual identity concerns, harassment, and/or assault as in-service sexual stressors" stated that "approximately 80% of military women report exposure." Marjan Ghahramanlou-Holloway et al., *An Evidence-Informed Guide for Working with Military Women and Veterans*, 42 PROF'L PSYCHOL.: RES. & PRAC. 1, 2 (2011).

6 Carolyn B. Allard et al., *Military Sexual Trauma Research: A Proposed Agenda*, *in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 112, 113 (Carolyn B. Allard & Melissa Platt eds., 2012).

7 Rachel Kimerling et al., *The Veterans Health Administration and Military Sexual Trauma*, 97.12 AM. J. PUB. HEALTH 2160, 2161 (2007).

8 Rowe, *supra* note 1, at 388.

9 *See, e.g.*, Spencer Ackerman, *Slowly, Military Opens the Door to Outside Prosecutions for Sexual Assault*, WIRED (May 17, 2013, 4:18 PM), http://www.wired.com/dangerroom/2013/05/hagel-dempsey-assault (citing

of Veterans Affairs (VA) to accommodate MST survivors' needs for medical treatment and empathic, bias-free benefits adjudication.[10] However, commentators emphasize the likelihood that pervasive systemic oversights within the VA and the Department of Defense (DoD) will result in continued incidences of MST among active duty service members and the erroneous denial of VA benefits to MST survivors who, in many cases, desperately need and rightfully deserve them.

While legal clinics and scholars have suggested broad reforms of VA and DoD policies on MST in the long term,[11] this Article offers a short-term practical orientation for working within the current constructs for documenting, substantiating, and adjudicating MST claims. We focus mainly on the issue of disability compensation because of its instrumental value to MST survivors, above and beyond the current free health care at VA facilities that has been made available to any person who claims to have suffered from MST, even if a former service member would otherwise be ineligible for the full array of VA benefits.[12] Although the VA offers survivors the ability to obtain care for MST-related psychiatric and physical conditions, it struggles to overcome significant hurdles facing MST survivors.

For example, many veterans face: (1) tremendous discomfort requesting benefits for sexual assaults, especially from revisiting the details of their abuse;[13] (2) residual effects of the VA's historic difficulty maintaining sensitivity to gender which manifests in male survivors having to interact with VA programs that focus almost exclusively on women's needs,[14] and female survivors often fearing that they may have to interact with male veterans at VA facilities who appear little different than their abusers, even if the facility

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to at least ten different pieces of legislation in the House to address commanders' role in the prosecution and disposition of charges related to military sexual assaults).

10 *Infra* Part II.

11 *See, e.g.*, *infra* note 58 and accompanying text.

12 John W. Brooker et al., *Beyond "T.B.D.": Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces*, 214 MIL. L. REV. 1, 99–100 (2012).

13 *See, e.g.*, Alicia Sandberg et al., *Reactions to a Survey Among Those Who Were and Were Not Sexually Assaulted While Serving in the Military*, 110 PSYCHOL. REP. 461, 466 (2012) (suggesting that general upset may stem from being asked about traumatic experiences).

14 *See, e.g.*, Katz, *supra* note 3, at 496 (noting how "MST is typically thought of as a 'women's issue,'" which may influence health care providers to make biased judgments about male veterans seeking healthcare services).

has professionals with specialized services oriented to women;[15] (3) the VA's affiliation with the military, which can fuel concerns that the VA represents the same interests as a military organization that quite possibly ignored the survivor's complaints or even retaliated against the survivor for making a complaint regarding the victimization;[16] (4) an adjudicatory system that requires MST survivors to prove by a 50% chance or greater that their assault occurred, despite presumptions of service-connection for combat-related mental or physical conditions;[17] (5) the fact that the VA continues to deny a significant number of MST claims, which undermines the VA's efforts at outreach to this population of survivors, specifically;[18] and, most significantly, (6) the fact that health care alone cannot address the significant consequences of MST on one's employment opportunities and employability, which often results in women victims' suspicion and distrust of male co-workers and a variety of other consequences, especially those related to self-sufficiency and independence.[19] For a combination of these reasons, free treatment at VA facilities for MST-related physical and mental conditions is not appealing or effective enough alone to meet the needs of MST survivors, a majority of whom have long-term needs related to their

15 Kristin M. Mattocks et al., *Women at War: Understanding How Women Veterans Cope with Combat and Military Sexual Trauma*, 74 SOC. SCI. & MED. 537, 544 (2012) ("[W]omen veterans who may have experienced some form of military sexual trauma may be unwilling to utilize VA services, for fear of encountering the same types of individuals who may have perpetrated the sexual trauma.").

16 *Id.*

17 *Infra* Part III.B.3.

18 Jaime Goldberg, *Military Sexual Assault Victims' PTSD Claims Neglected*, L.A. TIMES (July 19, 2012), http://articles.latimes.com/2012/jul/19/nation/la-na-military-rape-20120719 ("From 2008 to 2010, 32% of PTSD claims from veterans who were sexual assault victims were approved, compared with 53% of all other PTSD claims, according to the advocacy group Service Women's Action Network."). Older studies, in fact, highlighted more significant numbers of PTSD service-connection denials for women veterans seeking benefits, specifically. Ben Kappelman, Note, *When Rape Isn't Like Combat: The Disparity Between Benefits for Post-Traumatic Stress Disorder for Combat Veterans and Benefits for Victims of Military Sexual Assault*, 44 SUFFOLK U. L. REV. 545, 557 (2011) (noting 2008 VA statistics showing that while 17,075 women veterans successfully established a service-connection for their PTSD-related claims, 22,283 women veterans could not and were subsequently denied).

19 A number of the appellate cases involving the long-term effects of MST involved claimants' accounts of how they were unable to work with members of the opposite sex long after their discharge from the armed services. For a representative sample, see, e.g., Name Redacted, No. 10-00 016, 2013 BVA LEXIS 4410, at *31–32 (B.V.A. Feb. 7, 2013) (citing the veteran's status as "unemployable" on the basis that her "anger has become focused on the men who sexually assaulted her such that she would have difficulty working with men"). *See also* Name Redacted, No. 06-10 853A, 2013 BVA LEXIS 30435, at *17 (B.V.A. July 23, 2013) (citing the veteran's claim that "she was unable to be around men after her first sexual assault"). BVA decisions are available for review on the VA's public website, *infra* note 27, for those readers who do not have access to a subscription-based legal research service such as Westlaw or Lexis.

victimization while serving in the military. This may explain why a disproportionately high number of eligible veterans who suffered MST do not ultimately apply for VA benefits.[20]

This Article draws on the authors' combination of twenty years of experience within the military justice and VA system. We recognize the symbolic value of VA disability compensation as an incentive to file with VA, a way to offset the lack of steady employment income, and the freedom to pay for health care that is more variable and available through professionals with no connection to VA hospitals, clinics, patients, or programs.[21] The challenge presented is identifying a methodology to increase chances of success in the application process. To attain the objective, this Article is divided into five parts. Part II begins by identifying the patchwork of VA standards for adjudicating claims for service-connected disabilities arising from MST. These standards exist in a patchwork of agency, regulatory, and legislative rules which are often inconsistently applied at different levels of review within the VA's appellate structure.[22] Recognizing, for example, that adjudicators at the front-line Regional Office level are the most vital links to necessary benefits,[23] we take due care to examine the standards upon which they rely, particularly when they are not common to or even differ from the Board of Veterans' Appeals (BVA) and the United States Court of Appeals for Veterans Claims (CAVC) analyses.

After describing general considerations applicable to all MST adjudications, Part III eschews the traditional approach of treating MST as a unitary experience. Our experience litigating sexual assault cases in the military and evaluating MST-related decisions from the VA's Regional Offices reveals that certain characteristics of perpetrators, survivors, the manner in which the trauma was perpetrated, and the manifestation of symptoms over time

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20 *See, e.g.*, Ghahramanlou-Holloway et al., *supra* note 5, at 5 (describing various reasons why women veterans avoid seeking needed services from the VA); Nina Sayer et al., *A Qualitative Study of U.S. Veterans' Reasons for Seeking Department of Veterans Affairs Disability Benefits for Posttraumatic Stress Disorder*, 24 J. TRAUMATIC STRESS 699, 700 (2011) (observing that only five percent of women veterans eventually seek VA benefits for PTSD). This statistic is quite troubling, considering that rape is the leading cause of PTSD, often "as high or higher than combat exposure." Kimerling et al., *supra* note 7, at 2160.

21 *Infra* notes 68–70, 467–69, and accompanying discussions.

22 Jeffrey Parker, *Two Perspectives on Legal Authority Within the Department of Veterans Affairs Adjudication*, 1 VETERANS L. REV. 208, 208 (2009) (distinguishing between a "judicial" perspective among lawyers and an "administrative" perspective among non-lawyers within the VA and how legal training largely accounts for differences in the prioritization of potential sources of authority in VA adjudications).

23 *Id.* at 218 (observing that Regional Office adjudicators at the initial stage of claims review "look more for a fair result rather than for legal purity and may be more open to considering non-legal factors in the decision making process," which obviously accrues to the claimant's benefit).

raise unique evidentiary and practical considerations. In other words, factors related to the nature of the assault or harassment place a premium on different forms of evidence. For example, MST perpetrated upon men is entirely distinct from that perpetrated on women, and these, in turn, are distinct from MST involving solely verbal harassment. While the manner of inflicting trauma and its resulting effects might be nearly infinite, in this Part, we focus on the two overarching issues that have been overlooked in the scholarship, but which are raised—implicitly—in a substantial number of MST claims: cumulative trauma, i.e., the interaction of multiple traumatic experiences over the veteran's life course, and hazing-related MST.[24]

While anyone can be a victim of MST, the reality of re-victimization of former sexual assault and abuse survivors raises special considerations among those with pre-enlistment assault histories requiring the survivor to demonstrate not only that the military trauma occurred, but furthermore that existing symptoms can be traced to it, rather than an earlier traumatizing experience.[25] For mental conditions related to hazing, the sexual aspects of hazing incidents are often overlooked by the survivors and the professionals who may be assisting them. Because the VA has no special provisions for hazing-related claims during the benefits adjudication process, we highlight the manner in which most hazing is, in fact, sexual and rises to the level of MST, providing a vehicle to obtain benefits under a different set of special standards. Neither of these issues is addressed in the rubric of MST in either VA or scholarly literature on the topic, despite the pivotal nature of these issues in influencing VA benefit eligibility.

In evaluating these two distinct forms of MST, we utilized not only our own legal experience with the DoD and VA, but we also spent several months, with the assistance of attorney Kate Buzicky,[26] cataloging a sample of 2,170 MST-related cases decided between 2002 and 2012 within the BVA's voluminous *Decision Search* database.[27] By relying upon

24 These two topics are sufficiently inclusive to present a backdrop for considering other more evident and distinct patterns of sexual traumatization, including non-physical MST, gender differences in the experience of MST, and MST perpetrated by superiors. While each of these sub-issues deserves careful consideration, in this Article, the context of cumulative trauma and hazing offers the broadest and most inclusive perspective on overarching concerns for the VA;s evaluation of disability claims related to MST.

25 *Infra* Part III.B.3.

26 Kate Buzicky is a former Army judge advocate who currently works as an Assistant United States Attorney in Minneapolis, Minnesota.

27 U.S. Dep't of Veterans Affairs, Bd. of Veterans App., *Board of Veterans' Appeals Decision Search*, U.S. DEP'T OF VETERANS AFFAIRS, http://www.index.va.gov/search/va/bva.html (last visited Mar. 29, 2014) (containing thousands of BVA decisions from 1994 to 2013 with redacted personally identifying information).

this heretofore-untapped resource and by coding various decisions by key variables,[28] we compensated for the lack of an indexing system and culled important lessons about distinctions between types of MST claims and unique considerations related to these topics. It is our objective here to provide survivors and their supporters with the ability to quickly identify issues and evidentiary requirements that relate to the specific types of harm they suffered, rather than expecting them to synthesize an overwhelming amount of unfiltered material.

Having identified the VA's general MST considerations and special considerations related to often-missed patterns of MST, Part IV offers a tool that will empower front-line MST responders—whether they are Special Victims Prosecutors, Chaplains, Sexual Assault Response Coordinators, Victim Advocates, or friends—to maximize survivors' chances of a favorable VA benefit determination whenever they decide to file a claim. Considering that delayed reporting and the loss of valuable evidence accounts for the denial of most MST claims, survivors of MST must have the ability to capture evidence that will matter in a VA benefit determination *as close in time to the trauma as possible*. Law enforcement cannot collect evidence and military organizations cannot respond to MST until a survivor reports the abuse, and, too often, reports are delayed by so many years that reconstruction of events is nearly impossible. Restricted reporting, which limits the investigation of an offense by law enforcement until the survivor's decision to pursue an official report, further limits the ability to obtain valuable evidence.[29] Our practical solution to this widespread challenge is a self-guided short form to help MST survivors develop and preserve key evidence that is relevant for VA benefits, specifically. We also provide Letters of Introduction to facilitate only the most responsive and probative evidence from lay witnesses, medical providers, and mental health providers. Wide dissemination of these forms by any first-responder who learns of MST will provide survivors with the best chances of establishing benefit eligibility.

This Article concludes with a brief discussion of special considerations regarding MST claims within VA. Because months and years may pass before the opportunity to win an appeal, it is vital to understand how to make the initial application as strong as possible, thereby maximizing well being in all of its forms as early as possible. The first special consideration is one of timeliness of evidence preservation and presentation. Despite

28 For an extended version of the coding matrix and accompanying scoring key, see *infra* App. N.

29 *See, e.g.*, Ogilvie & Tamlyn, *infra* note 58, at 35 ("DoD's new restricted reporting options may eventually be harmful to a veteran's claim for a mental health disorder due to MST."); Hansen, *infra* note 58, at 558 (discussing limitations on command and law enforcement investigations if an active duty complainant elects to file a restricted report of sexual assault).

significant strides in providing MST-related health care to any survivor, regardless of ineligibility for other VA benefits,[30] we next discuss the vital role of disability compensation for MST survivors and why it must not be eclipsed by the fact that most survivors are now eligible for free VA healthcare, even if they would normally be ineligible for other benefits. Finally, we discuss how important it is to seek a VA trauma-focused treatment facility as soon as possible, even prior to filing a claim, because their staff will be far more capable of providing the kinds of evidence necessary to succeed in establishing service-connection.

I. A Needed Practical Orientation to the VA's Adjudication of Military Sexual Trauma Claims

Before commencing our analysis, we highlight the fact that cumulative trauma must be a primary consideration in the preparation of any MST claim, whether by the survivor himself or herself or by an MST first-responder in DoD or the civilian community. Many young men and women join the military in an effort to "escape" the harsh realities of family environments rife with physical, sexual, and emotional abuse.[31] In an American society where an estimated 27% of adult females and 15% of adult males report histories of sexual abuse as children,[32] the military is particularly appealing because it provides the resources for significant time away from the home during basic training and then geographic relocation, often to other countries, at no expense to the recruit. For many survivors of sexual trauma, the military provides a vehicle for attaining a new family devoted to important causes, which might provide a newfound sense of belonging, worth, and purpose.[33] Another attribute of military service for males who were sexually abused by

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30 *See* Ogilvie & Tamlyn, *infra* note 58, at 16 ("In 2010, a new VHA directive . . . mandated that VHA provide MST-related care to all veterans, despite whether the veteran was service-connected or even eligible for VA care."); VETERANS HEALTH ADMIN., DIRECTIVE 2010-033, at 1, 6 (July 14, 2010).

31 Anne G. Sadler et al., *Life Span and Repeated Violence Against Women During Military Service: Effects on Health Status and Outpatient Utilization*, 13 J. WOMEN'S HEALTH 799, 803 (2004) ("Almost half of the women (49%) [in a sample of 520 treatment-seeking veterans] who reported premilitary physical or sexual violence indicated that they joined the military in order to escape an abusive or distressing home life."); *see also* Turchik & Wilson, *supra* note 5, at 270 (discussing the possibility of the concepts of "escape" and a "fresh start" by enlisting in the military).

32 Turchik & Wilson, *supra* note 5, at 270.

33 MIC HUNTER, HONOR BETRAYED: SEXUAL ABUSE IN AMERICA'S MILITARY 8 (2007) (noting the perceived value of enlistment to become "a part of something important and bigger than oneself"). Sadly, this same quality is also one reason why sexual assault in the military is particularly harmful. Amy E. Street et al., *Sexual Harassment and Sexual Assault During Military Service, in* CARING FOR VETERANS WITH DEPLOYMENT RELATED STRESS DISORDERS: IRAQ, AFGHANISTAN, AND BEYOND 131, 139 (Josef I. Ruzek et al. eds., 2011).

other males is the ability to identify with a strong masculine gender identity that contrasts with their prior abuse experiences.[34]

Although experiences certainly vary among individuals and there are numerous other incentives for military membership, such as a sense of adventure and college education assistance,[35] the above factors help to explain why members of the active duty armed forces have significantly greater histories of pre-service sexual victimization than their civilian counterparts.[36] The studies, based on self-reported instances of lifetime abuse, reveal that 15% of male veterans and 49% of female veterans reported Child Sexual Assault (CSA) histories.[37] Sadly, CSA only partly accounts for pre-service sexual assault. A significant number of recruits enter the military with pre-service adult sexual assault (ASA),[38] and yet others with both pre-enlistment CSA and ASA.[39]

Despite the fact that "exact prevalence rates of MST are not known"[40] and the realization that "[t]he impact of sexual assault varies over time, and not every person will react the same

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34 HUNTER, *supra* note 33, at 10 ("No other organization is as identified with providing a place to prove one's manhood as the military.").

35 *Id.* at 3–11 (discussing twelve prevailing motivations for enlisting in the U.S. Armed Forces).

36 *See, e.g.*, Irene Williams & Kunsook Bernstein, *Military Sexual Trauma Among U.S. Female Veterans*, 25 ARCHIVES OF PSYCHIATRIC NURSING 138, 141 (2011) ("[B]oth men and women who join the military have higher rates of sexual and physical abuse victimization history than the general population."); Heidi M. Zinzow et al., *Trauma Among Female Veterans: A Critical Review*, 8 TRAUMA, VIOLENCE & ABUSE 384, 385 tbl.1, 389 (2007) (reporting that between 27% and 49% of female veterans reported experiencing child sexual abuse, statistics which are significantly higher than rates for the general population (17% to 32%)).

37 HUNTER, *supra* note 33, at 143. Such abuse relates to pre-service child sexual abuse, as reflected in child sexual abuse rates of 49% of females and 15% of males in a survey of 1,060 males and 305 females at Army installations. Leora N. Rosen & Lee Martin, *Impact of Childhood Abuse History on Psychological Symptoms Among Male and Female Soldiers in the U.S. Army*, 12 CHILD ABUSE & NEGLECT 1149, 1153 (1996).

38 *See, e.g.*, Kelly et al., *supra* note 4, at 458 (noting study results in which "one in four [female veterans] had been raped prior to her entry into the military"); Kimerling et al., *supra* note 7, at 2164 ("Approximately 30.3% of women sexually assaulted in the military also reported sexual assault while a civilian.").

39 *See generally* Heidi M. Zinzow et al., *Sexual Assault, Mental Health, and Service Use Among Male and Female Veterans Seen in Veterans Affairs Primary Care Clinics: A Multi-Site Study*, 159 PSYCHIATRY RES. 226, 226 (2008) (exploring detailed pre-enlistment sexual assault histories of 816 veterans of both genders obtaining services at four VA Medical Centers).

40 Brian N. Smith et al., *Posttraumatic Stress Symptomatology as a Mediator of the Association Between Military Sexual Trauma and Post-Deployment Physical Health in Women*, *in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 63, 65 (Carolyn B. Allard & Melissa Platt eds., 2012).

way,"[41] when such trauma occurs, for a great many MST survivors, their experiences have effectively eviscerated the promise of a "fresh start" in the military for pre-service sexual assault survivors by perpetuating the same devastating influences that formed the very basis of their enlistment.[42] The significant population of pre-service sexual abuse survivors in the ranks raises a number of troubling concerns that have wide-ranging implications on institutional responses to MST by the military and the VA. The large scholarship on "re-victimization" underscores how CSA and pre-service ASA predispose many survivors of these incidents to experience MST during their service.[43] On balance, "approximately two of three individuals who are sexually victimized are revictimized."[44] Unfortunately, some of the ways that survivors cope with sexual abuse may leave them at risk for sexual retraumatization.[45] For example, "[a] person who as a child assumed a passive or frozen

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41 HUNTER, *supra* note 33, at 179.

42 Brenda M. Booth et al., *Rape, Sex Partnership, and Substance Use Consequences in Women Veterans*, 24 J. TRAUMATIC STRESS 287, 292 (2011) (recognizing how "ironic" it is that women use the military to leave abusive families only to increase the chances of further abuse in service).

43 *See, e.g.*, Catherine C. Classen et al., *Sexual Revictimization: A Review of the Empirical Literature*, 6 TRAUMA, VIOLENCE & ABUSE 103, 103 (2005) ("Child Sexual Abuse . . . doubles or even triples the risk of sexual revictimization for adult women."); Henrietta H. Filipas & Sarah E. Ullman, *Child Sexual Abuse, Coping Responses, Self-Blame, Posttraumatic Stress Disorder, and Adult Sexual Revictimization*, 21 J. INTERPERSONAL VIOLENCE 652, 652 (2006) (observing the "link between childhood sexual abuse . . . and revictimization in the form of adult sexual assault" as well as the estimate that survivors of childhood sexual abuse [CSA] "are at least twice as likely to be revictimized as women with no reported CSA"); Tamra B. Loeb et al., *Associations Between Childhood Sexual Abuse and Negative Sexual Experiences and Revictimization Among Women: Does Measuring Severity Matter?*, 35 CHILD ABUSE & NEGLECT 946, 946–47 (2011) ("[W]omen with histories of [Childhood Sexual Abuse] are more likely to report engaging in consensual sexual intercourse at an earlier age . . . , more unintended pregnancies . . . and sexual partners . . . , a history of sexually transmitted infections . . . , and greater likelihood of being sexually revictimized as an adult."); Zinzow et al., *supra* note 36, at 394 ("A large percentage of women enter the military with prior . . . experiences [of sexual trauma] placing them at risk for cumulative trauma exposure during the course of their military service."). Importantly, this revictimization risk is not limited to women. Classen et al., *supra* at 112 ("[M]en with a history of CSA are 5.5 times more likely to be [sexually] assaulted in adulthood again by any type of perpetrator.").

44 Classen et al., *supra* note 43, at 124.

45 *See, e.g.*, Catalina M. Arata, *Child Sexual Abuse and Sexual Revictimization*, 9 CLINICAL PSYCHOL.: SCI. & PRAC. 136, 159–60 (2002) (discussing how "the behaviors [that survivors of childhood sexual assault] engage in to deal with negative symptoms have placed them in dangerous situations," thus "increas[ing] vulnerability to adult sexual assaults"). These troublesome behaviors often include "overreaction to low-level threats and also a failure to react appropriately to a signal of threat or risk of assault" rooted in dissociation or the experience of Posttraumatic Stress Disorder symptoms. Michelle A. Fortier et al., *Severity of Child Sexual Abuse and Revictimization: The Mediating Role of Coping and Trauma Symptoms*, 33 PSYCHOL. OF WOMEN Q. 308, 310 (2009).

response while being sexually abused may involuntarily react the same way when faced with an unwanted or inappropriate sexual experience as an adult."[46] This may help explain study results indicating that "approximately 30% of women sexually assaulted in the military also report sexual assault while a civilian, and 16.8% report child sexual abuse."[47] Although these repeated abuse factors do not account for all military sexual assaults, they explain why the risk of sexual revictimization often evades prevention efforts instituted by the Armed Forces, creating a steady stream of cases, regardless of official efforts.

Although widespread incidences of sexual assault and harassment occur in civilian environments, such behavior differs significantly from MST. MST presents an urgent need for prevention and response efforts because it "occurs within a restricted time period (typically 2 to 6 years of service)," dramatically increasing risks of exposure of service members compared to civilian populations.[48] While, no doubt, in-service sexual assault contributes to a public health epidemic due to its long-term effect on survivors' physical and mental health,[49] there are particular concerns related to MST survivors with pre-service sexual assault.[50] The double-deception of being exposed to repeated abuse while in a more vulnerable military environment not only compounds maladaptive coping troubles,[51] but it creates a palpable increase in the likelihood of post-MST sexual victimization while

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46 HUNTER, *supra* note 33, at 26.

47 Kimerling et al., *supra* note 7, at 2164.

48 Carolyn B. Allard et al., *Military Sexual Trauma Research: A Proposed Agenda, in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 112, 117 (Carolyn B. Allard & Melissa Platt eds., 2012).

49 *See, e.g.*, Williams & Bernstein, *supra* note 36, at 142–43 (observing that "PTSD stemming from MST is perhaps one of the most pressing mental health concerns facing female service members and veterans today" and that "the psychological trauma inflicted on [them] in conjunction with war trauma is so enormous that healthcare providers have found care for this vulnerable population to be very challenging").

50 Kelly et al., *supra* note 4, at 465 (recommending that the military "screen for pre-military [sexual] trauma at enlistment as well as during active duty" to identify those in need of specialized services).

51 *See, e.g.*, Himmelfarb et al., *supra* note 3, at 844 (observing that military environments may increase the risks of PTSD from MST due to heightened stress among all military members and greater access to weapons); Kimerling et al., *supra* note 7, at 2160 ("[A] number of issues uniquely associated with military settings may intensify the effects of [the in-service sexual assault]."). Horrifically, many aspects of Post-MST survival directly resemble incest survival, including the shared secrecy dynamic: "If you tell anyone about what happened, Daddy will go to jail and then everyone in the family will suffer and it will be your fault." HUNTER, *supra* note 33, at 29; *see also id.* at 144–47 (describing further ten similarities between the military environment and prior sexual abuse environments, which are conducive to more detrimental health consequences of MST that occurs as revictimization).

the survivor is still in the service or after the survivor has separated from the service.[52] Cumulative trauma likewise presents significant problems in the provision of health care services and VA benefits for those survivors who need it the most.

Under the VA's standards for determining benefits, a claimant must show that a stressful event occurred during the course of active military service and that the in-service stressor was the cause of a qualifying mental health diagnosis.[53] Of grave concern, even if a veteran can get past the significant hurdle of proving that the claimed sexual assault(s) occurred during military service, a disability adjudicator may deny a claim on the basis that any prior experience of sexual assault—especially recurring child sexual assault, which most is[54]—was the cause of a current mental health disorder, thus foreclosing appropriate compensation.[55] The issue essentially requires the evaluating mental health provider and the adjudicator to "disentangle" and then appropriately weight divergent traumatic experiences over one's lifetime, which is a terribly challenging task, as shown in the scholarship on cumulative trauma.[56]

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52 *See, e.g.*, Himmelfarb et al., *supra* note 3, at 843 (reporting results that veterans "with MST had about twofold increased odds for post-military [sexual] assaults" after their separation from the Service); Zinzow et al., *supra* note 39, at 230 (noting overall rates of revictimization of sexually assaulted veterans at 52% of males and 65% of females).

53 *See generally* Jennifer C. Shingle, *A Disparate Impact on Female Veterans: The Unintended Consequences of Veterans Affairs Regulations Governing the Burdens of Proof for Post-Traumatic Stress Disorder Due to Combat and Military Sexual Trauma*, 16 WM. & MARY J. WOMEN & L. 155, 165 (2009) ("[I]n order to establish a service-connection for PTSD due to military sexual trauma, the veteran must show: 1) a [qualifying] diagnosis . . . ; 2) that the [qualifying diagnosis] is related to military sexual trauma that occurred during active service; and 3) corroborating evidence of the trauma."). For a more detailed analysis, see *infra* Part II.

54 *See, e.g.*, Filipas & Ullman, *supra* note 43, at 666 (observing how the abuse spanned weeks to years for almost two thirds of a sample of 577 college women who reported histories of childhood sexual assault); Turchik & Wilson, *supra* note 5, at 270 (reporting that veterans with childhood sexual trauma histories are "more likely to report being sexually assaulted by a parent [and] longer durations of childhood sexual abuse").

55 *Infra* Part III (exploring VA determinations involving cumulative trauma and the factors that led to approval or denial of such claims).

56 Zinzow et al., *supra* note 39, at 234 ("[I]t is difficult to disentangle the effects of sexual assault from the effects of other traumatic events."); *see also* Kelly Scott-Storey, *Cumulative Abuse: Do Things Add Up? An Evaluation of the Conceptualization, Operationalization, and Methodological Approaches in the Study of the Phenomenon of Cumulative Abuse*, 12 TRAUMA, VIOLENCE & ABUSE 135, 140 (2011) (emphasizing that "the phenomenon of cumulative abuse and its relationship to health is much more complex than simply conceptualizing it as the sum of all victimization experiences"); *infra* Part III (exploring the manner in which VA adjudicators and appellate bodies consistently wrestle with this subject of causation for medically diagnosed conditions).

Surprisingly, although many commentators have discussed the difficulty of obtaining VA benefits for MST survivors, scholarly works—and proposed legislation, such as the Ruth Moore Act of 2013[57]—virtually ignore how to address this cumulative trauma hurdle, which applies to the great majority of military sexual assault victims.[58] Most critics identify the injustice resulting from the VA's application of different standards to claims for combat, versus sexual trauma-related claims.[59] Noting the presumption of service-connection for conditions stemming from combat developed in 2010,[60] they argue that sexual assault survivors are at a notable disadvantage because they are forced to prove that an assault occurred under a more demanding standard.[61] Those who urge the adoption of a similar

57 S. 294, 113th Cong. (2013) (modifying standards of proof to accept lay testimony on MST and its effects as corroborated by a medical opinion). For a description of pending MST legislation and Ruth Moore's lengthy battle to obtain VA benefits for MST, see AM. CIV. LIB. UNION & SERVICE WOMEN'S ACTION NETWORK, BATTLE FOR BENEFITS: VA DISCRIMINATION AGAINST SURVIVORS OF MILITARY SEXUAL TRAUMA 17, 3 (Nov. 2013) (discussing H.R. 2088 and H.R. 2528 and providing details about Ruth Moore in the textbox titled "One Survivor's Story").

58 Consider the absence of discussions of cumulative trauma in the legal scholarship on this issue. *See, e.g.*, AM. CIVIL LIB. UNION & SERVICE WOMEN'S ACTION NETWORK, *supra* note 57, at 15 (recommending "VA should use its PTSD combat regulation as a model to relax the evidentiary standard that applies to survivors of [MST] under 38 C.F.R. § 3.304(f)(5)" and providing related suggestions); Emily Hansen, Comment, *Carry That Weight: Victim Privacy Within the Military Sexual Assault Reporting Methods*, 28 J. MARSHALL J. COMPUTER & INFO. L. 551, 587 (2011) (recommending that empowerment of sexual assault response personnel over commanders in evaluating the merits of MST claims at confidential levels will improve overall reporting and evidentiary development of cases); Kappelman, *supra* note 18, at 564 (recommending policy changes to liberalize standards of proof for the in-service stressor element of MST similar to current presumptions for combat-PTSD); Brianne Ogilvie & Emily Tamlyn, *Coming Full Circle: How VBA Can Complement Recent Changes in DoD and VHA Policy Regarding Military Sexual Trauma*, 4 VETERANS L. REV. 1, 35–38 (2012) (proposing the liberalization of evidentiary standards for MST to permit corroboration based upon fear experienced by the assault, preservation of records developed in restricted reports of sexual assault, and VA-funded examinations of all claimants applying for MST benefits); Shingle, *supra* note 53, at 175 (recommending that VA MST evaluation standards "must be changed in order to lessen the burden of proof for victims of MST"); *cf.* Olympia Duhart, *PTSD and Women Warriors: Causes, Controls and a Congressional Cure*, 18 CARDOZO J.L. & GENDER 327 (2012) (suggesting that elimination of the bar to women participating in combat operations will help to limit the experience of PTSD among women veterans).

59 *See, e.g.*, Hansen, *supra* note 58, at 572 (opining that "current legislation favors veterans whose PTSD originated in combat, rather than from MST," and that "Department of Veterans Affairs requirements place an unrealistic, unfair, and discriminatory burden of proof on veterans who suffer from MST").

60 38 C.F.R. § 3.304(f) (2012).

61 *See* Kappelman, *supra* note 18, at 546 ("The current regulatory framework imposes a higher evidentiary burden on those veterans seeking compensation for PTSD because of sexual assault than on those seeking compensation for PTSD caused by exposure to combat."); Shingle, *supra* note 53, at 156 (observing how VA standards "create an arduous evidentiary burden female veterans must meet in order to qualify for disability benefits . . . notably more difficult . . . than [for] their male counterparts").

presumption of service-connection for sexual assault claims as the singular fix have completely missed the point that prior sexual abuse can still negate a service-connection claim.[62] Likewise the Federal Circuit's recent holding in *AZ v. Shinseki*,[63] that "the absence of a service record documenting an unreported sexual assault is not pertinent evidence that the sexual assault did not occur," may signify the dawn of a more critical approach to the VA's reasons and bases for rejecting MST claims. Nevertheless, this decision hardly eliminates the significant challenges posed by cumulative trauma and other considerations we address in this Article. In a larger context, cumulative trauma is a powerful example of the drawbacks in current approaches to MST. Scholars and advocates are largely focusing on legislative solutions at the cost of understanding the actual context in which VA adjudicators are reaching decisions. While many current suggestions *certainly do* help to highlight significant problems with the system,[64] few provide practical and tangible solutions that claimants can immediately implement. This Article is the first to recommend urgent solutions to this pressing challenge.

II. Pages from the Adjudication Playbook: Mastering the Legal, Administrative, and Practical Standards for Evaluating MST Claims at Regional Offices

A. The VA's Mission and Programs

The mission of the Department of Veterans Affairs is a simple one: "to care for him who shall have borne the battle, and for his widow, and his orphan."[65] The VA has articulated a set of department-wide core values and core characteristics that focus on acting with integrity; serving veterans and their families to the fullest extent possible and doing so with respect; and striving for excellence, accountability, and continuous improvement.[66]

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62 *See, e.g.*, Kappelman, *supra* note 18, at 553 (observing that "pre-military sexual abuse may pose an obstacle to obtaining benefits for PTSD caused by sexual assault during military service," but leaving this issue unresolved in his proposed solutions).

63 731 F.3d 1303, 1306 (Fed. Cir. 2013).

64 *See supra* notes 36–40 and accompanying text (describing various scholars' studies of the VA's system for evaluating and compensating claims and related recommendations to improve them).

65 *Mission Statement*, U.S. DEP'T OF VETERANS AFFAIRS, *available at:* www.va.gov/landing2_about.htm (last visited Mar. 25, 2014).

66 *Core Values and Core Characteristics*, U.S. DEP'T OF VETERANS AFFAIRS, *available at:* www.va.gov/icare/ (last visited Mar. 25, 2014). The VA's core values (i.e., "who the VA is") include integrity, commitment, advocacy, respect, and excellence, while the core characteristics (i.e., "what we stand for") include trustworthiness, accessibility, quality, innovation, agility, and integration.

Consistent with its mission, core values, and core characteristics, the VA offers a variety of benefits and services to eligible veterans, their dependents, and survivors.[67]

Disability compensation benefits are perhaps the most well known benefits paid by the VA. They are sought in large numbers.[68] These benefits, unlike Social Security disability benefits or VA pension benefits, are not limited or restricted by income.[69] VA disability compensation benefits are tax-free monthly monetary benefits typically paid to veterans with "service-connected" disabilities.[70] Service-connection means generally "that the facts, shown by the evidence, establish that a particular injury or disease resulting in disability was incurred coincident to service in the Armed Forces, or if preexisting such service, was aggravated therein."[71] Service-connection may also be granted for "any disease diagnosed after discharge when all the evidence, including that pertinent to service, establishes that the disease was incurred in service."[72]

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67 *See generally* U.S. DEP'T OF VETERANS AFFAIRS, FEDERAL BENEFITS FOR VETERANS, DEPENDENTS, AND SURVIVORS (2013), *available at http://www.va.gov/opa/publications/benefits_book/2013_Federal_Benefits_for_Veterans_English.pdf* (noting, for example, that the VA provides health care, disability compensation, pension, and burial and memorial benefits, as well as administers education, vocational rehabilitation, employment, home loan, life insurance, and dependents and survivors programs).

68 Press Release, U.S. Dep't of Veterans Affairs Office of Pub. & Intergovernmental Affairs, VA Completes Over 1 Million Compensation Claims in 2012 (Sept. 20, 2012), *available at* http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2388 [hereinafter *VA Office of Pub. & Intergovernmental Affairs*]. In Fiscal Year 2012, the adjudication of compensation claims accounted for 96.1% of the Board of Veterans' Appeals (BVA) workload. *See* BD. OF VETERANS' APPEALS, REPORT OF THE CHAIRMAN: FISCAL YEAR 2012 (2013), *available at:* http://www.bva.va.gov/docs/Chairmans_Annual_Rpts/BVA2012AR.pdf.

69 *See generally* SOC. SEC. ADMIN., WORKING WHILE DISABLED—HOW WE CAN HELP (2014), *available at* http://www.ssa.gov/pubs/EN-05-10095.pdf; *see also* 38 U.S.C.A. §§ 1502, 1503, 1521 (West 2002); 38 C.F.R. §§ 3.3, 3.23, 3.274, 3.342 (2012) (outlining the requirements for VA pension eligibility).

70 U.S. DEP'T OF VETERANS AFFAIRS, DISABILITY COMPENSATION BENEFITS FACT SHEET (2012), *available at* http://www.benefits.va.gov/BENEFITS/factsheets/serviceconnected/Compensation.pdf.

71 38 C.F.R. § 3.303(a) (2012); *see also* 38 U.S.C.A. § 1110; 1131 (West 2002).

72 38 U.S.C.A. §§ 1112, 1113 (West 2002); 38 C.F.R. § 3.303(d); *see also* 38 C.F.R. § 3.310(a) (2012); Allen v. Brown, 7 Vet. App. 439, 448 (1995) (noting that service-connection may also be granted on a secondary basis for a disability which is proximately due to or the result of a service-connected disability or where a service-connected disability aggravates a nonservice-connected disability).

B. The VA's Adjudication Realities

Despite completing over one million claims annually in each of the past three fiscal years,[73] the number of incoming claims is outpacing the VA's ability to adjudicate them,[74] and the ongoing debate over the VA's claims backlog has been well documented.[75] The reasons for the backlog are numerous,[76] and in response, the VA began implementing a series of "transformation initiatives" designed to attack the problem.[77] Notably, the VA's aspirational goal is to process all disability claims within 125 days with a 98% accuracy rate and to eliminate the claims backlog by 2015.[78]

In the meantime, however, the process of obtaining VA disability compensation benefits for claims based on personal assault, to include military sexual trauma, gets longer and more complex despite efforts to simplify it;[79] public confidence in the VA and the disability

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73 U. S. DEP'T OF VETERANS AFFAIRS, VETERANS BENEFITS ADMIN., VA STRATEGIC PLAN TO ELIMINATE THE COMPENSATION CLAIMS BACKLOG 3 (2013) [hereinafter VA STRATEGIC PLAN] (noting that the VA received in excess of 1 million claims during the past three fiscal years).

74 *Id.*; *VA Office of Pub. & Intergovernmental Affairs*, *supra* note 68.

75 VA STRATEGIC PLAN, *supra* note 73; U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-13-453T, VETERANS' DISABILITY BENEFITS: CHALLENGES TO TIMELY PROCESSING PERSIST (2013) [hereinafter GAO REPORT].

76 VA STRATEGIC PLAN, *supra* note 73 (identifying increased demand, increased access, and the Secretary's decision to presumptively grant service-connection for Parkinson's disease, ischemic heart disease, and B-cell leukemias to veterans who served in the Republic of Vietnam or were otherwise exposed to Agent Orange as reasons for the current claims backlog).

77 *Id.* These initiatives include the implementation of the fully developed claims (FDC) process; the use of segmented "lanes" to funnel claims into three categories: express, special operations, and core; the establishment of quality review teams, challenge training, and skills certification training; and the further refinement of paperless claims. On April 19, 2013, VA Under Secretary for Benefits Allison Hickey addressed the United States Court of Appeals for Veterans Claims 12th Judicial Conference and identified MST claims as a "special operations" lane claim. She also announced a new initiative to process claims pending at Regional Offices for over two years by issuing provisional decisions to claimants. *See also* Veterans Benefits Administration Letter 20-13-05 (Apr. 19, 2013).

78 VA STRATEGIC PLAN, *supra* note 73, at 5.

79 *Id.* at 3 (defining the backlog as any claim over 125 days old and noting that the claims backlog increased from 180,000 to 594,000 over the past three years as of the end of December 2012); *see also* GAO REPORT, *supra* note 75 (describing nine separate programs that the Veterans Benefits Administration is using to improve timeliness).

adjudication process declines;[80] and Congressional[81] and judicial oversight intensifies.[82] This Part discusses the unique features of the VA disability adjudication process and its participants, provides an overview of the VA disability adjudication process as it pertains to claims based on MST,[83] and attempts to equip the reader with the technical knowledge needed to successfully obtain service-connected disability compensation benefits for MST in the quickest timeframe and at the earliest stage possible while avoiding the VA appellate process.

C. The VA Adjudication Process Unique Features

Before delving into a discussion of how the disability adjudication process for MST claims works, it is important to note that this process has several unique features. First and most significantly, the process is designed to be non-adversarial and pro-claimant.[84]

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80 Bill Briggs, *Obama Urged to Step in to Fix VA Backlog*, NBC NEWS (Mar. 21, 2013), usnews.nbcnews.com/_news/2013/03/21/17404780-obama-urged-to-step-in-to-fix-va-backlog?lite; James Dao, *Veterans Wait for Benefits as Claims Pile Up*, N.Y. TIMES (Sept. 27, 2012), http://www.nytimes.com/2012/09/28/us/veterans-wait-for-us-aid-amid-growing-backlog-of-claims.html?hp&_r=0.

81 *Reclaiming the Process: Examining the VBA Claims Transformation Plan as a Means to Effectively Serve Our Veterans: Hearing before the H. Comm. on Veterans Affairs*, 112th Cong. (June 19, 2012), *available at* http://veterans.house.gov/hearing/VBA%20claims (last visited Mar. 30, 2013); Matt Fuller, *Miller Skeptical of VA's Technological Fixes for Claims Backlog*, CQ NEWS-POL'Y (Apr. 11, 2013); Leo Shane III, *Congressman Calls on Top VA Official to Resign Over Benefits Backlog*, STARS AND STRIPES (Mar. 20, 2013), http://www.stripes.com/news/congressman-calls-on-top-va-official-to-resign-over-benefits-backlog-1.212589.

82 National Org. of Veterans Advocates, Inc. v. Sec'y. of Veterans Affairs, 710 F.3d 1328 (Fed. Cir. 2013) (affording the Department of Veterans Affairs 60 days to show cause as to why sanctions should not be imposed for the VA's repeated application of invalidated hearing procedures); *see also* Bryant v. Shinseki, 23 Vet. App. 488 (2010) (describing the VA's responsibilities to a claimant during a hearing). The VA's proposed plan in response to the Court's Order to Show Cause to remedy the harm by its conduct was subsequently approved after revision and no sanctions were imposed. National Org. of Veterans Advocates, Inc. v. Sec'y. of Veterans Affairs, 725 F.3d 312 (Fed. Cir. 2013).

83 Personal assault as defined by the VA includes, but is not limited to, rape, physical assault, domestic battering, robbery, mugging, stalking, and harassment. *See* VA DISABILITY ADJUDICATION PROCEDURE MANUAL M21-1MR, Part IV, subpart ii, Ch. 1, Section D, 34 [hereinafter VA DISABILITY APM]. Military sexual assault under 38 U.S.C.A. §1720D(a), (f) (West 2002) requires "psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." Sexual harassment is defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in nature."

84 *See* Gallegos v. Principi, 16 Vet. App. 551, 555 (2003) (Steinberg, J., concurring) (describing the pro-claimant, non-adversarial nature of the VA adjudication process); Sanders v. Principi, 17 Vet. App. 232, 236

As a result, the VA is statutorily obligated to provide assistance to MST claimants in an effort to help them meet the burden of proof needed to substantiate a claim for service-connection.[85] Second, there is no statute of limitations for filing such claims,[86] the Federal Rules of Evidence generally do not apply,[87] and the record remains continuously open.[88] Third, review of these MST claims involves the interpretation and application of Title 38 of the United States Code and the Code of Federal Regulations, and "administrative" sources,[89] as well as complex medical and legal determinations in which the "benefit of the doubt" is resolved in a claimant's favor when there is an "approximate balance of positive and negative evidence regarding any issue material to the determination of a matter."[90] Fourth, determinations about whether to grant disability benefits for MST and the evidence used to make such determinations are subject to multiple levels of review by lawyers, non-lawyers, and medical professionals.[91]

(2003) (highlighting the veteran-friendly nature of the VA adjudication process); Caluza v. Brown, 7 Vet. App. 498, 508 (1995), *aff'd per curiam*, 78 F.3d 604 (Fed. Cir. 1996) (citing Douglas v. Derwinski, 2 Vet. App. 435, 442–43 (1992), and noting that "VA is not a party trying to disprove a claim; indeed, VA's special obligations to assist claimants are the antithesis of adversarial claims adjudication").

85 The Veterans Claims Assistance Act of 2000 (VCAA), Pub. L. No. 106-475, 114 Stat. 2096, codified in 38 U.S.C.A. §§ 5100, 5102, 5103, 5103A, 5107, 5126; 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) (imposing special responsibilities upon the VA in advising claimants of what evidence is needed to substantiate a claim and assisting claimants in developing and obtaining said evidence); *see also* Moody v. Principi, 360 F.3d 1306, 1310 (Fed. Cir. 2004) (noting that the VA has an obligation to "fully and sympathetically develop a veteran's claim to its optimum" and to "determine all potential claims raised by the evidence, applying all relevant laws and regulations") (quoting Hodge v. West, 155 F.3d 1356, 1362 (Fed. Cir. 1998)); Clemons v. Shinseki, 23 Vet. App. 1, 4 (2009) (finding that a claim for PTSD "cannot be a claim limited only to that diagnosis, but must rather be considered a claim for any mental disability that may reasonably be encompassed by several factors including: the claimant's description of the claim; the symptoms the claimant describes; and the information the claimant submits or that the Secretary obtains in support of the claim").

86 Manio v. Derwinski, 1 Vet. App. 140, 144 (1991).

87 Bielby v. Brown, 7 Vet. App. 260, 267–68 (1994) (noting that the Federal Rules of Evidence generally do not apply, but may be relied on "as a source of persuasive authority in establishing rules of procedural fairness to be applied in VA and Board [of Veterans' Appeals] proceedings").

88 Bell v. Derwinski, 2 Vet. App. 611, 612–13 (1992) (noting that the Secretary has "constructive, if not actual knowledge" of records generated by VA and that these records "could reasonably be expected to be part of the record 'before the Secretary and the Board'").

89 *See* Parker, *supra* note 22, at 209.

90 38 U.S.C.A. § 5107(b) (West 2002); 38 C.F.R. § 3.102 (2012); Gilbert v. Derwinski, 1 Vet. App. 49, 55–56 (1990).

91 *See generally* DANIEL T. SHEDD, CONG. RESEARCH SERV., R42609, OVERVIEW OF THE APPEAL PROCESS FOR

The VA disability adjudication process for MST claims can best be understood as a three-part process. The first part involves establishing eligibility to receive VA disability compensation benefits.[92] The second part involves establishing entitlement to the desired benefits.[93] The third part in the process, assigning a disability rating and effective date once service-connection is granted, will not be addressed in this Article because claimants have a far greater ability to directly influence the adjudication of service-connection claims than disability ratings, which are more dependent on an established rating system. In other words, the inability to achieve service-connection for a disability renders questions about disability ratings and effective dates meaningless, regardless of one's disability level.

D. Establishing Eligibility for MST Disability Compensation

Establishing eligibility to receive VA disability compensation benefits based on MST requires an analysis of whether a claimant has achieved "veteran" status and an assessment of the character of discharge from service. A "veteran" is "a person who served in the active military, naval, or air service."[94] The term "active military, naval, or air service" is defined to include "active duty," "any period of active duty for training during which the individual concerned was disabled or died from a disease or injury incurred or aggravated in line of duty," and "any period of inactive duty training during which the individual concerned was disabled or died from an injury incurred or aggravated in line of duty . . . ."[95] Additionally, eligibility to receive VA disability compensation benefits based on MST requires a discharge from service "under conditions other than dishonorable";[96] benefits are also generally not paid for disabilities that are the result of a claimant's own

VETERANS' CLAIMS (Apr. 29, 2013); BD. OF VETERANS' APPEALS, VA PAMPHLET 01-02-02A, HOW DO I APPEAL? (Apr. 2002), *available at* http://www.bva.va.gov/How_Do_I_Appeal.asp.

92 BARTON F. STICHMAN ET AL., VETERANS BENEFITS MANUAL 23 (2012).

93 *Id.*

94 38 U.S.C.A. § 101(2) (West 2002); *see also* 38 C.F.R. § 3.1(d) (2012).

95 38 U.S.C.A. § 101(24)(A)–(C); 38 C.F.R. § 3.6 (2012). Active duty for training also includes certain full-time duty in the Reserves and National Guard. 38 U.S.C. § 101(21), (22); 10 U.S.C. § 12401; 32 U.S.C. §§ 315, 502–505; *see also* Allen v. Nicholson, 21 Vet. App. 54, 58 (2007) (describing the basic eligibility requirements for veterans benefits based on a period of National Guard service).

96 38 U.S.C.A. §§ 101(2), 5303 (West 2002); 38 C.F.R. § 3.12 (2012); Duro v. Derwinski, 2 Vet. App. 530, 532 (1992) (noting that the VA is bound by service department findings for the purpose of establishing service in the Armed Forces); Brooker et al., *supra* note 12, at 1. While there are strict limitations on disability compensation, the VA permits former service members to receive medical health treatment arising from the MST regardless of whether the individual would be ineligible for other types of benefits including compensation. *Id.* at 99–100.

"willful misconduct or abuse of alcohol or drugs."[97]

VA accepts claims for MST disability compensation via three pre-discharge programs, including the Integrated Disability Evaluation System (IDES),[98] Benefits Delivery at Discharge (BDD),[99] and Quick Start (QS).[100] These programs are joint VA-DoD initiatives designed to accelerate receipt of VA disability benefits upon discharge from service. VA also accepts claims in writing and electronically for disability compensation from veterans after discharge from service. Regardless of the method used to initiate a claim for VA disability benefits based on MST, the claims are initially processed, developed, adjudicated, and granted or denied at one of the VA's intake sites, which include one of fifty-six Regional Offices (RO).[101]

A claimant's ultimate objective should be to successfully resolve his or her case at the RO level and to avoid the VA disability adjudication appeals process. However, as initial applications for disability benefits based on MST invariably are made stronger through knowledge of relevant appellate case law, an understanding of how the Board of Veterans' Appeals (BVA) applies this case law, and how the appeals process works, this Part includes such discussion. For the benefit of the reader, the flowchart in Appendix A highlights salient aspects of the adjudication and appellate process.

97 38 U.S.C.A. § 1110, 1131.

98 *See Pre-Discharge Programs*, U.S. DEP'T OF VETERANS AFFAIRS, http://benefits.va.gov/predischarge/index.asp?expandable=0&subexpandable=0 (last visited Mar. 23, 2014); *see also Integrated Disability Evaluation System*, U.S. MARINE CORPS WOUNDED WARRIOR REGIMENT, http://www.woundedwarriorregiment.org/wwr/assets/File/PEBIDES/Integrated_Disability_Evaluation_System_Slick_Sheet.pdf (last visited Mar. 23, 2014). Service departments may refer personnel to the IDES in circumstances where fitness for continued military service is questionable due to medical impairments. IDES allows VA to perform one medical examination, in conjunction with Medical and Physical Evaluation Board processes, to determine fitness for continued military service. This examination also serves as the basis for an initial VA disability rating that is binding on both VA and DoD.

99 *See* VA DISABILITY APM, *supra* note 83, at Part III, subpart i, Ch. 2, Sections A–B, 3. The BDD program allows military personnel with at least 60 and not more than 180 days of remaining active service to apply for VA disability compensation benefits. BDD participation also requires personnel to have a known separation or retirement date, to provide originals or copies of service treatment records, and to be available to participate in all necessary examinations prior to separation or retirement.

100 *Id.* The QS program, in contrast, allows military personnel with less than 60 days of remaining active service to apply for VA disability compensation benefits. QS participation also requires personnel to have a known separation or retirement date and to provide originals or copies of service treatment records.

101 For a complete listing of the VA's Regional Offices, *see Regional Office Websites*, U.S. DEP'T OF VETERANS AFFAIRS, http://www.benefits.va.gov/benefits/offices.asp (last visited Mar 29, 2014).

E. The Role and Functions of the Regional Office

The RO (also known as a Veterans Service Center) employs a "claims processing initiative (CPI) model" to handle incoming claims.[102] This model theoretically focuses on "complete and accurate development of claims," encourages "specialization" among employees, and according to VA, allows "management the flexibility to adjust resources to meet the demands of changing workload requirements" in order to improve efficiency in handling all aspects of claims adjudication and to reduce errors.[103] The Veterans Service Center is led by a Service Center Manager and an Assistant Service Center Manager whose employees are divided into six teams with specifically defined roles.[104] These teams include the (1) triage team,[105] (2) development activity, [106] (3) rating activity,[107] (4) authorization activity,[108] (5) appeals team,[109] and (6) public contact team.[110] The RO's use of the CPI model, described as a "production line approach," generally limits employee involvement to one particular aspect of the claims adjudication process.[111] Assuming that an MST claim is not granted and/or a claimant does not appeal an initial unfavorable RO decision, at least four separate individuals will handle or review the claim (with some of these individuals

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102 *See* VA DISABILITY APM, *supra* note 83, at Part III, subpart i, Ch. 1.

103 *Id.*

104 *Id.* (defining team roles).

105 *Id.* ("[The triage team] reviews and controls all mail, and processes actions that can be completed without the claims folder or with only on a brief review of the claims folder.").

106 *Id.* The development activity, in contrast, "obtains evidence for contentions that require a rating decision, and prepares administrative decisions," and determines when claims are ready for the issuance of a rating decision. *Id.*

107 *Id.* The rating activity "makes decisions on claims that require consideration of medical evidence."

108 *See* VA DISABILITY APM, *supra* note 83, at Part III, subpart i, Ch. 1 ("[The authorization activity] obtains evidence for contentions that do not require a rating decision, processes awards, and notifies claimants of decisions.").

109 *Id.* The appeals team handles appeals once a valid notice of disagreement is received, as well as remanded appeals, develops issues in appellate status, and issues rating decisions arising from appeals. A separate entity, the Appeals Management Center, also performs development on remanded claims.

110 *Id.* The public contact team is tasked with handling interactions with claimants, correspondence, and inquiry and outreach issues.

111 *See* STICHMAN ET AL., *supra* note 92, at 941.

doing so more than once).[112]

The most pivotal teams for developing and adjudicating MST claims are the development and rating activities. Development activity employees are referred to as Veterans Service Representatives (VSRs).[113] Rating activity employees are called Rating Veterans Service Representatives (RVSRs).[114] While these employees are expected to be knowledgeable of and to apply formal legal authorities (i.e., statutes, regulations, VA General Counsel precedential opinions, and precedential opinions from the United States Court of Appeals for Veterans Claims (CAVC) or the United States Court of Appeals for the Federal Circuit (Federal Circuit)) when adjudicating MST claims, in practice, they are instead more apt to rely on "administrative" sources such as the *VA Disability Adjudication Procedure Manual*, fast letters, training letters, and circulars.[115] The reasons for reliance on these "administrative" sources are numerous, and some suggest that claimants fare better when a rater adopts an administrative perspective rather than a legal one,[116] but it bears noting that most RO employees are not trained lawyers.[117]

F. The Role and Responsibilities of Veterans Service Representatives

VSRs have the primary responsibility for conducting the initial development of a claim. This development includes, but is not limited to, ensuring the completeness of a claim (i.e., having a properly signed and substantially complete application with identification of the benefit sought), verifying basic eligibility (i.e., dates of service and character of

112 Additionally, Quality Review Teams (QRTs) located at each RO as well as the Veterans Benefits Administration Systematic Technical Accuracy Review (STAR) Program reexamine a random sampling of rating decisions for accuracy. The RO QRTs tend to review the rating decisions prior to dispatch to a claimant, while the STAR Program is conducted after dispatch. These reexaminations result in at least another two individuals handling and reviewing a claim.

113 *See* VA DISABILITY APM, *supra* note 83, at Part III, subpart ii, Ch. 1, Section A.

114 *See id.* at Subpart iv, Chapter 5.

115 *See* Parker, *supra* note 22, at 210–11; *see also* Rory E. Riley, *Simplify, Simplify, Simplify—An Analysis of Two Decades of Judicial Review in the Veterans' Benefits Adjudication System,* 113 W. VA. L. REV. 67, 85 (2010).

116 *See* Parker, *supra* note 22, at 218.

117 *Id.*; *see also* CTR. FOR NAVAL ANALYSES, FINAL REPORT FOR THE VETERANS' DISABILITY BENEFITS COMMISSION: COMPENSATION, SURVEY RESULTS, AND SELECTED TOPICS (2007); DANIEL HARRIS, FINDINGS FROM RATERS AND VSOS SURVEYS (2007), *available at* http://www.veteranslawlibrary.com/files/Commission_Reports/CNA_May_2007_Survey_Results.pdf (noting that while 40.4% of RVSRs surveyed had college degrees, 25.5% had less education).

discharge), processing submitted documents properly, and obtaining and updating records as appropriate.[118] Importantly, the VSRs are also tasked with determining when a claim is ready to be transferred to the RVSRs for the issuance of a rating decision.[119]

G. The Duty to Notify MST Claimants

Upon receipt of a "substantially complete" application for VA disability compensation based on MST, VSRs have corresponding duties to notify a claimant of the information and evidence needed to substantiate a claim (duty to notify) and to assist in the development of that evidence (duty to assist).[120] After receipt of such application, the RO's designated Women Veterans Coordinator (WVC) contacts a claimant to inquire whether he or she filed a restricted or unrestricted report with the service department and/or whether he or she elected to undergo a sexual assault forensic examination (SAFE).[121] If so, VSRs request such records from the DoD.[122] Despite the title, the WVC serves as the point person for male and female claimants seeking compensation based on MST.[123]

Thereafter, proper notice from VA must inform a claimant of "any information and medical or lay evidence" not of record that (a) is "necessary to substantiate the claim," (b) VA will seek to provide, and (c) the Veteran is expected to provide.[124] A claimant has up to one year from the date of the notice letter to provide the requested information.[125]

118 *See* VA DISABILITY APM, *supra* note 83, at Part III, subpart ii, Ch. 1.

119 *Id.*

120 38 C.F.R. § 3.159(a)(3) (2012). A substantially complete application means "an application containing the claimant's name; his or her relationship to the veteran, if applicable; sufficient service information for VA to verify the claimed service, if applicable; the benefit claimed and any medical condition(s) on which it is based; the claimant's signature; and in claims for nonservice-connected disability or death pension and parents dependency and indemnity compensation, a statement of income."

121 VA DISABILITY APM, *supra* note 83, at Part IV, subpart ii, Ch. 1, Section D, 17.

122 *Id.*

123 *See* Margret Bell, Ph.D., Veterans Health Admin., *Training Presentation: Veterans Who Experienced Military Sexual Trauma or Other Forms of Personal Assault* (Apr. 21, 2011).

124 38 U.S.C.A. § 5103(a) (West 2002); 38 C.F.R. § 3.159(b) (2012). Quartuccio v. Principi, 16 Vet. App. 183, 186–87 (2002).

125 38 C.F.R. § 3.159(b) (2012) (If the requested information is not provided within thirty days, VA can decide the claim prior to the expiration of the one-year period based on the evidence of record. If a claimant submits evidence thereafter, VA is obligated to re-adjudicate the claim. If evidence is not received within one year, the claim is deemed abandoned. 38 C.F.R. § 3.158 (2012)).

Although this duty to notify is typically owed to a claimant prior to an initial unfavorable decision on a claim by the RO,[126] the CAVC has recognized that providing the requisite notice for a service-connection claim based on MST may not be feasible prior to an initial unfavorable decision "until VA knows or has reason to know of the existence of evidence raising the possibility of an in-service assault."[127] Often, claimants who experience MST will apply for benefits related to it without identifying their traumatic sexual incident. Shame, the desire not to revisit the experience, or feelings that sexual trauma is not as legitimate as combat trauma are often linked to such initial reluctance.[128]

The issuance of a fully compliant notice letter followed by re-adjudication of the claim is sufficient to cure any timing and content notice errors in cases where a claimant did not receive proper notice prior to the initial unfavorable decision on the claim by the RO.[129] To the extent that any timing and content notice error goes uncorrected, VA must address the error and determine whether a claimant was prejudiced by it.[130] Proper notice in the context of a service-connection claim must identify all disabilities claimed and address the following elements: "(1) Veteran status; (2) existence of a disability; (3) a connection between the veteran's service and the disability; (4) *degree of disability*, and (5) *effective date of the disability*."[131] For the benefit of the reader, a sample notice letter is included in Appendix M.[132]

126 Mayfield v. Nicholson, 444 F.3d 1328, 1333 (Fed. Cir. 2006); Pelegrini v. Principi, 18 Vet. App. 112, 120 (2004).

127 Gallegos v. Peake, 22 Vet. App. 329, 336 (2008).

128 Courtney Valdez et al., *Veterans Health Administration Mental Health Treatment Settings of Patients who Report Military Sexual Trauma*, *in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 20, 21 (Carolyn B. Allard & Melissa Platt eds., 2012) (discussing the role of self-blame and social stigma in survivors' withholding of sexual trauma from physicians and medical professionals).

129 Prickett v. Nicholson, 20 Vet. App. 370, 376 (2006). The defect can also be cured by undertaking a prejudicial error analysis such as by showing that the claimant had actual knowledge or that he or she could reasonably be expected to understand the information and evidence needed to substantiate the claim. *See generally* Bernard v. Brown, 4 Vet. App. 384, 394 (1993).

130 *See* Shinseki v. Sanders, 556 U.S. 396, 408 (2009) (eschewing a mandatory presumption of prejudice in favor of a case-by-case assessment based on a review of the record of whether the error was outcome determinative).

131 Dingess/Hartman v. Nicholson, 19 Vet. App. 473, 484 (2006). The degree (percentage) of disability and its effective date are assigned only after service-connection for a disability is granted.

132 It bears noting that these notice letters, as evidenced by the sample in Appendix M, are complex. Unfortunately, much of the complexity stems from the inclusion of information as required by law and as a result of case law interpreting the Veterans Claims Assistance Act. Undoubtedly, the complexity of these letters

Throughout all development and evidence-gathering phases for service-connection claims based on MST, experts in the field advise WVCs and VSRs to respond sensitively to claimants, accommodate gender preferences, offer options or choices to claimants when possible, listen empathically, explain the reasoning behind decisions, and to recognize the inherent difficulty for claimants in participating in the claims process.[133] The flow-chart that appears in Appendix B summarizes the manner in which VSRs develop service-connection claims based on MST.[134]

H. The "Heightened" Duty to Assist MST Claimants and the Importance of Alternative Evidence Sources

Service-connection claims based on MST also require VSRs to provide particularized notice and to assist a claimant in obtaining or producing evidence corroborating a claimed in-service assault.[135] As part of the VA's "heightened duty" to provide this notice in these cases, the VSRs must advise a claimant that he or she may submit evidence from sources other than service records to corroborate the claimed in-service assault, suggest potential sources for such evidence, and assist a claimant in developing and/or obtaining such alternate sources of evidence.[136] Additionally, the VSRs must notify a claimant that evidence of behavioral changes following the alleged in-service assault may constitute

makes it difficult for the average claimant to understand the adjudication process, the legal constructs and requirements inherent in the adjudication process, and the kinds of information and evidence being requested of him or her.

133 *See* Bell, *supra* note 123.

134 *See generally* VA DISABILITY APM, *supra* note 83, at Part IV, subpart ii, Ch. 1, Section D, 17; Training Letter 11-05: *Adjudicating PTSD Claims Based on MST* (Dec. 2, 2011); Fast Letter 10-25: *Corroborating MST Using DD Form 2910, Victim Reporting Preference Statement, or Similar Forms* (July 15, 2010); Veterans Benefits Administration Training Letter 05-04: *Military Sexual Trauma Training Material* (Nov. 10, 2005); *Pursuing A Service-connection Claim for Conditions Related to MST: Trainee Guide* (Jan. 2012) [hereinafter *MST Trainee Guide*]; *Rating Job Aids-PTSD* (Sept. 28, 2012); Broadcast, Veterans Benefits Network, The Adjudication of Claims for Service-connection for PTSD Based on Personal and Sexual Assault (Aug. 19, 2003).

135 *See* Patton v. West, 12 Vet. App. 272, 280 (1999); VA DISABILITY APM, *supra* note 83, at Part IV, subpart ii, Ch. 1, Section D, 17. In *Patton*, the CAVC noted that "in personal-assault cases[,] the Secretary has undertaken a special obligation to assist a claimant . . . in producing corroborating evidence of an in-service stressor." *Patton*, 12 Vet. App. at 280. The RO is required as part of this "special obligation" to send a claimant a "special PTSD personal-assault letter" and questionnaire to assist VA in identifying alternate sources of evidence to establish an in-service stressor. *Id.* at 281–82.

136 38 C.F.R. § 3.304(f)(5) (2012); Gallegos v. Peake, 22 Vet. App. 329, 335 (2008); Bradford v. Nicholson, 20 Vet. App. 200, 206 (2006).

"credible supporting evidence of the stressor."[137]

According to 38 C.F.R. § 3.304(f)(5), alternative sources of evidence to corroborate the claimed in-service assault includes, but is not limited to, "records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy."[138] Personal diaries, journals, letters, and e-mails can also serve as an alternate form of evidence.[139] Similarly, evidence of behavior changes following the claimed in-service assault include, but are not limited to, "a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes."[140]

In conjunction with providing this notice to a claimant, VSRs also request that he or she complete VA Form 21-0781a.[141] This form asks a claimant to provide personal and unit information as well as specific information about the date, location, and description of the claimed in-service assault.[142] A copy of this form appears in Appendix C. The pertinent regulation, 38 C.F.R. § 3.304(f)(5), also makes clear that VA will not deny a service-connection claim for PTSD based on MST without first advising a claimant of these alternative sources or behavior changes and their usefulness in proving the claim. VA may submit any evidence that it receives to "an appropriate medical or mental health professional for an opinion as to whether it indicates that a personal assault occurred."[143]

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137 *Gallegos*, 22 Vet. App. at 335.

138 38 C.F.R. § 3.304(f)(5).

139 VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 4, Section H.

140 *Id.*

141 *See* VA Form 21-0781a, Statement in Support of Claim for Service-connection for PTSD Secondary to Personal Assault, *available at* http://www.vba.va.gov/pubs/forms/VBA-21-0781a-ARE.pdf (last visited Mar. 29, 2014).

142 *Id.*

143 38 C.F.R. § 3.304(f)(5); *see also Veterans Benefits Administration* Training Letter 05-04, *supra* note 134.

I. The Duty to Obtain Relevant Records for MST Claimants

The VA's duty to assist an MST claimant in all cases is two-fold.[144] Because many of the MST claims are filed several years or decades after the assault, the VA's duty to assist has particular resonance for these individuals. First, VA must make "reasonable efforts"[145] to obtain relevant evidence (including federal and non-federal records) necessary to substantiate an MST claim.[146] Commonly requested Federal records include, but are not limited to, military records, service medical records (including mental health or obstetrical/ gynecological records), in-service hospitalization reports, personnel records, medical and other records from VA facilities, records from non-VA facilities providing examination or treatment on the VA's behalf, and records from other federal agencies such as the Social Security Administration.[147] Commonly requested non-federal records include, but are not limited to, private medical records and hospitalization reports, employment records, and worker's compensation records.[148] But, "VA is not obligated to embark on an 'unguided safari' to seek all potentially relevant records."[149] When VA is unable to obtain relevant records despite reasonable efforts, it is required to notify a claimant of:

(i) The identity of those records VA was unable to obtain;

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144 38 U.S.C.A. § 5103A(a)(1), (b)(1); 38 C.F.R. § 3.159(c).

145 "Reasonable efforts" in the context of non-federal records contemplate an initial request and at least one follow-up request unless the response to the initial request indicated that the records do not exist or that further attempts to obtain them would be futile. 38 U.S.C.A. § 5103A(c)(1). In the context of federal records, VA must make as many requests as needed to obtain the records "unless it is reasonably certain that such records do not exist or that further efforts to obtain these records would be futile." 38 U.S.C.A. § 5103A(b)(3), (c).

146 Golz v. Shinseki, 590 F.3d 1317, 1321 (Fed. Cir. 2010) ("Relevant records" are those that "relate to the injury for which the claimant is seeking benefits and have a reasonable possibility of helping to substantiate the veteran's claim."); *see also* Schafrath v. Derwinski, 1 Vet. App. 589, 593–94 (1991) (noting duty to assist requires effort to secure records that are potentially relevant or explain the failure to do so).

147 VA has been held to be in constructive possession of all VA records and as such, owes an ongoing duty to associate relevant records with the claims file. Bell v. Derwinski, 2 Vet. App. 611, 612–13 (1992).

148 Unless a claimant provides the requested private records to VA, VA must obtain a release of information to obtain these records on a claimant's behalf. *See* VA Form 21-4142, *Request for and Authorization to Release Medical Records or Health Information*. This form is reprinted in App. D.

149 Raugust v. Shinseki, 23 Vet. App 475, 479 (2010) (citing Brokowski v. Shinseki, 23 Vet. App. 79, 89 (2009)); *see also* Gobber v. Derwinski, 2 Vet. App. 470, 472 (1992) (noting that the "'duty to assist' is not a license for a 'fishing expedition' to determine if there *might* be some *unspecified* information which could possibly support a claim") (emphasis in original).

> (ii) An explanation of the efforts VA made to obtain the records;
>
> (iii) A description of any further action VA will take regarding the claim, including but not limited to, notice that VA will decide the claim based on the evidence of record unless a claimant submits the records VA was unable to obtain; and
>
> (iv) A notice that the claimant is ultimately responsible for providing the evidence.[150]

VA also has a separate "heightened duty" to consider and discuss the evidence of record and supply well-reasoned bases for its decision to MST claimants as a consequence of missing or destroyed service records.[151]

J. The Duty to Obtain Medical Examinations for MST Claimants

Second, VA must, in certain circumstances, obtain a medical examination or opinion once relevant records have been obtained and associated with the claims file.[152] VA will provide a medical examination or obtain a medical opinion where there is:

> (1) Competent evidence of a current disability or persistent or recurrent symptoms of a disability;
>
> (2) Evidence establishing that an event, injury, or disease occurred in service;
>
> (3) An indication that the disability or persistent or recurrent symptoms of a disability may be associated with a claimant's service or with another service-connected disability, but

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150 38 C.F.R. § 3.159(e) (2012).

151 Washington v. Nicholson, 19 Vet. App. 362, 369–70 (2005). Part of this "heightened duty" includes advising a claimant of alternate sources of evidence such as military records, statements from service medical personnel, "buddy" statements, state or local accident and police reports, medical evidence from civilian or private physicians or facilities where the claimant was seen or treated during service or shortly after discharge, letters or photographs from service, pharmacy prescription records, employment examination reports, or insurance examination reports, and Surgeon General's Office extracts or morning/sick reports. VA DISABILITY APM, *supra* note 83, at Part III, subpart iii, Ch. 2, Section E.

152 38 U.S.C.A. § 5103A(d) (West 2002); 38 C.F.R. § 3.159(c)(4); McLendon v. Nicholson, 20 Vet. App. 79, 82–83 (2006).

> (4) Insufficient competent medical evidence to make a decision on the claim.[153]

Consistent with the VA's pro-claimant stance, it may not undertake additional evidentiary development, to include obtaining an examination, when the "sole purpose" is to obtain evidence against a claim.[154] However, a claimant is generally not entitled to a VA examination based solely on his or her own conclusory statements indicating that there is a relationship between an in-service illness or injury and a current disability; the record must also contain a factual basis for supporting those statements.[155]

Once VA undertakes the effort to provide an examination for a service-connection claim, "even if not statutorily obligated to do so, [VA] must provide an adequate one or, at a minimum, notify the claimant why one will not or cannot be provided."[156] Importantly, the CAVC has made clear that the duty to assist a claimant "is not always a one-way street. If

153 *McLendon*, 20 Vet. App. at 81. The Federal Circuit in *Waters v. Shinseki*, 601 F.3d 1274, 1277 (Fed. Cir. 2010), held that each element of 38 U.S.C.A. § 5103A(d)(2) establishes a different evidentiary standard. The evidentiary standard of subsection (A), which concerns a current disability, requires "'competent evidence' of the 'claimant's disability.'" Accordingly, in addressing the first requirement for determining whether a VA examination is necessary, VA must make two sequential determinations: "(1) an assessment of whether there is evidence of a current disability or persistent or recurrent symptoms thereof" and then "(2) an assessment that such evidence is competent." *McLendon*, 20 Vet. App. at 81. A "current disability" includes a disability which existed at the time a claim for VA disability compensation is filed or during the pendency of the claim, even if that disability subsequently resolves. McClain v. Nicholson, 21 Vet. App. 319, 321 (2007).

154 Mariano v. Principi, 17 Vet. App. 305, 312 (2003). *But see* Douglas v. Shinseki, 23 Vet. App. 19, 26 (2009) (pointing out that even if a veteran has presented favorable, uncontroverted medical evidence, VA may seek further evidentiary development if the favorable evidence, along with the other evidence of record, is not sufficient to permit a fully informed decision; the additional development must be undertaken in "an impartial, unbiased, and neutral manner").

155 38 U.S.C.A. § 5103A(d); 38 C.F.R. § 3.159(c)(4); *Waters*, 601 F.3d at 1278; Wells v. Principi, 326 F.3d. 1381, 1384 (Fed. Cir. 2003) (indicating that a medical examination is not required if the appellant has not presented a *prima facie* case for the benefit claimed).

156 Barr v. Nicholson, 21 Vet. App. 303, 311–12 (2007) (citing Daves v. Nicholson, 21 Vet. App. 46, 52 (2007)). An opinion is considered adequate when "the examiner provides sufficient detail so that the rating specialist can interpret the report and make a subjective determination as to whether the condition meets the rating criteria." Buczynski v. Shinseki, 24 Vet. App. 221, 225–26 (2011); Stefl v. Nicholson, 21 Vet. App. 120, 123 (2007) (an adequate opinion is based on consideration of an appellant's prior medical history and examinations and describes the disability in sufficient detail so that the Board's evaluation of the claimed disability is a "fully informed one"). VA is also obligated in limited circumstances to seek clarification for an inadequate private medical opinion. *See* Savage v. Shinseki, 24 Vet. App. 259, 270 (2011) (the missing information must be "relevant, factual, and objective—that is, not a matter of opinion—and where the missing evidence bears greatly on the probative value of the private examination report.").

a veteran wishes help, he cannot passively wait for it in those circumstances where he may or should have information that is essential to obtaining the putative evidence."[157] Instead, a claimant must present and support a claim for benefits,[158] cooperate in the development of his or her claim by adequately identifying relevant records, and participate in a VA examination, when appropriate.[159] In our research of denied MST claims, a very significant number of denials resulted from claimants' inability, and in some cases refusal, to provide necessary additional information requested by VA adjudicators.

K. Establishing Entitlement for MST Disability Compensation

As noted above, the second part of the VA disability adjudication process involves establishing entitlement to the desired benefits. Service-connection may be granted for disease or injury incurred in or aggravated by service.[160] Establishing service-connection for an acquired psychiatric disorder (other than PTSD) generally requires "(1) the existence of a present disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the present disability and the disease or injury incurred or aggravated during service—the so-called 'nexus requirement."[161] Service-connection for certain chronic disabilities, including psychosis,[162] may be granted on a presumptive basis if manifested to a compensable degree within one year after separation from service.[163]

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157 Wood v. Derwinski, 1 Vet. App. 190, 193 (1991).

158 Fagan v. Shinseki, 573 F.3d 1282, 1286 (2009) (claimant bears the burden of "present[ing] and support[ing]" all material elements of the claim) (citing 38 U.S.C.A § 5107(a)).

159 Turk v. Peake, 21 Vet. App. 565, 568 (2008); Loving v. Nicholson, 19 Vet. App. 96, 102–03 (2005); Dusek v. Derwinski, 2 Vet. App. 519, 522 (1992). The failure to report for a scheduled VA examination in the absence of good cause in connection with an original service-connection claim results in the RVSRs evaluating the claim based on the evidence of record. 38 C.F.R. § 3.655(b) (2012). Examples of good cause include, but are not limited to, illness or hospitalization of the claimant or death of an immediate family member. 38 C.F.R. § 3.655(a).

160 Allard et al., *supra* note 6. In addition, a claimant is generally presumed to be of sound condition upon entrance into service. *See* 38 C.F.R. § 3.304(b); *cf.* 38 U.S.C. § 1111 (West 2002); 38 U.S.C.A. § 1153; Horn v. Shinseki, 25 Vet. App. 231 (2012) (discussing the evidence necessary to rebut the presumption of soundness).

161 38 C.F.R. § 3.303(a); Holton v. Shinseki, 557 F.3d 1362, 1366 (Fed. Cir. 2009) (quoting Shedden v. Principi, 381 F.3d 1163, 1167 (Fed. Cir. 2004)); Hickson v. West, 12 Vet. App. 247, 253 (1999).

162 38 C.F.R. § 3.384 (2012).

163 38 U.S.C.A. §1112 (West 2002); 38 C.F.R. § 3.307, 3.309 (2012). Eligibility for service-connection based on a presumptive basis requires 90 continuous days or more during a war period on or after December 31, 1946. Additionally, the regulation granting presumptive service-connection for chronic diseases based on

Establishing service-connection for PTSD requires that there be (1) "medical evidence diagnosing the condition in accordance with 38 C.F.R. § 4.125(a)"; (2) "a link, established by medical evidence, between current symptoms and an in-service stressor"; (3) "and credible supporting evidence that the claimed in-service stressor occurred."[164] The diagnosis of a mental disorder must conform to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 1994) (DSM-IV) and be supported by the findings of a medical examiner.[165] VA is also required to evaluate the supporting evidence in light of the "places, types, and circumstances of such veteran's service as shown by the veteran's service record, the official history of each organization in which such veteran served, and all pertinent medical and lay evidence . . . ."[166]

The evidence necessary to establish the occurrence of a recognizable stressor during service to support a diagnosis of PTSD varies depending upon whether a claimant engaged in "combat with the enemy."[167] In the absence of clear and convincing evidence to the contrary, and provided that the claimed stressor is "consistent with the circumstances, conditions, or hardships" of a claimant's service, a claimant's lay testimony alone may establish the occurrence of the claimed in-service stressor if the evidence establishes that a claimant engaged in combat with the enemy and the claimed stressor is related to that combat.[168] Lay testimony, by itself, is not sufficient to establish the occurrence of the alleged

a continuity of symptomatology applies only to those diseases listed in 38 C.F.R. § 3.309(a). *See* Walker v. Shinseki, 708 F.3d 1331, 1336–37 (Fed. Cir. 2013).

164 38 C.F.R. § 3.304(f) (2012); Cohen v. Brown, 10 Vet. App. 128, 138 (1997). For claims filed on or after October 29, 2008, VA amended the regulations governing adjudication of PTSD claims by eliminating the need to provide evidence corroborating the occurrence of a claimed in-service stressor in claims in which PTSD was diagnosed in service. *See* 74 Fed. Reg. 14,491-01 (Mar. 31, 2009).

165 *See* 38 C.F.R. § 4.125(a) (2012); *Cohen*, 10 Vet. App. at 140 (noting that unless there is evidence to the contrary, a mental health professional is presumed to make his or her diagnoses in accordance with the DSM-IV criteria as to both the adequacy of the symptomatology and the sufficiency of the stressor).

166 38 U.S.C.A § 1154(a) (2012).

167 The VA General Counsel has held that "[t]he ordinary meaning of the phrase 'engaged in combat with the enemy,' as used in 38 U.S.C. § 1154(b), requires that a veteran have participated in events constituting an actual fight or encounter with a military foe or hostile unit or instrumentality." The determination regarding whether evidence establishes that a veteran engaged in combat with the enemy is resolved on a case-by-case basis with evaluation of all pertinent evidence and assessment of the credibility, probative value, and relative weight of the evidence. DVA Op. Gen. Counsel Prec. 12-99 (Oct. 18, 1999); 65 Fed. Reg 6,256-03 (Feb. 8, 2000).

168 *See* 38 U.S.C.A. § 1154(b) (West 2002); 38 C.F.R. § 3.304(d); DVA Op. Gen. Counsel Prec. 12-99, *supra* note 167. While 38 U.S.C.A. § 1154(b) relaxes the evidentiary burden for a combat veteran with respect

stressor if VA determines that a claimant did not engage in combat.[169] Instead, there must be credible supporting evidence of the alleged stressor from any source.[170] Ordinarily, credible supporting evidence of the actual occurrence of an in-service stressor cannot consist solely of after-the-fact medical nexus evidence.[171] This means, for example, that a VA examiner's opinion that an in-service stressor actually occurred, in the absence of supporting evidence, is insufficient to establish its occurrence if that opinion is the sole evidence of record on that particular point.

In the context of service-connection claims based on MST, this general rule is "not operative."[172] In other words, a claimant is permitted to use after-the-fact medical nexus evidence to prove the occurrence of the in-service assault.[173] The most common form of after-the-fact medical nexus evidence is a VA or private medical opinion in which a physician or mental health professional concludes, based on the specific facts of a case, that the in-service assault occurred even if supporting evidence is otherwise absent. As such, VA has described this approach to adjudicating MST service-connection claims as being "liberal" and "open-minded."[174] Further, there need not be evidence that actually proves the claimed assault occurred.[175] Rather, a claimant, in conjunction with assistance from VA, must advance or produce enough evidence to show at least an "approximate balance of positive and negative evidence" (i.e., 50% chance or greater) that the assault occurred.[176]

Effective July 12, 2010, VA amended 38 C.F.R. § 3.304(f) by liberalizing in certain circumstances the procedural standards for establishing the occurrence of an in-service

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to evidence of an in-service occurrence of an injury, it does not create a statutory presumption that a combat veteran's disease or injury is automatically service-connected. Rather, the veteran must still provide competent evidence of a relationship between an injury in service and a current disability. *See* Dalton v. Nicholson, 21 Vet. App. 23, 37 (2007).

169 Dizoglio v. Brown, 9 Vet. App. 163, 166 (1996).

170 YR v. West, 11 Vet. App. 393, 397 (1998); Moreau v. Brown, 9 Vet. App. 389, 395 (1996).

171 *Moreau*, 9 Vet. App. at 396.

172 Patton v. West, 12 Vet. App. 272, 280 (1999).

173 *Id.*

174 VETERANS BENEFITS ADMINISTRATION, MILITARY SEXUAL TRAUMA: MARKERS AND CLAIMS DEVELOPMENT (2011) [hereinafter MARKERS AND CLAIMS DEVELOPMENT].

175 *MST Trainee Guide*, *supra* note 134.

176 *Id.*

stressor for non-combat veterans.[177] Previously, as noted above, VA was required to undertake extensive development to determine whether a non-combat veteran actually experienced the claimed in-service stressor, and lay testimony, by itself, was not sufficient to establish the occurrence of the alleged stressor.[178] The amended version of 38 C.F.R. § 3.304(f)(3) eliminated the need for stressor corroboration in circumstances in which a veteran's claimed in-service stressor was related to "fear of hostile military or terrorist activity."[179] Specifically, the amended version of 38 C.F.R. § 3.304(f)(3) states:

> If a stressor claimed by a Veteran is related to the Veteran's fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or a psychiatrist or psychologist with whom VA has contracted, confirms that the claimed stressor is adequate to support a diagnosis of [PTSD] and the Veteran's symptoms are related to the claimed stressor, in the absence of clear and convincing evidence to the contrary, and provided the claimed stressor is consistent with the places, types, and circumstances of the Veteran's service, the Veteran's lay testimony alone may establish the occurrence of the claimed in-service stressor.[180]

Significantly, the reduced evidentiary burden enjoyed by claimants who allege service-connection for PTSD based on a stressor related to "fear of hostile military or terrorist activity" generally does not apply to claims for PTSD based on MST.[181] The CAVC acknowledged this disparity in *Acevedo v. Shinseki*, noting that "lay testimony alone may be sufficient to establish the occurrence of that stressor [when VA evaluates a claimed stressor under subsection (f)(3)] if the stressor is consistent with [a claimant's] service

177 *See* 75 Fed. Reg. 39,843-01 (effective July 13, 2010).

178 Dizoglio v. Brown, 9 Vet. App. 163, 166 (1996).

179 *See* 38 C.F.R. § 3.304(f)(3) (2010) (codified in 75 Fed. Reg. 39,852) (July 13, 2010) ("Fear of hostile military or terrorist activity" means that "a veteran experienced, witnessed, or was confronted with an event or circumstance that involved actual or threatened death or serious injury, or a threat to the physical integrity of the Veteran or others, such as from an actual or potential improvised explosive device; vehicle-imbedded explosive device; incoming artillery, rocket, or mortar fire; grenade; small arms fire, including suspected sniper fire; or attack upon friendly military aircraft, and the Veteran's response to the event or circumstance involved a psychological or psycho-physiological state of fear, helplessness, or horror.").

180 *Id.*

181 Acevedo v. Shinseki, 25 Vet. App. 286, 289–90 (2012). The CAVC noted, however, that based on the plain language and legislative history of 38 C.F.R. § 3.304(f), VA was not prohibited from evaluating service-connection claims based on personal assault under (f)(3) provided that the circumstances of the claimed stressor were related to "fear of hostile military or terrorist activity." *Id.* at 291.

and a VA psychiatrist or psychologist opines that the stressor is adequate to support a diagnosis of PTSD."[182] In contrast, lay testimony must be corroborated by other evidence to establish the occurrence of the stressor when VA evaluates a claimant's MST stressor under subsection (f)(5).[183]

L. The Role and Responsibilities of Rating Veterans Service Representatives

With a basic understanding of the development activities performed by the VSRs as well as the pertinent laws and regulations related to MST claims, the remainder of this Part shifts focus to examining the nature and scope of the work performed by the RVSRs. Stressor corroboration, in its most elementary sense, requires a claimant to provide, at minimum, (1) a stressor capable of documentation, (2) the location of the assault, (3) the approximate date of the assault (within a two-month window), and (4) the unit of assignment at the time of the assault.[184] An RVSR's duties and responsibilities in reviewing and evaluating the evidence in support of a service-connection claim based on MST are extensive. the VA's overarching motto in handling an MST claim is similar to any other kind of VA disability compensation claim: "[g]rant if you can, deny if you must."[185] RVSRs are not to rely on personal opinions or attitudes as the basis for judging the evidence in any claim, especially since the severity of an MST incident or the response thereafter is "in the eye of the victim."[186] Moreover, RO training materials advise RVSRs to adjudicate each claim objectively and sympathetically, avoid preconceptions, the use of insensitive language, or the suggestion that a claimant is lying or at fault so as to avoid re-traumatization.[187] Instead,

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182 38 C.F.R. § 3.304(f)(3); *Acevedo*, 25 Vet. App. at 291; *see also* Rick Maze, *Panel Guts Bill Easing Veterans Sexual Assault Claims*, ARMY TIMES, Apr. 25, 2013 (noting that a House of Representatives panel gutted a bill that would have relaxed the evidentiary requirements for VA disability compensation claims based on sexual assault).

183 38 C.F.R. § 3.304(f)(5); Menegassi v. Shinseki, 638 F.3d 1379, 1382 (Fed. Cir. 2011).

184 VA DISABILITY APM, *supra* note 83, at Part IV, subpart ii, Ch. 1, Section D.

185 *See Rating Job Aids*, *supra* note 134; *cf.* Tim Forkes, *Veterans Administration: Delay, Deny, Wait 'Til I Die*, BALT. POST-GAZETTE (July 25, 2013), *available at* http://baltimorepostexaminer.com/veterans-administration-delay-deny-wait-til-i-die/2013/07/25. Despite the VA's overarching motto, the practical experiences of many claimants involved in the adjudication process is often summed up as "Delay, Deny, Wait Till I Die," a common perception that VA is intentionally delaying or denying claims until a claimant dies.

186 *Rating Job Aids*, *supra* note 134.

187 *Id.*; *see also* 38 C.F.R. § 4.23 (2012); VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 5 (in evaluating evidence, RVSRs are advised to show fairness and courtesy to all claimants, even those who might be critical, abusive, or antagonistic).

these training materials remind RVSRs that the focus is to remain on the violent act itself rather than the sexual aspects of the claim or the victim's behavior.[188] Precisely how to avoid natural, subconscious, ingrained prejudices, and cultural acceptance of "rape myths," is a question plaguing lawyers and the judiciary, let alone lay claim adjudicators.[189]

M. The "Detective" Role

RO training guides acknowledge that many instances of MST go unreported due to the military "environment" and its focus on organizational cohesiveness, among other factors.[190] Given that many of these incidents are unreported and evidence to support an MST claim "may be *extremely* difficult to obtain," RO training materials teach RVSRs first and foremost to act as "detectives" to identify alternative sources of evidence (i.e., "markers") that might substantiate the claim.[191] Markers are defined as "evidentiary signs, events, or circumstances indicating a *possibility* that a claimed stressor occurred."[192] MST markers are characterized by changes in behavior and "may be the only evidence that a stressful event occurred."[193] Importantly, as noted above, there need not be evidence that actually proves the assault occurred.[194] Rather, there must be at least a 50% chance or greater that the assault occurred.[195]

Appendix E provides a non-exhaustive list of behavior change markers while in service. Post-service behavior changes, lay statements, and mental health treatment also

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188 *Rating Job Aids*, *supra* note 134.

189 *See, e.g.*, Evan R. Seamone, *Understanding the Person Beneath the Robe: Practical Methods for Neutralizing Harmful Judicial Biases*, 42 WILLAMETTE L. REV. 1, 5 (2006) (noting the major problems with prevailing admonitions to eliminate bias in the legal profession as "the lack of specific instructions to gain awareness of subconscious negative influences, the lack of methods to limit the harmful effects of such influences, and the lack of reliable indicators that a technique has successfully neutralized the bias").

190 *See MST Trainee Guide*, *supra*, note 134.

191 *Id.* Markers are also defined as "isolated events, which by themselves have no specific relationship to the traumatic event, but take on meaning when viewed in the context of other facts and circumstances contemporary to the trauma or harassment." *Id.*

192 MARKERS AND CLAIMS DEVELOPMENT, *supra* note 174.

193 *MST Trainee Guide*, *supra* note 134. According to the VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 4, Section H, 30, evidence of any behavior change can constitute a marker.

194 *MST Trainee Guide*, *supra* note 134.

195 *Id.*

warrant special consideration on a case-by-case basis. Ideally, the more contemporaneous in time to the claimed assault, the more probative such changes, statements, and treatment will be.[196] However, post-service behavior changes, including substance abuse or mental health treatment, can be markers if they are not caused by an inter-current post-service event or if the incident can reasonably be associated with an in-service assault.[197] Similarly, lay statements are indicative of markers when an individual provides the statements with personal knowledge of a claimant's statements or behavior changes, or after discharge from service, but with knowledge of the in-service timeframe.[198] Importantly, any evidence of a marker (even a single one) appearing during the approximate timeframe of the in-service assault is enough to schedule a claimant for a VA examination to (1) obtain a clinician's opinion on the issue of medical diagnosis, (2) determine whether that marker indicates a possibility that a claimed assault occurred, and (3) obtain a clinician's opinion on the issue of whether the currently diagnosed psychiatric disorder, to include PTSD, is related to the in-service assault.[199]

N. Evaluating Evidence in Support of MST Claims

In addition to the expectation that RVSRs have command of pertinent controlling legal and administrative authorities, and the ability to identify possible markers, they must also determine the competency, credibility, and probative weight of medical and lay evidence; account for evidence that is persuasive or not persuasive; assess the need for further evidentiary development, to include scheduling a VA examination or obtaining additional outstanding records; reconcile evidentiary conflicts; and provide adequate "reasons and bases" for rejecting material evidence favorable to a claimant.[200] However, RVSRs are not required to discuss, in detail, all of the evidence a claimant submits or that which is obtained on his or her behalf.[201] RVSRs are also instructed to accept evidence at face value unless

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196 VETERANS BENEFITS ADMINISTRATION, PROCESSING MST-RELATED CLAIMS: A VBA PRIORITY (2012) [hereinafter PROCESSING MST-RELATED CLAIMS].

197 MARKERS AND CLAIMS DEVELOPMENT, *supra* note 174; PROCESSING MST-RELATED CLAIMS, *supra* note 196.

198 *Id.*

199 MARKERS AND CLAIMS DEVELOPMENT, *supra* note 174.

200 38 U.S.C.A. §§ 5104(b), 7104(d) (West 2002); 38 C.F.R. § 3.103(b)(1) (2012); Macarubbo v. Gober, 10 Vet. App. 388, 389 (1997); Eddy v. Brown, 9 Vet. App. 52, 58–59 (1996); VA DISABILITY APM, *supra* note 83, at Part III, Subpart iv, Ch. 5.

201 Gonzalez v. West, 218 F.3d 1378, 1380–81 (Fed. Cir. 2000).

it is contradicted by other evidence of record or by "sound medical or legal principles."[202]

While VA is not mandated to provide a claimant an examination in each MST case before it, nearly every single case involves an assessment of medical and lay evidence, and it is the quality and completeness of this evidence that frequently determines the outcome of a claim and whether the benefit sought on appeal is granted. The terms "competency," "credibility," and "probative weight" (or value) are "terms of art" with specific meanings.

According to 38 C.F.R. § 3.159(a)(1), competent medical evidence is "evidence provided by a person who is qualified through education, training, or experience to offer medical diagnoses, statements, or opinions."[203] Competent medical evidence also includes statements "conveying sound medical principles contained in medical treatises, medical or scientific articles, and research reports or analyses."[204] In contrast, competent lay evidence is "any evidence not requiring that the proponent have specialized education training or experience."[205] Credibility relates to whether evidence is "inherently believable" or plausible,[206] while the probative weight (or value) of evidence relates to its persuasiveness (either alone or in concert with other evidence of record) about a particular fact.[207]

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202 VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 5.

203 38 C.F.R. § 3.159(a)(1) (2012).

204 38 C.F.R. § 3.159(a)(1) (2012); Mattern v. West, 12 Vet. App. 222, 228 (1999).

205 38 C.F.R. § 3.159(a)(2) (2012). Lay evidence is commonly provided by a claimant, his or her spouse, a child, sibling, parent, friend, employer, clergy, or fellow service member.

206 VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 5; *see also* Caluza v. Brown, 7 Vet. App. 498, 511 (1995) (in weighing credibility, VA may consider interest, bias, inconsistent statements, bad character, internal inconsistency, facial plausibility, self interest, consistency with other evidence of record, malingering, desire for monetary gain, and demeanor of the witness); Cartright v. Derwinski, 2 Vet. App. 24, 25 (1991) (noting that a pecuniary interest may affect the credibility of a claimant's testimony, but not his or her competency to testify).

207 VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 5; *see also* Layno v. Brown, 6 Vet. App. 465, 469 (1994) (distinguishing between competency, "a legal concept determining whether testimony may be heard and considered," and credibility, "a factual determination going to the probative value of the evidence to be made after the evidence has been admitted").

O. Medical Evidence

In reviewing medical evidence, RVSRs are permitted to assign greater weight to one medical opinion over another.[208] However, VA has declined to adopt a "treating physician rule" which would give the opinion of a treating physician greater weight.[209] In assessing the probative weight of medical evidence, RVSRs may consider the following: (1) the training, experience, expertise, and/or specialty of the physician; (2) the basis, specificity, and certainty of the opinion and the physician's reasoning for it, including but not limited to whether and the extent to which the physician reviewed prior clinical records or other evidence in the claimant's file; (3) the physician's knowledge of a claimant's medical and personal history; (4) the length of time the physician treated the claimant; and (5) the physician's reason for the contact (i.e., for treatment purposes vs. examination for a disability claim).[210] But, the absence of evidence showing symptoms or treatment generally may not be considered substantive negative evidence.[211] In addition, RVSRs are precluded from making their own medical judgments; rather, their findings must be supported by the independent medical evidence of record.[212] Medical opinions must also be "read as a whole" to determine the examiner's rationale.[213]

Practically speaking, this means that the most effective medical opinions have certain foundational elements. These foundational elements include an assessment of the physician's credentials, the articulation of a full and accurate factual basis to support a given conclusion, familiarity with a claimant's medical history, and consideration of

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208 Guerreri v. Brown, 4 Vet. App. 467, 470–71 (1993) ("The probative value of medical opinion evidence is based on the medical expert's personal examination of the patient, the physician's knowledge and skill in analyzing the data, and the medical conclusion that the physician reaches . . . . As is true with any piece of evidence, the credibility and weight to be attached to these opinions [are] within the province of the adjudicator.").

209 Winsett v. West, 11 Vet. App. 420, 424–25 (1998); *Guerreri*, 4 Vet. App. at 471–72.

210 VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 5.

211 Buczynski v. Shinseki, 24 Vet. App. 221, 224 (2011). *But see* Kahana v. Shinseki, 24 Vet. App. 428, 440 (2011) (Lance, J., concurring) (citing *Buczynski*, 24 Vet. App. at 225–26 and Fed. R. Evid. 803(7) to note that as an exception to the general rule "the Board may use silence in SMRs [service medical records] as contradictory evidence only if the alleged injury, disease, or related symptoms would ordinarily have been recorded in the SMRs").

212 Colvin v. Derwinski, 1 Vet. App. 171, 172 (1991).

213 Monzingo v. Shinseki, 26 Vet. App. 97, 106 (2012); *see also* Moore v. Nicholson, 21 Vet. App. 211, 218 (2007), *rev'd on other grounds, sub nom.*, Moore v. Shinseki, 555 F.3d 1369 (Fed. Cir. 2009).

pertinent research and test results.[214] In addition to addressing these foundational elements, the most effective medical opinions also address all theories reasonably raised by the record; provide a complete rationale for the stated medical conclusions; avoid, to the extent possible, speculative language; and discuss and apply the "benefit of the doubt" rule, where appropriate.[215]

P. Lay Evidence

A claimant is generally competent to provide statements or testimony on matters that are capable of lay observation or about which he or she has first-hand knowledge.[216] Additionally, lay testimony is competent to establish the presence of observable symptomatology that is not medical in nature.[217] Lay evidence can be competent and sufficient to establish a diagnosis of a condition when "(1) a layperson is competent to identify the medical condition, (2) the layperson is reporting a contemporaneous medical diagnosis, or (3) lay testimony describing symptoms at the time supports a later diagnosis by a medical professional."[218] Lay evidence does not lack credibility "merely because it is unaccompanied by contemporaneous medical evidence"; however, adjudicators may weigh the absence of contemporaneous medical evidence against the lay evidence.[219] In the context of MST claims, a claimant is competent to report psychiatric symptoms.[220] And, although lay persons are competent to provide opinions on some medical issues,[221] determining the etiological relationship between a currently diagnosed psychiatric disorder and a period of active military service or to an incident therein, including an alleged sexual assault, falls outside the realm of common knowledge of a lay person.[222]

214 James D. Ridgway, *Erratum to: Mind Reading and the Art of Drafting Medical Opinions in Veterans Benefits Claims*, 5 PSYCHOL. INJURY & L. 72, 77–79 (2012), *available at* http://link.springer.com/content/pdf/10.1007%2Fs12207-012-9119-6.pdf.

215 *Id.* at 79–81.

216 Washington v. Nicholson, 19 Vet. App. 362, 368 (2005); Charles v. Principi, 16 Vet. App. 370, 374 (2002); Layno v. Brown, 6 Vet. App. 465, 469 (1994).

217 Barr v. Nicholson, 21 Vet. App. 303, 307–08 (2007).

218 Jandreau v. Nicholson, 492 F.3d 1372, 1376–77 (Fed. Cir. 2007).

219 Buchanan v. Nicholson, 451 F.3d 1331, 1337 (Fed. Cir. 2006).

220 *Id.*

221 Kahana v. Shinseki, 24 Vet. App. 428, 435 (2011).

222 *Id.* at 438 (Lance, J., concurring) ("The question of whether a particular medical issue is beyond the competence of a lay person—including both claimants and [VA adjudicators] must be determined on a case-

As noted above, the absence of contemporaneous medical evidence does not automatically render lay evidence not credible for a service-connection claim based on MST. For instance, the Board granted service-connection for PTSD based on MST in May 2002.[223] The veteran's service medical and personnel records were negative for diagnosis, complaint, or treatment for a sexual assault. However, the veteran reported complaints of nervous trouble, sleep problems, depression, and headaches in service. She also received in-service treatment for stress and muscle problems. Post-service, the veteran received VA treatment for depression, intrusive thoughts, and traumatized feelings, among other symptoms. She confided to a VA clinician that a military police officer beat and raped her in service in 1967 while stationed at an Air Force base after she refused to sleep with him.

She denied reporting the incident at that time, in part because she barely knew her assailant, her clothing covered the bruises from the assault, the assailant was transferred shortly after the incident, she feared that no one would believe her, and because she did not want her mother to learn of the incident. The veteran told a fellow service member that she was raped, but was unable to contact this individual. Included in the claims file is a statement from the veteran's former husband. He recounted a 1971 incident in which he playfully wrestled the veteran onto their bed. The veteran's "mood immediately shifted from jovial to somber. When he asked what was wrong, he recalled the veteran broke into tears and cried for several minutes." She then reported being raped in service and stated that their "rough play triggered the unpleasant memory of the assault."

Despite the lack of contemporaneous records, the Board found that the veteran provided consistent details regarding the approximate date, the nature of the claimed incident, and the names of individuals with purported knowledge of the claimed incident. The Board further noted that the former husband's statement corroborated the veteran's account of the incident. Post-service VA medical opinions linked the veteran's PTSD to the in-service assault. Resolving all doubt in the veteran's favor, the Board pointed out that there was no evidence to refute the occurrence of the in-service sexual assault, nor was the veteran's truthfulness or credibility called into question.[224]

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by-case basis. Simply put, any given medical issue is either simple enough to be within the realm of common knowledge for lay claimants and adjudicators or complex enough to require an expert opinion."); *see also Jandreau*, 492 F.3d at 1377 n.4 (lay persons competent to identify a broken leg, but not a form of cancer). *But see* Davidson v. Shinseki, 581 F.3d 1313, 1316 (Fed. Cir. 2009) (rejecting a categorical rule that medical evidence is required when the determinative issue is either medical etiology or a medical nexus).

223 Name Redacted, No. 96-23 520, 2002 WL 32560370 (B.V.A. May 17, 2002).

224 *Id.*

The above-cited case is an important example related to stressor corroboration and the use of lay evidence in the absence of contemporaneous medical evidence. While the Board certainly could have rejected the former husband's statement as merely being an observation of the veteran's demeanor on a specific occasion, the Veterans Law Judge instead viewed the statement as a first-hand witnessed account of the veteran's stress reaction under conditions reminiscent of the in-service rape. Importantly, it is also noteworthy that the former husband's statement, although initially made many years after the in-service rape, recalled an incident that took place within four years of the rape.

Q. Medical Opinion Concerns

In assigning weight to each piece of relevant medical or lay evidence, there are some commonly relied upon legal conventions to keep in mind. These include the following: (1) VA may assume the competence of a VA examiner unless that competence is otherwise challenged;[225] (2) a medical opinion that contains only data and conclusions is not entitled to any probative value; there must be factually accurate, fully articulated, sound reasons for the conclusion;[226] (3) "[t]he failure of the physician to provide a basis for his opinion goes to the weight or credibility of the evidence";[227] (4) a medical opinion based on an inaccurate history, or an incomplete or inaccurate factual premise has essentially no probative value;[228] (5) the medical treatise, textbook, or article must provide more than speculative, generic statements not relevant to the veteran's claim but must discuss generic relationships with a degree of certainty for the facts of a specific case;[229] (6) a general and inconclusive statement about the possibility of a link, such as "may have," is not sufficient to establish a relationship between the current disorder and military service;[230] and (7) a

225 Rizzo v. Shinseki, 580 F.3d 1288, 1292 (Fed. Cir. 2009); Cox v. Nicholson, 20 Vet. App. 563, 569 (2007) (holding that the VA may assume the competence of a VA examiner unless that competence is otherwise challenged).

226 Nieves-Rodriguez v. Peake, 22 Vet. App. 295, 304 (2008).

227 Hernandez-Toyens v. West, 11 Vet. App. 379, 382 (1998); Mense v. Derwinski, 1 Vet. App. 354, 356 (1991).

228 Kightly v. Brown, 6 Vet. App. 200, 205–06 (1994); Reonal v. Brown, 5 Vet. App. 458, 460–61 (1993).

229 Wallin v. West, 11 Vet. App. 509, 514 (1998); Sacks v. West, 11 Vet. App. 314, 316–17 (1998).

230 Polovick v. Shinseki, 23 Vet. App. 48, 54 (2008) (holding that an opinion phrased as "may well be" was speculative and did not support a service-connection grant); Bloom v. West, 12 Vet. App. 185, 187 (1999) (explaining how an opinion phrased as "could" was speculative without a clear theory of etiology); Beausoleil v. Brown, 8 Vet. App. 459, 463 (1996) (finding that medical evidence which merely indicates that an alleged disorder may or may not be related to military service is too speculative to establish a relationship to military

speculative medical opinion is not per se inadequate, but the examiner must provide a basis for that determination and "[t]he phrase 'without resort to speculation' should reflect the limitations of knowledge in the medical community at large and not those of a particular examiner."[231]

R. Credibility Concerns

In the BVA decisions we analyzed, numerous denials involved allegations of inaccurate histories. Such inaccuracies provide the adjudicator a basis to then disregard any evidence provided by a claimant and also to discount the probative weight assigned to medical opinions which rely on these inaccuracies. We believe that knowledge of some of the leading bases which result in a claimant being labeled an inaccurate historian or "not credible," will only help future claimants avoid this trap. Consider the following:

- A significant lapse in time between service and post-service medical treatment may be considered as part of the analysis of a service-connection claim.[232]
- "Evidence which is simply information recorded by a medical examiner, unenhanced by any additional medical comment by that examiner, does not constitute 'competent medical evidence'" and "a bare transcription of lay history is not transformed into 'competent medical evidence' merely because the transcriber happens to be a medical professional."[233]
- VA need not accept a non-combat veteran's lay statements asserting that an event (as opposed to medical symptoms) actually occurred, even though there is no "affirmative documentary evidence provid[ing] otherwise." Rather, all the evidence of record, including the absence of documentation in the military records, must be weighed in determining whether an event actually occurred.[234]
- An examiner's "reliance on a veteran's statements renders a medical

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service); Tirpak v. Derwinski, 2 Vet. App. 609, 611 (1992) (same).

231 Jones v. Shinseki, 23 Vet. App. 382, 390 (2010).

232 Maxson v. Gober, 230 F.3d 1330, 1333 (Fed. Cir. 2000); *Mense,* 1 Vet. App. at 356.

233 Howell v. Nicholson, 19 Vet. App. 535, 539 (2006); LeShore v. Brown, 8 Vet. App. 406, 409 (1995).

234 Bardwell v. Shinseki, 24 Vet. App. 36, 40 (2010).

report incredible only if [VA] rejects the statements of the veteran."[235]

- The BVA and CAVC are bound by the law and are without authority to grant benefits on an equitable basis.[236]

Similarly, it has been common practice for Regional Office adjudicators to deny service-connection for MST claims primarily on the grounds that it was less likely than not that the alleged assault occurred because the incident was not reported to superiors or annotated in in-service medical records. Typically, in the absence of such documentation, a claimant and his or her report of in-service assault is deemed not credible and the service-connection claim is denied. The Federal Circuit's recent decision, *AZ v. Shinseki*,[237] invalidated this practice. One of the claimants in *AZ* had been beaten, raped, and verbally abused by a sergeant/senior non-commissioned officer and had become pregnant as a result of the rape.[238] The Regional Office denied the service-connection claim and the BVA upheld the denial, in significant part based upon the absence of records documenting the assault and the lack of a report to military authorities.

Highlighting the VA's own recognition that sexual assault is under-reported in the military,[239] other "'unique' disincentives to report,"[240] and the fear of reprisal most victims face in the aftermath of MST,[241] the Federal Circuit rejected two of the VA's most prominent bases for denial of MST claims. Specifically, the Federal Circuit held that "the absence of a service record documenting an unreported sexual assault is not pertinent evidence that the sexual assault did not occur."[242] Furthermore, neither the BVA nor CAVC can treat "a veteran's failure to report an in-service sexual assault to military authorities as pertinent evidence that the sexual assault did not occur."[243] Although the *AZ* decision represents only two factors on a laundry list of other markers or variables that can potentially be

235 Coburn v. Nicholson, 19 Vet. App. 427, 432–33 (2006).

236 Harvey v. Brown, 6 Vet. App. 416, 425 (1994). Only the Secretary retains the statutory authority to consider equitable relief. 38 U.S.C.A. § 503(a) (West 2002).

237 AZ v. Shinseki, 731 F.3d 1303 (Fed. Cir. 2013).

238 *Id.* at 1306.

239 *Id.*

240 *Id.* at 1313–14.

241 *Id.* at 1322.

242 *Id.* at 1305.

243 *AZ*, 731 F.3d at 1306.

weighed against a claimant, these two factors matter more significantly because they arise in the majority of cases. While it is unclear how *AZ* will be applied moving forward, this decision represents a major rejection of the heavily relied upon evidentiary standards that had previously been used to undercut a claimant's attempt for disability compensation.

After assigning weight to each piece of relevant medical or lay evidence, RVSRs are subsequently tasked with considering the totality of the evidence, with special attention on answering the following questions:

> (1) Did the evidence originate in service or in close proximity to service?
>
> (2) Is the medical opinion supported by clinical data and review of medical records?
>
> (3) How detailed is the medical opinion?
>
> (4) Is the opinion based on personal knowledge or a history provided by another person?[244]

In cases where there is an "overwhelming imbalance" either for or against a claim, the claim is decided accordingly.[245] If, however, there is an "approximate balance of positive and negative evidence" (i.e., equipoise, or a 50% chance or greater), the "benefit of the doubt" is resolved in a claimant's favor and the claim is granted.[246]

The above description reveals perhaps unexpected duties to aid claimants, standards in their favor, and ideals designed to recognize the serious dilemmas attendant in sexual victimization during military service. With so much impetus to support a claimant in his or her attempts to demonstrate at least a 50% likelihood, one must ponder why denial rates are so high. Vitally, the reader must keep in mind that there are still bases to deny claims within the bounds of the standards described herein.

As noted, the initial threshold to establish eligibility for VA disability compensation benefits requires a claimant to be able to (1) establish "veteran" status; and to have (2) a discharge or release from service under "conditions other than dishonorable." A claimant's

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244 VA DISABILITY APM, *supra* note 83, at Part III, subpart iv, Ch. 5.

245 *Id.*

246 *Id.* However, the benefit of the doubt rule is not for application in cases where the preponderance of the evidence is against a claim.

failure to satisfy these initial threshold requirements will result in denial of the claim as a matter of law, without consideration of the actual merits of the claim. Assuming that a claimant has established "veteran" status and has a discharge or release from service under "conditions other than dishonorable," the following factors can nevertheless result in the denial on the merits of a service-connection claim based on MST: (1) the absence of a diagnosed psychiatric disorder during the claims period;[247] (2) the lack of sufficient corroboration to show the possibility that the claimed assault occurred; and (3) the lack of a sufficient nexus linking a currently diagnosed psychiatric disorder to a period of qualifying service or to any incident therein, including the claimed sexual assault.

Beyond this, there are other concerns. Bias, particularly acceptance of "rape myths," is not limited to adjudicators. It affects physicians and mental health professionals alike, raising more serious concerns, such as whether the bias of a medical evaluator can indirectly influence the RVSR's decision, even if he or she has made an effort to meet the VA's objective of a more empathic response. As evidenced in our analysis of BVA opinions, some have referenced medical evaluators whose analyses not only approach but surpass condemnation of the applicant's lifestyle and sexual choices.[248]

Additionally, while the guidelines, fast letters, training letters, and other decision-making aids make many suggestions, there is still room to interpret them against claimants. In our reading of Board decisions, we have observed a number of opinions in which RVSRs and/or the BVA have improperly treated each example of sexual trauma markers on a laundry list as being necessary prerequisites for a positive finding so that absence of a single one either disqualifies the claimant or is weighed against him or her.[249]

Furthermore, we have found a complete lack of guidance in the literature on causation regarding how to evaluate cumulative trauma. For these reasons, the generic MST manuals, despite the hard work that went into their creation, and despite the VA's best intentions, mainly reveal the need to look more carefully at context as well as applied examples. Part

247 Brammer v. Derwinski, 3 Vet. App. 223, 225 (1992); *cf.* McLendon v. Nicholson, 20 Vet. App. 79, 82–83 (2006).

248 *See, e.g.*, Name Redacted, No. 06-21 878, 2008 BVA LEXIS 24748, at *7–8 (B.V.A. July 25, 2008) (justifying denial of the male sexual assault victim's claim in part on the basis that the examiner could not understand how the claimant could easily talk about turning to prostitution following his discharge or his "sexual exploits" but had problems discussing details of the sexual trauma he experienced while in the service).

249 Name Redacted, No. 00-20 684, 2002 WL 32559473 (B.V.A. Oct. 24, 2002); *cf.* Dennis v. Nicholson, 21 Vet. App. 18, 22 (2007) (citing Abernathy v. Principi, 3 Vet. App. 461, 465 (1992) (noting that merely listing evidence before stating a conclusion does not constitute an adequate statement of reasons and bases)).

III below embraces this demanding challenge with the aim of showing how to ensure that evidence is compelling enough to regain the advantages that the claimant rightly deserves.

III. MST as an Aggravation of Pre-Enlistment Sexual Trauma

MST is too often "associated with a lifetime history of interpersonal trauma, including childhood sexual abuse and sexual assault prior and subsequent to military service."[250] Female service members are at risk for cumulative trauma; first, simply by joining the service where they are more likely to be assaulted, and, second, on an independent and additive basis when they have been sexually victimized prior to their entry into service.[251] Because "at least one third of female veterans have child abuse histories,"[252] because childhood sexual assault normally results in PTSD and other mental health conditions experienced in childhood,[253] and because those veterans who actually seek treatment from the VA are usually ones with significant sexual trauma histories, including pre-enlistment abuse,[254] many VA claimants implicitly raise issues of MST as aggravation of a pre-existing psychiatric condition.

The VA's analysis of MST claims involving cumulative trauma requires consideration of all the factors that contributed to current symptoms. Accordingly, the BVA will remand a case for a determination of how much childhood sexual abuse contributed to a claimed psychiatric condition related to MST when the veteran mentions the past trauma during

250 Jane Luterek et al., *Posttraumatic Sequelae Associated with Military Sexual Trauma in Female Veterans Enrolled in VA Outpatient Mental Health Clinics*, *in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 49, 50 (Carolyn B. Allard & Melissa Platt eds., 2012).

251 Maureen Murdoch et al., *The Association Between Military Sexual Stress and Psychiatric Symptoms After Controlling for Other Stressors*, 44 J. PSYCHIATRIC RES. 1129, 1130 (2010) ("[C]hildhood maltreatment and other stressors could confound observed associations between military sexual stress and psychiatric outcomes, mediate associations, or carry additive effects."); Williams & Bernstein, *supra* note 36, at 138 ("A[] risk factor for sexual aggression and sexual assault in the military is a soldier's own history of childhood abuse."); Zinzow et al., *supra* note 39, at 233 ("[M]ilitary personnel not only enter the service with higher rates of trauma, but . . . those who have prior sexual assault experiences are at increased risk for trauma exposure during or after their military service.").

252 Himmelfarb et al., *supra* note 3, at 841; Zinzow et al., *supra* note 36, at 389.

253 George Glumac, *Post-Traumatic Stress Disorder: A Review of the Psychiatric Literature for the Legal Profession*, 21 ADVOCATES' Q. 336, 351 (1999) ("Many [survivors of CSA] developed PTSD as children as a consequence of their abuse.").

254 *See, e.g.*, Valdez et al., *supra* note 128, at 20, 26–27 (discussing the overrepresentation of MST survivors in VA outpatient healthcare settings specifically because they offer interventions tailored to multi-trauma sufferers).

the course of a psychiatric examination but the examiner fails to quantify its impact.[255] The BVA will also place greater weight upon medical opinions that take consideration of prior trauma histories than those that do not.[256] Consideration of other possible traumatic sources of claimed psychological harm is after all a hallmark of a "credible forensic examination" and has traditionally been the reason why medical examiners have not relied primarily upon "the claimant's assertion concerning the cause of psychological impairments."[257] If, on the one hand, examiners simply presume causation, and ignore alternative causes, or, on the other hand, dismiss other potential causes summarily, this could lead to an erroneous outcome.[258] As Professor Maureen Murdoch explains, "[f]ailing to adequately control for such experiences could cause investigators to over- or underestimate sexual stress' influence on psychiatric symptoms—possibly substantially so."[259] The challenge thus becomes what to do with the multiple events and how to reconcile their combined effect. During such a process, however, it often becomes too convenient to overemphasize the existence of any other preexisting traumatic event, regardless of its comparative severity, as a break in the chain of causation.[260]

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255 *See, e.g.*, Name Redacted, No. 05-18 339, 2008 WL 4311282 (B.V.A. Apr. 4, 2008) (remanding in a case involving two separate sexual assaults, to ascertain "what impact, if any, the Veteran's history of childhood sexual assault, noted in psychotherapy sessions, had on her current major depressive disorder and PTSD"). *See also* Name Redacted, No. 98-13 395, 2002 WL 32571132 (B.V.A. Mar. 21, 2002) ("Unless an examiner was presented with the report of both the pre-service molestation and the inservice harassment, a diagnosis of [PTSD] due to the in-service harassment is of little probative value.").

256 Name Redacted, No. 05-18 339, 2010 WL 5378303 (B.V.A. Oct. 6, 2010) (finding childhood sexual abuse history more causative of current symptoms than multiple in-service sexual assaults and hazing and recognizing that preference will be accorded to "whether or not and to what extent they review prior clinical records and other evidence"); *see also* Gabrielson v. Brown, 7 Vet. App. 36 (1994).

257 Glumac, *supra* note 253, at 350; *see also id.* at 351 ("In the evaluation of the PTSD claimant, the prior existence of PTSD must be considered.").

258 *See, e.g.*, WILLIAM E. FOOTE & JANE GOODMAN-DELAHUNTY, EVALUATING SEXUAL HARASSMENT: PSYCHOLOGICAL, SOCIAL, AND LEGAL CONSIDERATIONS IN FORENSIC EXAMINATIONS 122 (2005) ("[I]f a life problem is caused by earlier life events and has continued through the time of the evaluation, that problem may be mistaken for a symptom resulting from the alleged sexual harassment.").

259 Murdoch et al., *supra* note 251, at 1130.

260 *See, e.g.*, Elk v. United States, 87 Fed. Cl. 70, 86 (2009) (criticizing the common practice of citing numerous potential preexisting life stressors as more "significant" traumas in cases involving subsequent sexual trauma without any clear indications of their impact); James T. Brown, *Avoiding Litigation Neurosis: A Practitioner's Guide to Defending Post Traumatic Stress Disorder Claims*, 20 AM. J. TRIAL ADVOC. 29, 56, 58 (1996) (noting how "[s]uccessful defense of a PTSD claim is centered around an attack on the causal link between the alleged traumatic event and the plaintiff's perceived symptoms" and suggesting that the defense probe the following for such evidence: "[p]rior psychological treatment," "child custody issues," and "sexual

Cumulative trauma dilemmas likely account for many denied MST claims, in a more obscured manner.[261] Even where veterans can credibly establish an in-service sexual assault, adjudicators routinely deny claims on the overarching basis that current symptoms were more proximately related to other nonservice-connected causes.[262] Such denials have occurred despite increased efforts to assist MST claimants specifically, and they will continue even if legislation implements a new presumption that in-service sexual trauma actually occurred. Much of the problem with cumulative psychological trauma deals with significant differences in the assessment of physical—as opposed to mental and emotional—harm, where psychiatric symptoms inure more suspicion on the basis that they derive entirely from self-reports and are less capable of objective proof.[263] Whether the domain is VA adjudication, workers' compensation, employment discrimination, or civil tort system, decision-makers in these forums all suffer from a lack of concrete standards on apportionment of harm caused by the combination of pre-existing psychiatric conditions.[264]

In any of the varied legal forums, survivors of sexual trauma with childhood sexual abuse histories face particularly significant challenges in the apportionment of responsibility for aggravated injuries from subsequent sexual abuse.[265] The VA stands out,

abuse as a child").

261 In MST claims, which normally arise in the context of PTSD, one would otherwise assume higher rates of success. *See, e.g.*, Heathcote W. Wales, *Causation in Medicine and Law: The Plight of the Iraq Veteran*, 35 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 373, 387 (2009) ("Because causality of the traumatic event is assumed in PTSD, and because the VA typically relies on clinical expert testimony to establish service-connection, many veterans diagnosed with PTSD post-discharge should be successful in claims for disability.").

262 *Infra* Part III.A.

263 Richard L. Newman & Rachel Yehuda, *PTSD in Civil Litigation: Recent Scientific and Legal Developments*, 37 JURIMETRICS 257, 258 (1997) ("The courts have long struggled with the degree and nature of proof necessary for recovery from psychological and emotional injuries, particularly when unaccompanied by physical injury.").

264 Consider the comments of a special master whose dismissal of expert testimony on apportionment was ultimately reversed in a case involving a sexual harassment victim who had experienced a rape prior to her employment: "There's no accepted method for assigning weight to a particular stressor as a causative factor when [there's] more than one stressor" and "[t]here . . . is no scientifically developed psychiatric model or procedure for determining whether a particular stress caused a particular symptom or mental state." Jenson v. Eveleth Taconite Co., 130 F.3d 1287, 1294–95 (8th Cir. 1997). Although the Eighth Circuit did not resolve the underlying problem or identify any preferred model for apportionment, it nevertheless found that the special master should have accepted expert testimony attempting to establish causation. *Id.* at 1295.

265 Elizabeth F. Kuniholm & Kim Church, *Damages—"Thin-Skull Plaintiff," Preexisting Condition, and Indivisible Injury*, 4 LITIGATING TORT CASES § 54.53 (Roxanne Barton Conlin & Gregory S. Cusimano eds., 2012) ("[P]reexisting vulnerability of a victim, where a preexisting emotional harm or condition is exacerbated

however, in the even greater burdens it imposes on veterans with MST claims under the rubric of "secondary service-connection" based on aggravation of nonservice-connected conditions.[266] Because the VA is unique in the evidentiary burdens it imposes, this Part first examines the VA's standards, which provide several bases for denial in the multi-step approach to aggravation involving cumulative trauma. After identifying a number of practical pointers for applicants, mainly dealing with the nature of the medical examiner's report, we then compare the VA's approach to other courts' alternatives for addressing cumulative sexual trauma issues. Although improvements are few, we take note of theories and considerations within these varied forums that may assist in helping VA claimants. Where possible, we draw on the scientific literature to recommend specific theories of causation that will aid VA claimants and medical evaluators in quantifying the amount of aggravation caused by in-service sexual trauma. This Part concludes with a discussion of hazing in the backdrop of a claimed sexual assault since this form of trauma adds a number of considerations that may not be present in other patterns of MST perpetration.

A. The VA's Concept of Aggravation of Nonservice-Connected Injuries

The VA recognizes a number of ways to establish a service-connected disability, including direct service-connection, and various presumptions.[267] Recognizing that some in-service injuries result in harm by interacting with nonservice-connected injuries, or conditions that do not rise to the level of compensable disabilities, legal standards also offer some means of compensating for the aggregate harm. In cases where veterans suffer from personality disorders or pre-existing developmental disabilities,[268] and a competent medical evaluation determines that an in-service injury "superimpose[s]" itself over the non-compensable condition, 38 C.F.R. § 4.127 permits compensation despite nonservice-connected causes.[269] Generously, where it is impossible for adjudicators to determine how much of the current disability is attributable to the in-service injury versus the non-compensable one, the VA embraces responsibility for the total injury, on the following theory:

by a later sexual assault or victimization creates many issues of proof for the advocate seeking justice for the sexual abuse victim.").

266 *Infra* Part III.B.

267 *See, e.g.*, Combee v. Brown, 34 F.3d 1039, 1043 (Fed. Cir. 1994) (describing direct incurrence, aggravation, or a statutory presumption as the ways to establish service-connection in the VA adjudication process).

268 "Mental Retardation" is the term adopted in the regulation.

269 *See, e.g.*, DVA Op. Gen. Counsel Prec. 82–90 (1990).

> While VA will compensate overlapping symptoms as if the overlapping symptoms were all due to the effects of the service-connected condition, we do this in specific situations where it is impossible for a medical examiner to distinguish which symptoms are due to the service-connected disability and which are due to the nonservice-connected disability, such as where two separate disabilities share common symptoms. Where various symptoms affecting a single body part or system can be separated into those attributable to service-connected disability and those attributable to the nonservice-connected disability, VA evaluates for compensation only on those symptoms attributable to the service-connected disability.[270]

Importantly, this rule is limited by the operation of Section 4.127 solely to "mental retardation and personality disorders."[271] Aggravation of a nonservice-connected disability exists in the entirely separate universe of 38 C.F.R. § 3.310 and its constellations of secondary service-connection rules are far more limiting.

B. The Five Elements of Secondary Service-connection

Secondary service-connection, as opposed to primary service-connection, addresses those situations where the "increase in severity of a nonservice-connected disease or injury . . . is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease."[272] In the simplest terms, the theory permits VA benefits for "additional disability resulting from the aggravation of a nonservice-connected [secondary] condition by a service-connected condition."[273] As the seminal *Allen v. Brown* CAVC opinion highlights, compensation in these scenarios will be limited solely to "the degree of disability (but only that degree) over and above the degree of disability existing prior to the aggravation."[274] According to the VA's position, any different standard permitting compensation for the entire injury would lead to "absurd results" where the government would be underwriting a host of harm contributors other

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270 71 Fed. Reg. 52,744, 52,746 (Sept. 7, 2006).

271 38 C.F.R § 4.127.

272 38 C.F.R. § 3.310.

273 Libertine v. Brown, 9 Vet. App. 521, 522 (1996).

274 Allen v. Brown, 7 Vet. App. 439, 448 (1995).

than military service.[275] Under the guise of "*Allen* Aggravation," the VA more recently implemented a series of steps to evaluate claims involving aggravation of nonservice-connected conditions by service-connected ones.

1. Worsening of the Condition During Service

The primary inquiry addresses the factor of temporality, searching for evidence of a worsening of the veteran's condition *during* his or her service. Namely, "aggravation may not be conceded where the disability underwent no increase in severity during service on the basis of all the evidence of record pertaining to the manifestations of the disability prior to, during, and subsequent to service."[276] Here, evaluators search specifically for evidence of psychiatric problems during service, instances in which the veteran sought psychiatric treatment or reported psychiatric problems—including those issues noted at the time of discharge—and any other evidence suggesting that the veteran suffered a psychiatric disorder during service.[277] If the claimant does not show a worsening of the condition during service, he or she cannot succeed in demonstrating that military service was the cause of the decline in condition. Important to this analysis, the examiners will likely count it against the veteran if medical records show any sign of improvement during service of a condition after the veteran reports it.[278]

2. Severity of Harm Suffered

The second inquiry deals with the magnitude of the harm suffered. Here, it is incumbent upon the veteran to demonstrate that the in-service trauma reached the *underlying condition* and worsened it, as opposed to causing the onset of *only symptoms*.[279] If the worsening of the condition is limited to "temporary or intermittent flare-ups" of the preexisting condition, such harm will not rise to the level of aggravation and cannot be compensated, despite the hardships it caused.[280] In one example, a male service member with a history of

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275 71 Fed. Reg. 52,744, 52,746 (Sept. 7, 2006).

276 *See, e.g.*, 38 U.S.C. § 1153; 38 C.F.R. § 3.306(a); Name Redacted, No. 08-11 000, 2011 BVA LEXIS 40281, at *5 (B.V.A. Sept. 28, 2011).

277 *See, e.g.*, Name Redacted, No. 08-11 000, 2011 BVA LEXIS 40281, at *39–40 (B.V.A. Sept. 28, 2011).

278 *See* Beverly v. Brown, 9 Vet. App. 402, 405–06 (1996).

279 Davis v. Principi, 276 F.3d 1341, 1346–47 (Fed. Cir. 2002); Crowe v. Brown, 7 Vet. App. 238, 247–48 (1994).

280 Hunt v. Derwinski, 1 Vet. App. 292, 297 (1991).

child sexual trauma including being raped, perceived that a sergeant was "grooming him for sex" and making various sexual advances on him.[281] The medical examiner found that the veteran "suffered with PTSD as a residual of his childhood trauma," rather than MST,[282] but that "even if no assault of the Veteran occurred in service, the Veteran's belief that he was being advanced upon would be enough to exacerbate the psychological symptoms resulting from the history of sexual trauma."[283] On the basis of this finding, the Board remanded the case because the examiner failed to address whether the exacerbation was temporary or permanent.[284] On the notion of flare-ups, if it has been some time (e.g., years) since the veteran's discharge from service, the veteran should provide proof of psychiatric problems between entry into civilian life and the time of the claim. Long periods without medical treatment or symptomatology, such as ten-year gaps, have similarly led many adjudicators to reject a theory of aggravation.[285]

3. Causal Nexus Between MST and Worsening of the Underlying Condition

Supposing the veteran can demonstrate worsening of the condition during service, and can further demonstrate that this impairment affected the underlying condition, the veteran must thirdly link the aggravation to the in-service sexual stressor, which normally comes through a medical opinion that the in-service trauma was the cause of the aggravation. As a noteworthy example, a 2007 BVA opinion reveals a claimant who served as a military policewoman.[286] She described incidents of harassment based on being in an "all-male" profession.[287] While the Board found her account of a rape by her commander to be lacking credibility, it did find credible her account of another in-service incident where a Lieutenant Colonel physician had improperly placed his hand on her thigh close to her vaginal area while asking her questions about her sex life.[288] She had reported him to law enforcement

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281 Name Redacted, No. 07-22 565, 2012 BVA LEXIS 16051, at *16 (B.V.A. June 5, 2012).

282 *Id.* at *19.

283 *Id.* at *20.

284 *See id.*

285 *See* Maxson v. Gober, 230 F.3d 1330, 1333 (Fed. Cir. 2000) (noting that "[e]vidence of a prolonged period without medical complaint can be considered" as negative evidence against the veteran).

286 *See* Name Redacted, No. 02-15 018, 2007 BVA LEXIS 25523, at *5 (B.V.A. Oct. 1, 2007).

287 *Id.* at *7 (quoting from the VA medical records).

288 *See id.* at *6, *17.

and the criminal investigation revealed two other victims with similar accounts.[289] She claimed this event contributed to her PTSD diagnosis, in addition to the fact that she was repeatedly denied promotions as a result of having reported some of her sexual trauma.[290]

The Board considered her pre- and post-enlistment history, which included numerous traumatizing events, including repeated sexual abuse prior to age eighteen.[291] The medical examiner and the Board focused on her past and concluded that "dozens of other traumas . . . account for her PTSD symptomatology."[292] Although the decision mentioned the possibility of service-connection for aggravation of a condition, and despite the fact that the abuse from the physician was from an authority figure who may have resembled and resurrected prior abusive scenarios, the Board did not remotely entertain a theory of aggravation.[293] With no mention of a link between childhood trauma and in-service aggravation, the Board linked her current symptoms exclusively to an "extensive history of pre-service . . . traumatic experiences, all basically having to do with sexual abuse and rape."[294]

In yet another case, a veteran who lived in service as a man was undergoing a transgender operation at the time of the VA claim of PTSD.[295] Her military duties in the Air Force included still photography of concededly "gruesome" scenes.[296] However, the most traumatizing scene of all involved a physically abused toddler.[297] To the veteran, exposure to the aftermath of the child abuse during crime scene documentation "reminded her of when she was abused as a child," causing severe distress and ongoing nightmares.[298] This was contrasted with a pre-service history of sexual trauma.[299] On consideration of these past events, the medical examiner found "PTSD in her youth . . . possibly aggravated

289 *See id.* at *6.

290 *Id.* at *7, *15.

291 *Id.* at *8–10.

292 Name Redacted, No. 02-150 18, 2007 BVA LEXIS 25523, at *12 (B.V.A. Oct. 1, 2007).

293 *Id. passim.*

294 *Id.* at *11–12.

295 Name Redacted, No. 08-11 000, 2011 BVA LEXIS 40281, at *1 (B.V.A. Sept. 28, 2011).

296 *Id.* at *17, *24.

297 *Id.* at *15.

298 *Id.* at *18.

299 *Id.* at *13.

by service."[300] However, the Board, while "conced[ing]" to the veteran's exposure to "sometimes gruesome and repulsive" scenes during service,[301] concluded:

> The examiner opined, unequivocally, that the veteran's PTSD was related directly to her childhood abuse. While the examiner also indicated that her PTSD was "possibly aggravated" by service, the Board finds that the additional qualified assessment is speculative at best, and does not provide a basis to establish service-connection.[302]

As in the prior case, what was missing was a specific theory of aggravation, and a link between the in-service trauma and childhood trauma.

The rationales in these decisions are similar to ones in civil cases. The refusal to presume an aggravating relationship with sexual trauma is best reflected in the South Dakota Supreme Court's *Shippen v. Parrot* opinion, where the plaintiff had been sexually molested for a nine-year period.[303] The abuse survivor had the benefit of therapy and treatment.[304] However, at the age of twenty-three, when many of his symptoms had subsided, the abuser again entered his life and performed a number of non-consensual sexual acts, over the struggles and protests of the victim.[305] In court, the plaintiff claimed that the two subsequent events in his adulthood had negated the mental health progress he made, ultimately resulting in his moving out of an apartment to the streets, becoming scared and confused, and suffering panic attacks.[306] Because the medical examiners "merely described [the plaintiff's] mental problems" without discussing how they were linked to aggravation of the child abuse and did not originate from the child abuse alone, the court refused to permit damages for the subsequent aggravating events: "There is no evidence of the necessary predicate that the [later two] assaults aggravated a preexisting condition and were a substantial factor in

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300 *Id.* at *19.

301 Name Redacted, No. 08-11 000, 2011 BVA LEXIS 40281, at *26 (B.V.A. Sept. 28, 2011).

302 *Id.* at *37.

303 Shippen v. Parrott, 553 N.W.2d 503, 506 (S.D. 1996), *abrogated by* Jensen v. Kasik, 758 N.W.2d 111 (S.D. 2008), *overruled on other grounds*, Baye v. Diocese of Rapid City, No. 07-5056-KES, 2010 U.S. Dist. LEXIS 17611 (D. S.D. Feb. 26, 2010), *aff'd*, 630 F.3d 757 (8th Cir. 2011).

304 *Shippen*, 553 N.W.2d at 506.

305 *Id.* at 505, 510.

306 *Id.*

bringing about [his] future harm."[307] In the VA claims process as well, claimants must heed the warning to clearly articulate theories of aggravation.

Ultimately, because MST "itself is not a disability for which service-connection can be granted under the VA's current benefits system," when a medical examiner states that in-service sexual trauma more likely than not aggravated a veteran's mental condition, this will be insufficient as a causal nexus, unless it further demonstrates precisely how the etiology of the veteran's condition is linked to the in-service trauma.[308]

4. Apportionment of Damages Between the Pre-existing Condition and the New Traumatic Injury

The fourth inquiry requires apportionment of the harms between the nonservice-connected condition and the in-service aggravation. Prior to 2006, this meant that the medical examiner had to conclude that the in-service stressor was at least more likely than not responsible for the aggravation. Problematically, mental health professionals are trained to assess causation in a very conservative manner in a non-forensic setting. This usually means that they will discuss probabilities with cautious terms "such as 'possible' and 'history of' unless they are absolutely certain their opinion is correct."[309] In sexual abuse cases, which often result in determinations that it is impossible to apportion cumulative traumas, these guarded types of comments are more likely. Because of this, when evaluators use more ambiguous phrases such as the aggravating harm of the in-service trauma "may" have been responsible for the current diagnosis, this word choice alone nearly always precludes a finding of secondary service-connection.[310]

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307 *Id.* at 509.

308 Name Redacted, No. 02-10 748, 2008 BVA LEXIS 5209, at *16 (B.V.A. Feb. 14, 2008).

309 James D. Ridgway, *Lessons the Veterans Benefits System Must Learn on Gathering Expert Witness Evidence*, 18 FED. CIR. B.J. 408, 410 n.44 (2009); *see also* Deirdre M. Smith, *The Disordered and Discredited Plaintiff: Psychiatric Evidence in Civil Litigation*, 31 CARDOZO L. REV. 749, 765 (2010) ("[P]sychiatry does not provide a suitable, uncontroversial conception of causation that can be imported easily into the legal realm.").

310 *See, e.g.*, Obert v. Brown, 5 Vet. App. 30, 33 (1993) ("[A]s appellant 'may' have been showing symptoms, the implication is he 'may not have' been showing symptoms. Dr. Webster's statement is, therefore, speculative."); Stegman v. Derwinski, 3 Vet. App. 228, 230 (1992) (rejecting a service-connection claim when "the medical evidence favorable to appellant's claim does little more than suggest a possibility that the veteran's illnesses *might* have been caused by his wartime radiation exposure") (emphasis in original); Tirpak v. Derwinski, 2 Vet. App. 609, 611 (1992) ("Dr. Barnard's letter, which stated that the veteran's death *may or may not have* been averted if medical personnel could have effectively intubated her husband . . . is speculative and would not 'justify a belief by a fair and impartial individual that the claim is well grounded.'") (emphasis

A different dilemma emerges when there is a definite causal connection for some of the additional harm, but problems determining precise weights for apportionment, i.e., the in-service trauma certainly aggravated the underlying condition and made it worse, but to an unknown degree. For slightly over a decade, from 1995 when *Allen* was decided until October of 2006, adjudicators suffered from a lack of guidance regarding those cases where medical evaluators and the evidence clearly indicated pre-enlistment trauma and in-service aggravation, but offered more tenuous indications of apportionment. Apparently, in some cases, adjudicators awarded benefits for the entire injury in a manner that was similar to Section 4.127. In other cases, adjudicators simply rejected a finding of aggravation sufficient for secondary service-connection. For example, a noteworthy BVA case involved a female service member who claimed PTSD as the result of ongoing sexual harassment by seven noncommissioned officers superior in rank to her,[311] which included an event in Iceland during which "she was physically assaulted by a man she believes intended to rape her, but was stopped by two other men."[312] She presented ample evidence that included statements from a witness recounting her daily crying episodes and accompanying "erratic" behavior.[313] A fellow Airman stationed at the same base, who knew the veteran, provided a statement that "she had no doubts that due to the sexual harassment that she personally had received, that all the women, including the appellant, were receiving the same or worse treatment."[314] In this case, the veteran herself noted the impact of the abuse by claiming a total loss of interest in men following the in-service trauma, resulting assumption of a lesbian lifestyle, and efforts to avoid men, including horrible fears at the thought of being touched by them.[315] The VA's panel of psychiatric examiners reviewed the evidence and concluded that the sexual harassment she faced while serving was "unacceptable, and clearly outside the realm of normal human experience."[316]

Despite their adoption of key aspects of the account as credible, the panel members also addressed her history of ongoing child molestation between the ages of eight and eleven, which had been perpetrated by a brother-in-law, including nearly every sexual act

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in original) (citing 38 U.S.C. § 5107(a)).

311 Name Redacted, No. 98-13 395, 2004 BVA LEXIS 57092, at *39 (B.V.A. Oct. 6, 2004).

312 *Id.* at *39–40.

313 *Id.* at *36.

314 *Id.*

315 *Id. passim.*

316 *Id.* at *44.

fathomable short of rape.[317] The evidence even showed that she had later "tried to shoot" the perpetrator with a gun.[318] The panel, faced with a cumulative trauma puzzle, compared the intensity of the in-service sexual harassment and attempted rape with the childhood sexual assault: "We would have to say that there is a wide disparity between the severity of sexual trauma she suffered at the hands of her brother-in-law . . . and the harassment she alleges from her years in service."[319] To the panel, the in-service MST "cannot be objectively characterized as having a high degree of severity compared with her repeated near-rapes at age 10 and later."[320] While the panel acknowledged a view that "such symptoms were repressed when she was a teenager, and emerged only after the trigger of the later sexual harassment," they nevertheless discounted this theory due to the absence of complaints in her service medical records.[321] The experts thus concluded, "[i]t would appear that to whatever extent she suffers from post-traumatic symptoms, these would be due more to the stressors of child abuse than the sexual harassment which she alleges from the service."[322]

The VA panel's approach to cumulative trauma was a simple objective comparison of which acts they perceived to be more severe with no theoretical support. "Near-rapes" by an in-law during childhood won the balance over ongoing sexual harassment by superiors, which included a physical assault by a man who had to be restrained to stop from raping her. While, below, we note concerns of the Federal Court of Claims with such empty analysis, this case is important to consider for its lack of a methodology for apportioning severity of harm as well as its emphasis on the childhood period involving sexual trauma. That a denial of service-connection so easily resulted, during a time when there was further requirement to establish a pre-aggravation baseline, highlights the necessity of presenting evidence in a claim which underscores the nature of aggravation and relies upon a specific theory supporting a causal nexus.

Often, in these circumstances involving cumulative trauma, to determine the level of impact, medical evaluators compare the perceived severity of different forms of abuse, giving greater causal weights to what was perceived as more serious. Not only have years of child abuse been weighted as being more likely to result in current PTSD symptomatology

317 Name Redacted, No. 98-13 395, 2004 BVA LEXIS 57092, at *39 (B.V.A. Oct. 6, 2004).

318 *Id.* at *27.

319 *Id.* at *43.

320 *Id.* at *44.

321 *Id.*

322 *Id.* at *44–45.

than a one-time rape in service, a "date rape" in service was minimized in comparison with a veteran's extreme stress over "being re-deployed only some 30 days after the birth of one of her children."[323] As opposed to merely comparing severity of events, opposite outcomes might just as easily emerge from use of a different theory of apportionment, reflecting the high likelihood for error in such empty causal attributions.

1. Ability to Determine a Baseline for the Underlying Condition Prior to the Aggravation

In an effort to fully implement *Allen* in circumstances involving aggravation of a preexisting injury, the VA revised 38 C.F.R. § 3.310 in 2006 by adding a new requirement in subsection (b). This amended section provides that the evidence must establish a "baseline level of severity of the nonservice-connected disease or injury."[324] In mandating a baseline level of severity, the section permits an adjudicator to determine the compensable amount of aggravation by subtracting the baseline from the current level of disability.[325] In recognition that it may be difficult to obtain documentation and evidence of the baseline predating the aggravation, and that "aggravation is generally an ongoing process,"[326] the provision also permits proof of the baseline in the form of "medical evidence created *before* the onset of aggravation *or* by the earliest medical evidence created at any time between the onset of aggravation and the receipt of medical evidence establishing the current level of severity."[327] The commentary in the *Federal Register* explains how this alternative still permits the claimant to show worsening of the condition at any time prior to the claim even if older evidence is lost or inaccessible.[328] The calculus for a Section 3.310(b) apportionment is thus:

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323 Name Redacted, No. 08-18 140, 2010 BVA LEXIS 24484, at *25 (B.V.A. May 24, 2010).

324 38 C.F.R. § 3.310(b) (2006).

325 *Id.*

326 71 Fed. Reg. 52,744-01, 52,745 (Sept. 7, 2006).

327 38 C.F.R. § 3.310(b) (2006) (emphasis added).

328 71 Fed. Reg. 52,744-01, 52,745 (Sept. 7, 2006) (explaining that, "[f]or example, if the aggravation was sometime in 1996, but the veteran can only produce medical evidence from 1999, the 1999 medical evidence would be accepted for the purpose of establishing the baseline level of severity").

Current Level of Disability

-

Baseline Level Prior to Aggravation

-

Increases in Severity Due to the Normal Progress of the Disease (if Ascertainable)

=

Extent of Compensable Aggravation

Fig. One

While this baseline requirement meets *Allen*'s objective of compensating only the amount of the aggravation caused by the service-connected injury, it denies compensation for the entire condition, as was the case prior to the amendment. The law following the 2006 amendment is as follows: "The responsibility for establishing a baseline level of disability in [*Allen* aggravation] claims rests with the veteran. If no baseline can be established, no aggravation can be demonstrated, and the deduction issue would be moot."[329] Notably, the commentary in the *Federal Register* explicitly recognized the VA's application of a contrary decision criterion for fully compensating aggravated disability under Section 4.127, but distinguished Section 3.310(b), finding that, in instances of *Allen* aggravation, "only the incremental increase in disability is to be compensated."[330] The 2006 amendment generally tracks the law of torts, except for the vital additional exception that permits total compensation if damages cannot be apportioned.[331]

To better envision how a mental health evaluator might approach the assessment of potential *Allen* aggravation, Appendix F reprints excerpts of a BVA order on remand in a case where the veteran was raped at the age of 13 by a stranger shortly after her parents' divorce, and was subsequently raped while in service.[332] Immediately below, we reprint the Veterans Law Judge's specific instructions regarding the inability to identify a pre-aggravation baseline, which highlight the difficulty of this task:

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329 *Id.* at 52,746.

330 *Id.*

331 Smith, *supra* note 309, at 761–62 (observing the general rule that "the defendant is liable only for the extent of the exacerbation of the preexisting condition and not the entirety of the plaintiff's injury").

332 Name Redacted, No. 09-37 499, 2012 WL 6874129 (B.V.A. Nov. 29, 2012).

> If the opinion and/or supporting rationale cannot be provided without invoking processes relating to guesses or judgment based upon mere conjecture, the examiner should so specify in the report, and explain why any opinion could not be offered. In this regard, if the examiner concludes that there is insufficient information to provide an etiologic opinion without [resort] to mere speculation, the examiner should state whether the inability to provide an opinion is due to a need for further information (with such needed information identified) or because the limits of medical knowledge have been exhausted regarding the etiology of the Veteran's claimed PTSD and/or other psychiatric disorder.[333]

Because of the insertion of a baseline requirement in 2006, it may be more difficult for claimants to establish a service-connection. In situations where there is indisputable evidence that MST occurred, and that it aggravated an existing mental health condition, lack of an established baseline will nevertheless preclude the finding of service-connection and the award of disability compensation benefits. The requirement of a quantifiable baseline has been challenged on the basis that it presupposes that emotional and physical harm operate in the same manner, and that medical evaluators are able to objectively separate the causes of emotional harm.[334] Despite the concerns raised by these criticisms, the baseline requirement continues to act as a primary obstacle for MST survivors and is the reason that many MST survivors are denied compensation for pre-existing conditions that are aggravated during the course of service.

C. Lessons from Other Forums

Because the VA's recent revisions to secondary service-connection standards not only make it harder to succeed in these claims, but also fail to offer practical suggestions for meeting the new evidentiary thresholds, it is helpful to consider frameworks for addressing cumulative trauma from other legal fora. For instance, the notion of cumulative trauma

333 *Id.*

334 The *Federal Register*, in implementing the 2006 amendment, acknowledged concerns with the difficulty of determining comparative causation in *Allen* aggravation cases, but said nothing of the distinction between physical and emotional harm. The singular example pertaining to psychosis was instead used to point out the "absurd" result where the veteran might be compensated for the entire harm caused by the combination of nonservice aggravation when the in-service trauma accounted for only 30% of it. 71 Fed. Reg. 52,744-01, 52,746 (Sept. 7, 2006). On the topic of objective standards, the VA commentary notes that the "VA believes that, if medical evidence is adequately developed, computation of the degree of aggravation should be attainable. The degree of aggravation would be addressed based on the objective medical evidence of record." *Id.* at 52,744.

from multiple sexual stressors often arises in the context of employment discrimination cases and tort actions for negligent or intentional infliction of emotional distress. Although we operate under no illusion that there are uniformly reliable standards governing apportionment of damages in these forums, the courts have addressed some of the same challenges in ways that could inform the VA's five-step approach to secondary service-connection aggravation claims. In reviewing these concepts, it is important to note the fact that nearly all jurisdictions have been impacted to some degree by the law's historical reluctance to provide compensation for emotional harm. The legal system's longstanding suspicion of mental health disorders is readily apparent in the requirement that a plaintiff provide proof of physical injury to support a claim of emotional distress.[335]

Although the law's skepticism toward mental health disorders has changed, there is still no uniform legal rule across jurisdictions regarding how to assess damages in cumulative trauma cases involving psychological harm.[336] This lack of uniformity is most evident in the application of the "eggshell" or "thin skull" plaintiff rule to psychological trauma. Normally, in the context of physical harm, the thin skull plaintiff rule holds that, no matter how vulnerable a specific individual is to injury based on a pre-existing condition, the culpable defendant will "take the victim as he finds him," and will be responsible for the full extent of the injuries incurred.[337] However, jurisdictions differ in their application of this rule, with some refusing to "extend [it] to claimants with an eggshell psyche."[338] This means that, in assessing liability, courts are often asked to "distinguish between the

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335 *See, e.g.*, J. Stanley McQuade, *The Eggshell Skull Rule and Related Problems in Recovery for Mental Harm in the Law of Torts*, 24 CAMPBELL L. REV. 1, 3–4 (2001) (explaining that "[t]he law has always viewed mental disorders with some suspicion"); *see also* GARY B. MELTON ET AL., PSYCHOLOGICAL EVALUATIONS FOR THE COURTS: A HANDBOOK FOR MENTAL HEALTH PROFESSIONALS AND LAWYERS 405 (3d ed. 2007) (noting that hostility to claims for mental injury often reflects concerns related to demonstrating causal links, when the cause of a mental injury is uncertain, as well as "a fear of malingering").

336 Smith, *supra* note 309, at 757.

337 Michael J. Pangia, *Posttraumatic Stress Disorder: Litigation Strategies*, 64 AIR L. & COM. 1091, 1092 (1999) ("It is a widely accepted legal princi[ple] that you must take the plaintiff as you find him, regardless of whether the same injury would not have occurred in the so-called normal person."); *see also* Brown, *supra* note 260, at 47 ("The classic eggshell plaintiff is a person who is extremely vulnerable to even minor trauma but is asymptomatic prior to the injury.").

338 Brown, *supra* note 260, at 47; *see also* Rachel V. Rose et al., *Another Crack in the Thin Skull Plaintiff Rule: Why Women with Post Traumatic Stress Disorder who Suffer Physical Harm from Abusive Environments at Work or School Should Recover from Employers and Educators*, 20 TEX. J. WOMEN & L. 165, 180–81 (2011) ("While the norm among jurisdictions is to apply the 'thin skull' rule to pre-existing physical conditions, there remains little consensus about its application to mental injuries.").

ordinarily sensitive person and a supersensitive person"[339] and to deny compensation to those persons whose harm could not have been expected to have befallen the ordinarily sensitive person.

1. Objective Reasonableness

Applied to emotional harm, the eggshell plaintiff rule holds that where "the defendant's conduct would subject him to liability for severe distress to a reasonable person, he is also liable for damages to an especially sensitive person."[340] While the VA does not overtly recognize "objective reasonableness" within its inquiries on aggravation, and, in fact, the CAVC recognizes a liberalized PTSD standard which allows for a causal connection to traumatic events that would not be likely to result in the same effect on "almost everyone,"[341] such considerations often inform mental health evaluations and adjudicators' analyses in practice. Reasonableness most commonly arises in the consideration of whether a traumatic incident is severe enough to meet the *Criterion A* threshold for the causal event in a PTSD diagnosis.[342] Under this diagnostic standard, "[i]n sexual harassment cases, most triggering incidents simply do not constitute life-threatening events."[343] In a noteworthy example

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339 Brown, *supra* note 260, at 47; *see also* Pangia, *supra* note 337, at 118–19 ("[W]hen it comes to mental or emotional trauma, some jurisdictions may not allow a recovery for the 'supersensitive' or predisposed psyche.").

340 DAN B. DOBBS ET AL., THE LAW OF TORTS § 397 (2d ed. 2012); *see also* Smith, *supra* note 309, at 756 ("In most instances, before any liability may be imposed, courts require a showing of a particular degree of emotional harm—usually 'severe'—that 'a reasonable person in the same circumstances would suffer.'") (internal citation omitted); RESTATEMENT (THIRD) OF TORTS (LIABILITY FOR PHYSICAL AND EMOTIONAL HARM) § 46 cmt. i (Tentative Draft No. 5, 2007) (recognizing liability if the acts "would cause reasonable persons to suffer serious emotional disturbance").

341 Cohen v. Brown, 10 Vet. App. 128, 141 (1997).

342 *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, § 309.81, at 463–64 (4th ed. 2000) (describing examples of causal events, such as "violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness," which are normally life-threatening in nature). Some psychological researchers have purposely omitted "verbal sexual harassment without threats of force" from their definition of "sexual trauma because such comments cannot meet the Criterion A for PTSD." *See also* Himmelfarb et al., *supra* note 3, at 838.

343 FOOTE & GOODMAN-DELAHUNTY, *supra* note 258, at 131. However, "most" does not mean all. *See, e.g.*, Katz, *supra* note 3, at 485 (observing that "verbal sexual harassment was the most prevalent and the strongest predictor of symptoms and readjustment" in a sample of veterans reporting MST); Mindy B. Mechanic et al., *Mental Health Consequences of Intimate Partner Abuse: A Multidimensional Assessment of Four Different*

mentioned previously, a male veteran who was raped during childhood later suffered MST arising from repeated sexual advances from a sergeant who he perceived was "grooming him for sex."[344] The senior sergeant's behavior triggered adverse psychological reactions that revived issues related to his childhood abuse.[345] However, the medical evaluator found that the PTSD had developed in childhood and that the sexual advances, though sufficiently disruptive to aggravate "residual PTSD," were not serious enough to meet the threshold for PTSD's causal event requirement.[346] In reaching such determinations, there may indeed arise the question of whether the type of MST complained of would cause a reasonable person to experience the same reaction.

The second manner in which reasonableness may still find its way into the VA evaluation of cumulative trauma involves comparative assessments of different trauma types. In many cases, the adjudicators and mental health evaluators directly acknowledge that they consider the type of reaction a normal person would have to a particular type of trauma, which influences their selection of *the* primary cause of current symptoms from a range of potential contributors. In the previously mentioned BVA decision regarding the veteran who was sexually molested by a brother-in-law for five years, the evaluator's major reason for finding insufficient aggravation was the evaluator's belief that "repeated near-rapes at age [ten] and later" could not "be objectively characterized as having a higher degree of severity" than attempted rape and pervasive sexual harassment during Service."[347] In another noteworthy example, the medical evaluator and the Board considered the claim of a former military policewoman who suffered repeated physical and sexual abuse as an abandoned child during moves from one orphanage to another. They compared these "dozens" of events from her childhood, "all basically having to do with sexual abuse and rape," to her account of in-service abuse at the hands of a senior-ranking physician who had touched her inappropriately near her vaginal area during a medical examination while

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Forms of Abuse, 14 VIOLENCE AGAINST WOMEN 634, 649 (2008) (discussing that some research results indicate that "emotional and verbal abuse . . . [are] significant individual predictors . . . to posttraumatic stress symptoms in battered women").

344 Name Redacted, No. 07-22 565, 2012 BVA LEXIS 16051, at *16 (B.V.A. June 5, 2012).

345 *Id.* at *19 ("[T]he Veteran's belief that he was being advanced upon would be enough to exacerbate the psychological symptoms resulting from the history of sexual trauma.").

346 *Id.* at *18–19 ("The examiner said that, even if the sergeant had made advances toward the Veteran, it would not satisfy the Criterion A for a diagnosis of PTSD.").

347 Name Redacted, No. 98-13 395, 2004 BVA LEXIS 57092, at *44 (B.V.A. Oct. 12, 2004).

mentioning sexual acts.[348] To the medical evaluator and the Board, "[e]ven if the incident where Lt. Col. D.K. touched her leg is accurate, this would fall short of a *rape-type incident* and would not necessarily be considered traumatic."[349] While the scientific research rejects the view that the magnitude of trauma can be ascertained simply by similarity of type, the Board often adopts a theory of service-connection that requires rape as a condition precedent to awarding service-connection in a cumulative trauma scenario. The approach unfairly minimizes the harm of non-penetrative sexual assaults.

Even though the VA has not adopted the eggshell plaintiff doctrine outright, some noteworthy points from courts and scholars can assist claimants in advocating to receive benefits for their injuries. The greatest insight emerges from the fact that apportionment of different psychological injuries requires psychiatrists and mental health professionals to adopt unconventional methods in arriving at causal estimates. However, rather than using a traditional "working theory" approach to causation, as mental health professionals do in treatment settings, existing legal standards force professionals to adopt a "binary ('yes, no') and linear (Event A causes Condition B)" approach.[350] In this transformation, the courts perpetuate a "legal fiction" that such precision is attainable, when the assessments of causation are inevitably and inescapably "normative" and "value-based."[351] While the courts often lack specific standards and jury instructions explaining the precise steps of apportionment,[352] some guidance does exist. Professionals have, for example, developed analytical structures that can help to yield rough numerical equivalents. Importantly, Professor Gary Melton and his colleagues offer an analytical taxonomy that differentiates between "sole cause," "major factor," "aggravating factor," "minor factor," and "unrelated factor."[353] Professor Jacob Stein further classifies the worsening of harm in four different ways:

- Activation of a previously latent condition;
- Re-activation of a condition that was previously under control;

348 Name Redacted, No. 02-15 018, 2007 BVA LEXIS 25523, at *11–12 (B.V.A. Oct. 10, 2007).

349 *Id.* at *13 (emphasis added).

350 Smith, *supra* note 309, at 759, 762 (citing Izabela Z. Schultz, *Psychological Causality Determinations in Personal Injury and Workers' Compensation Contexts*, *in* PSYCHOLOGICAL INJURIES AT TRIAL 102, 104 (Izabela Z. Schultz & Douglas O. Brady eds., 2003)).

351 Smith, *supra* note 309, at 763.

352 *Id.* at 760.

353 MELTON ET AL., *supra* note 335, at 420.

- Aggravation of a preexisting physical or mental condition or disease; and
- Acceleration or hastening of disability or death.[354]

Because VA decisions routinely require mental health evaluators to articulate a specific theory for aggravation in secondary service-connection claims,[355] use of this taxonomy will go far in supporting a claim. For any case involving a preexisting condition, Stein then divides the history into three parts: "[1] [T]he prior condition, [2] the recovery period, if any, and [3] the subsequent injury."[356] Within this context, he recommends the following targeted inquiries to approximate interactive influences:

- Did the prior medical symptoms and suffering subside?
- Did the plaintiff continue with medical treatment during the recovery?
- Was the plaintiff's ability to work affected during the recovery period?
- Did he or she take an inordinate number of sick or vacation days?
- What does the employer say about the plaintiff's ability to work during the recovery period?
- Finally, what about the plaintiff's current condition? Is it different from the prior condition or does it differ in degree?[357]

These inquiries can be helpful in proving the nature of aggravation suffered by the VA claimant. While a number of these considerations might even be considered as neutral or even negative evidence against proving that MST occurred, the same factors can simultaneously weigh rather heavily in support of establishing a lower pre-aggravation baseline by demonstrating a dormant condition that did not activate until the infliction of the MST.

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354 JACOB A. STEIN, 2 STEIN ON PERSONAL INJURY DAMAGES TREATISE § 11.1 (3d ed. 2013).

355 *See, e.g.*, Ridgway, *supra* note 309, at 409–11 (discussing various criteria for an adequate medical opinion).

356 2 STEIN, *supra* note 354, at § 11.1.

357 *Id.*

2. Inevitably Indivisible Harms

The Eggshell Plaintiff rule usually arises "to explain why [plaintiffs'] injuries may initially seem out of proportion to the initial injury . . . ."[358] Other principles arise independently in cumulative trauma cases. The most notable concern deals with apportionment of damages between different emotional harms during one's lifespan to quantify the nature of aggravation. While juries are routinely instructed to conduct these analyses, the surprising reality is that they do not receive any objective standards informing them how to engage in the process.[359] Quantification of damages, which is recognized as "one of the most challenging tasks of fact finders" in the civil tort system, raises precisely the same issues as Section 3.310's amendment requiring a pre-aggravation baseline.[360]

Many courts rely on the policy considerations expressed in the *Second Restatement of Torts* for holding the defendant liable for the entire damages if it is not possible to allocate respective amounts between different injuries:

> The reason for the exceptional rule placing the burden upon the defendant is the injustice of allowing a proved wrongdoer who has in fact caused harm to the plaintiff to escape liability merely because the harm which he has inflicted has combined with similar harm inflicted by other wrongdoers, and the nature of the harm itself has made it necessary that evidence be produced before it can be apportioned. In such a case the defendant may justly be required to assume the burden of proving that evidence, or if he is not able to do so, of bearing the full responsibility. As between the proved tortfeasor who has clearly caused some harm, and the entirely innocent plaintiff, any hardship due to lack of evidence as to the extent of harm should fall upon the former.[361]

While some might argue that the military is similar to a sexual assault perpetrator since MST occurs at the hands of senior-ranking personnel,[362] or that the military leadership has

358 Smith, *supra* note 309, at 761.

359 *Id.* at 757 ("[T]here is no framework in either psychiatry or the law to guide fact finders on the appropriate use of psychiatric evidence to resolve factual disputes regarding causation and the apportionment of psychological damages.").

360 *Id.* at 781–82.

361 RESTATEMENT (SECOND) OF TORTS § 433(B)(2) cmt. d (1965).

362 Clearly, senior-ranking personnel have greater access to subordinates and more power to influence

too often condoned sexual assaults within its ranks,[363] the disability application process is distinguishable. Service-connection is not analogous to negligent hiring or retention which would make an employer accountable for knowing of, or enabling, sexual assault or harassment, nor does service-connection place the military in the shoes of the perpetrator. Even acknowledging these differences, a major public policy justification for imposing full liability in cases of aggravation still exists because of the nature of MST. The Eighth Circuit case of *Jenson v. Eveleth Taconite Co.* identified the complexity of accounting for the causal contribution of sexual trauma among other potential stressors. *Jenson* involved a plaintiff who had been raped prior to commencing employment wherein she suffered additional trauma: "Plaintiffs were required to show that defendants' sex discrimination and sexual harassment were substantial factors in causing their emotional harm . . . . [W]hat the plaintiffs did not have to prove was that other factors did *not* contribute to that harm."[364] It is clear that imposing a burden on veterans to show that factors, other than the service-related trauma, did *not* cause or contribute to their injury, would result in substantial injustice.

Another case highlights the problematic manner in which many experts encourage unfair burden-shifting in cumulative trauma cases. In its 2009 *Elk v. United States* decision, the Court of Federal Claims seized the opportunity to address the manner in which a defense expert used common tactics to downplay the nature of sexual abuse suffered by a Native American woman who endured years of unwanted sexual overtures from the same Army recruiter that culminated in a more serious sexual assault after he drove her to an isolated area. The court condemned the expert's effort "merely to toss out a litany of 'stressors' that might have contributed to [the victim's] mental state at any given time."[365] The court further

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their careers. *See, e.g.*, Carol O'Brien et al., *Difficulty Identifying Feelings Predicts the Persistence of Trauma Symptoms in a Sample of Veterans who Experienced Military Sexual Trauma*, 196 J. NERVOUS & MENTAL DISEASE 252, 253 (2008) (noting in their study that "[78%] of women and 73% of men [who experienced MST] reported that the rank of the perpetrator was higher than their own"); Anne G. Sadler et al., *Factors Associated with Women's Risk of Rape in the Military Environment*, 43 AM. J. INDUS. MED. 262, 266 (2003) (observing in their study that one-forth of MST victims in a study did not report their abuse because the rapist was a ranking officer).

363 Jane Harman, *Rapists in the Ranks: Sexual Assaults are Frequent, and Frequently Ignored, in the Armed Services*, L.A. TIMES, Mar. 31, 2008, at A15 ("The absence of rigorous prosecution perpetuates a culture tolerant of sexual assault—an attitude that says 'boys will be boys.'").

364 Jenson v. Eveleth Taconite Co., 130 F.3d 1287, 1294 (8th Cir. 1997).

365 Elk v. United States, 87 Fed. Cl. 70, 86 (2009). To the court, although the expert "accused [the victim] of being 'unreliable' and 'manipulative,' it was *he* who fit that description" based on the tactics he employed so carelessly to refute causation. *Id.* at 87.

disapproved of comparisons between life events for the purpose of establishing which one was supposedly more traumatizing than the others. This case has direct relevance to cumulative trauma cases at the VA because BVA opinions are rife with the same faulty and unsupported logic in cases denying secondary service-connection for MST.

In *Elk*, the expert testified: "My professional experience, with multiple victims of sexual assault and actual rape, suggests that where the assault was relatively minor, and arguably represented a misunderstanding, the emotional distress attributable to a miscarriage would have been significantly greater."[366] The court rejected the testimony as a strong example of "closed-mindedness," noting how, "[a]t all events, Dr. Mills never remotely explained why the presence of these additional stressors meant that [the victim] was not experiencing [PTSD] as a result of the assault."[367] The court went on, "[t]he weight placed by [defendant and expert] on [the victim's] prior emotional problems seemingly proceeds from the *faulty notion* that they somehow relieve defendant from liability."[368]

The *Elk* decision is important because it holds that it is insufficient in a case of cumulative trauma apportionment merely to cite potential stressors without demonstrating how they actually supersede the harmful effects of the subsequent sexual trauma. *Elk* is also important because it clearly challenges attempts to overstate the impact of previous life events as pre-existing "significant" sources of trauma.[369] The mere reference to a friend's suicide attempt, the death of a close family friend, and a miscarriage were insufficient to deny the causal link between the plaintiff's injuries, and the assault committed by the recruiter. Furthermore, in addressing "supposed inconsistencies and omissions" noted by the expert in support of his analysis, the judge explained:

> [I]n the end, there was no factual basis to support any of his views, nothing, that is, except the naked impression that [the plaintiff], her parents, and other relatives were exaggerating her injuries for financial gain. But such armchair cynicism, even by a forensic psychiatrist, is not a substitute for hard evidence or unbiased analysis.[370]

366 *Id.* at 84 n.23 (citing expert).

367 *Id.* at 85.

368 *Id.* (emphasis added).

369 *Id.* at 84–85.

370 *Id.* at 87. Notably, the court gave only the weight of mere armchair speculation to the following factors that the examiner heavily relied upon:

All of these points about common tactics in forensic evaluations of cumulative trauma offer prescient insights into the proper weight to be placed on various conclusions by mental health examiners that RO adjudicators too often take at face value when evaluating these claims. Namely, adjudicators place an unjust burden on the veteran by demanding precise quantification and clearly-identified theories, while they comparatively give undue deference to experts' opposing theories of intervening and superseding causes of aggravation despite the fact that these opinions have no such indicators of reliability.

3. Best Practices in Conceptualizing the Interaction of Trauma Types

The effects of any traumatizing event on an individual will largely depend on personal factors because people react differently to the same traumatic events.[371] Every evaluation of trauma in a specific individual will inevitably require fact-specific analysis that carefully considers the service member's unique history. Despite an inherent level of relativity, and the challenges of these evaluations, scientific studies of cumulative trauma—particularly multiple types of sexual trauma over the life course—have identified optimal methodologies for considering combined effects on a person's mental condition. Though the scholarship uses different names for cumulative trauma, e.g., "retraumatization," "revictimization," "cooccurence," "cumulative exposure/effects," "lifetime trauma," "lifespan victimizations," "polytraumatization," and "poly victimization,"[372] this research provides claimants and mental health evaluators with a better idea of what theories are the most sound. This scholarship can also help evaluators and advocates construct more defensible models of causation to deal with the magnitude of specific traumatic events in a manner that also meets the VA's requirement for an aggravation nexus, permanent worsening of the condition, and an identifiable pre-aggravation baseline, while challenging

- Failure to disclose to the examiner that she had received psychiatric treatment a year prior to the attack;
- her own attribution of some depressive symptoms to other life events besides the attack;
- indications on psychometric tests that she had secondary motivations;
- inconsistencies between statements she made to investigators about the attack with her later deposition testimony; and
- inconsistencies between a statement she provided and a witness's recollection of the same events.

Id. at 83–84.

371 FOOTE & GOODMAN-DELAHUNTY, *supra* note 258, at 125 ("The severity of the target's response [to sexual harassment] may vary as a function of the personal vulnerability of the target.").

372 Scott-Storey, *supra* note 56, at 136.

the assumption that MST is comparatively less severe than pre-enlistment abuse and is therefore insufficient to generate or aggravate current symptomatology. While there are some who suggest that childhood sexual abuse, when present, automatically accounts for current severe symptoms,[373] the issue is far more complex and current research rejects this common assumption.

It is, no doubt, "difficult to disentangle the effects of" different sexual assaults occurring over time and of "sexual assault from the effects of other traumatic events."[374] But, the current research, while clearly still developing and leaving a number of questions unanswered,[375] has led to scientifically supported conclusions about survivors of multiple traumas at different stages in their lives. At the outset, we recognize the commonsense finding that longer and more intense acts of child abuse are more likely to result in adult mental health conditions.[376] However, we equally recognize that the task of apportionment cannot simply stop there. Instead, this statement must be balanced against these additional factors:

- Research has generally established a "dose, response" model, in which the greater the number of traumatic events, the greater the psychological symptoms;[377]

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373 FOOTE & GOODMAN-DELAHUNTY, *supra* note 258, at 133 ("[S]ome legal and mental health professionals have concluded that child sexual abuse is a source of a number of emotional problems that may be mistaken for reactions to sexual harassment.").

374 Zinzow et al., *supra* note 39, at 234.

375 *See, e.g.*, Scott-Storey, *supra* note 56, at 139 ("[W]hat remains unclear in the cumulative [trauma] literature is whether every different type of abuse or experience of abuse has an incrementally worse impact on health? Or does there come a point when the cumulative impact on health becomes capped, in which no differences are seen?"); *id.* at 141 ("[I]t is still unclear whether each additional adversity or cumulative experience makes the outcome worse, or whether some adversities potentiate the harmful effects of other adversities.").

376 FOOTE & GOODMAN-DELAHUNTY, *supra* note 258, at 136 (observing that (1) "the more severe the sexual abuse (i.e., penetration as compared to fondling) and [(2)] the longer the duration of the abuse (i.e., multiple incidents over multiple years), the more likely that the child sexual abuse victim will be diagnosed later with Borderline Personality Disorder").

377 *See, e.g.*, Victoria M. Follette et al., *Cumulative Trauma: The Impact of Child Sexual Abuse, Adult Sexual Assault, and Spouse Abuse*, 9 J. TRAUMATIC STRESS 25, 33 (1996) (observing that "[e]xposure to multiple types of trauma experiences may affect a client's rate of recovery from subsequent traumatic events"); Scott-Storey, *supra* note 56, at 137 (noting that "more experiences of abuse, whether repetition of the same type, differing types, or a combination of both, result in health outcomes that differ from those associated with an isolated experience of abuse").

- Consideration of the cumulative impact of trauma over the life course is more predictive of current symptomatology than trauma inflicted at any single period;[378]
- There appears to be a certain threshold for number of traumatic incidents over time after which the cumulative impact of these traumas becomes more harmful on mental health;[379]
- Childhood sexual abuse appears less predictive of victimization and current symptomatology than more recent abuse;[380]
- Some experts believe the most severe and problematic cumulative trauma diagnosis for mental health professionals involves the combination of combat trauma with MST, not child sexual assault and MST;[381]
- Researchers have developed specific diagnostic categories and assessment measures for Cumulative Trauma Disorders,[382] which are more accurate for addressing mental health conditions because existing measures largely fail to capture the additive and interactive effects of

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378 *See, e.g.*, John Briere et al., *Accumulated Childhood Trauma and Symptom Complexity*, 21 J. TRAUMATIC STRESS 223, 223 (2008) (observing that "the combined effects of . . . multiple [trauma] experiences" are different from the effects of "solely their last or most severe trauma exposure"); Giroa Keinan et al., *The Association Between Cumulative Adversity and Mental Health: Considering Dose and Primary Focus of Adversity*, 21 QUALITY LIFE RES. 1149, 1149 (2012) (describing how "[s]tudies show that lifetime cumulative adversity exerts a more lasting influence on functioning than discrete events do").

379 Keinan et al., *supra* note 378, at 1154 ("[E]xposure to a dose of three or more potentially traumatic events in life [results in] long-term posttraumatic effects on present psychological functioning.").

380 *See, e.g.*, FOOTE & GOODMAN-DELAHUNTY, *supra* note 258, at 130 (noting study results involving sexually harassed individuals with a history of childhood sexual abuse, in which "[t]he presence or absence of a history of any type of trauma did not predict the presence of PTSD symptoms" and in which "[a]pproximately equal proportions of [victims] . . . reported a pattern of symptoms congruent with PTSD"); Scott-Storey, *supra* note 56, at 139 (noting "*recency of the [sexually traumatic] experience*, relationship to the perpetrator, and number of perpetrators" as some of the most powerful predictors of worse health outcomes among women) (emphasis added).

381 Williams & Bernstein, *supra* note 36, at 142–43 (noting that "the psychological trauma inflicted on female soldiers as a result of MST in conjunction with war trauma is so enormous that health care providers have found caring for this population to be very challenging").

382 *See, e.g.*, Ibrahim A. Kira et al., *Cumulative Trauma Disorder Scale (CTD): Two Studies*, 3 PSYCHOL. 643 (2012) (developing a specific scale to better account for multiply traumatized populations).

accumulated traumas.[383]

Recognition of these basic premises has enabled researchers to reach a consensus on three basic errors in the assessment of combined traumas. First, it is misleading to adopt a linear approach tracing current symptoms to discrete events, when considering the impact of cumulative trauma over time.[384] Second, "misleading or biased results" are likely to result when the evaluator "focus[es] on one particular stressor type" without accounting for the totality of "complex trauma."[385] Third, the prevailing focus on past trauma, rather than the more recent traumatic event, is not optimal.[386] Finally, attributing current mental health symptomatology to childhood sexual trauma, rather than adult sexual trauma, should not be the result simply because an adult is more likely to be sexually traumatized if he or she experienced childhood sexual assault.

Complex trauma cases often involve dissociative reactions that easily produce severe mental health consequences based on a particular individual's manner of processing the trauma. As the North Carolina Supreme Court favorably noted in a case involving adult sexual harassment as aggravation of a condition related to CSA, a dissociative disorder occurs when a person has stored information in their psyche as segments rather than a whole through a process of avoidance. "A traumatic experience can cause the parts to reunite, and the person then remembers their bad experience."[387] This reality makes it far less accurate

383 *See, e.g.*, Thomas Ehring & Dorothea Quack, *Emotion Regulation Difficulties in Trauma Survivors: The Role of Trauma Type and PTSD Symptom Severity*, 41 BEHAV. THERAPY 587, 587 (2010) (noting criticism of the PTSD diagnosis on the basis that it is ill-suited to account for "the more complex problems experienced by adult survivors of childhood interpersonal trauma, especially if the traumatic events have occurred repeatedly or chronically").

384 Keinan et al., *supra* note 378, at 1155 ("[T]he impact of accumulating adverse experiences in life is contingent upon certain psychological thresholds, and . . . this impact is not necessarily linear but rather modulated by aggregation of experiences."); *see also* Scott-Storey, *supra* note 56, at 139 ("The value of examining an entire life history of abuse so [as] not to falsely attribute health outcomes to abuse sustained at a specific point in time.").

385 Murdoch et al., *supra* note 251, at 1133; *see also* Scott-Storey, *supra* note 56, at 137–38 ("[O]nly examining a single type of abuse could conceal the potentially augmented effects from combined types of abuse on health outcomes." Further, "psychological abuse, stalking and harassment, workplace bullying, and witnessing violence . . . have all been found to independently contribute to poorer health.").

386 Kira et al., *supra* note 382, at 643 (noting a number of problems with the current status of trauma theory, including that "[i]t is more focused on past traumatic events, commonly ignoring the present ongoing and those continuous traumatic stressors . . . [and that this] tends to obsure the dynamics of the ongoing traumatic events that have unique effects that may modulate, add to or amplify the effects of the past traumas").

387 Poole v. Copland Inc., 498 S.E.2d 602, 602–04 (N.C. 1998). The *Poole* Court reinstated the jury's

to assign greater causal weight to trauma simply by virtue of its facial severity, or the time period when it occurred. Sexual harassment alone can undo progress made in the treatment of past rape or sexual assault, creating permanent harm. It is simply wrong to assume that there must be trauma of an identical or worse nature in order for subsequent MST to meet the threshold for a qualified secondary service-connection aggravator. Instead, for example,

> [a] man who experienced abuse as a child and then served in a combat zone in war can start experiencing traumatic symptoms by witnessing a car accident years later. If none of his previous traumas were resolved, they may have been bubbling below the surface, waiting for one more traumatic event to occur before the symptoms exploded.[388]

Along these very same lines, in a case involving sexual harassment and sexual assault, characterized by non-consensual kissing by the supervisor of a corrections officer who had suffered child abuse and rape by her father in childhood, the District of Columbia District Court upheld a theory of aggravation in which the abuse by a superior at work "tapped into deeply repressed emotions about her childhood abuse" because he had "*authority over her* . . . that destroyed the coping mechanisms that she had constructed over the years, and caused her to react so severely to the harassment."[389] The observations above offer indispensable guidance because they refute the default assumption in most VA adjudications that childhood sexual trauma is more severe and accounts for more current mental health maladies than later sexual abuse occurring in adulthood for a shorter period of time.

The studies further underscore the pivotal nature of the context surrounding the more recent events. As noted in a 2007 study of MST survivors by Rachel Kimerling et al., which accounted for pre-enlistment sexual trauma, "the effects of previous trauma or

award of damages when sexual harassment in the workplace aggravated a mental health condition initially caused from multiple incidents of child and adult sexual abuse, including a two-week period when she was locked in a closet, bound by duct tape, and intermittently raped by one of her father's friends. The theory of aggravation was that the workplace sexual trauma "had caused a flashback, and all the earlier experiences were remembered, (which) caused serious mental health problems for the plaintiff."

388 Shiloh A. Catanese, *Traumatized by Association: The Risk of Working Sex Crimes*, 74 FED. PROB. 36, 36 (2010).

389 Webb v. Hyman, 861 F. Supp. 1094, 1103 (D.D.C. 1994) (emphasis added). *Compare Webb*, 861 F. Supp. 1094; Poole v. Copland Inc., 498 S.E.2d 602, 602–04 (N.C. 1998) *with* Pokrifchak v. Weinstein, No. 16314-8-III, 1998 WL 303732, at *1, *3 (Wash. Ct. App., June 9, 1998) (finding a lack of proximate cause under circumstances wherein a woman who had been injured in a chain-reaction car collision sued the responsible driver for aggravating mental health conditions related to her child sexual abuse when she unexpectedly remembered the abuse during chiropractic treatments for the injuries from the collision).

civilian sexual assaults do not account for the strong relation observed between MST and PTSD."[390] From a theoretical perspective, it is sound to presume that credible accounts of military sexual abuse—in addition to the factors that generally make adult sexual revictimization more traumatizing[391]—are more likely the *major contributing cause* because of the additional contextual factors surrounding MST: (1) the inherent accessibility of weapons in the military environment increasing perceptions of a threat of physical harm for noncompliance; (2) the inability to remove oneself from the military environment (i.e., being on duty twenty-four hours, seven days per week); (3) the level of betrayal inherent in abuse by someone in whom trust should be implicit by duty and the value of loyalty; and (4) the heightened level of stress already experienced by individuals serving in uniform.[392] This coincides with research suggesting that MST is generally far more harmful at the psychological level than other forms of trauma—such as childhood sexual assault.[393] Ultimately, advocates, mental health evaluators, and VA adjudicators alike must never lose sight of the fact that "characteristics of the military setting and culture may exacerbate the negative consequences of MST as compared to sexual violence that occurs in civilian arenas."[394]

Evaluators can improve the quality of their analyses by treating life events as unrelated to or minor contributors to the current mental health condition unless the evidence shows ongoing psychiatric care and symptoms prior to the MST. This will help avoid placing an unjust burden on the claimant. Proceeding from this point, within the taxonomy of unrelated to sole aggravating factor, the evaluator may then allocate rough percentage

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390 Kimerling et al., *supra* note 7, at 2164.

391 *See, e.g.*, Scott-Storey, *supra* note 56, at 138 ([R]esearch has consistently supported that the more types of abuse experienced, or cumulative experiences, the worse the health outcomes.").

392 Himmelfarb et al., *supra* note 3, at 844; Katz, *supra* note 3, at 489; Williams & Bernstein, *supra* note 37, at 138 (discussing the particularly harmful consequence of being assaulted by your comrades in PTSD reactions, which "can be worse than being assaulted by strangers or enemies").

393 *See, e.g.*, Kimerling et al., *supra* note 7, at 2164 ("[T]he effects of previous trauma or civilian sexual assaults do not account for the strong relation observed between MST and PTSD."); Alina Surís et al., *Mental Health, Quality of Life and Health Functioning in Women Veterans: Differential Outcomes Associated with Military and Civilian Sexual Assault*, 22 J. INTERPERSONAL VIOLENCE 179, 192–93 (2007); Jessica A. Turchik et al., *Utilization and Intensity of Outpatient Care Related to Military Sexual Trauma for Veterans from Afghanistan and Iraq*, 39 J. BEHAV. HEALTH SERVS. & RES. 220, 221 (2012) ("MST has been found to be more highly associated with PTSD than premilitary or postmilitary sexual assault among veteran women.").

394 Jennifer L. Strauss et al., *Is Military Sexual Trauma Associated with Trading Sex Among Women Veterans Seeking Outpatient Mental Health Care?*, *in* MILITARY SEXUAL TRAUMA: CURRENT KNOWLEDGE AND FUTURE DIRECTIONS 78, 81 (Carolyn B. Allard & Melissa Platt eds., 2012).

equivalents for each of the trauma types presented by a case, as reflected in the *Cumulative Trauma Allocation Scale*, below:

Unrelated	Minor	Aggravating	Major	Sole
0%	25%	50%	75%	100%

Fig. Two—Cumulative Trauma Allocation Scale

Although exact approximations will remain elusive under any model developed, given the "legal fiction" surrounding the task of apportioning emotional harm,[395] this tool can assist evaluators and advocates in establishing a pre-aggravation baseline supported by theoretically sound principles. New MST legislation can certainly eliminate the problems and burdens of cumulative trauma apportionment by exempting MST claims from 38 C.F.R. § 3.310(b)'s pre-aggravation baseline requirement.[396] Until such time, however, the Scale and the current knowledge of the study of complex trauma permit a more defensible and accurate methodology for apportionment. This is far better than the current guesswork applied in these cases that often results in injustice for survivors of MST.

D. Hazing-Related Sexual Trauma

Within the scholarly literature, hazing is defined as "committing acts against an individual or forcing an individual to commit an act in order for the individual to be initiated into or affiliated with an organization."[397] These initiations commonly occur in teams of individuals working toward a common goal, such as fraternities, sports teams, and most notably in the Armed Forces, with the desired effect of enforcing discipline and building cohesion within the groups.[398] The objective of instilling such discipline and cohesion in order to keep troops alive in the worst combat conditions places a different level of significance and sometimes justification on hazing perpetrated within the military, causing

395 Smith, *supra* note 309, at 768, 783.

396 For example, it could include the provision, "In claims related to MST, regardless of prior traumatic events in the Veteran's lifetime, if there is sufficient evidence of the claimed MST, the inability to identify a pre-aggravation baseline under 38 C.F.R. § 3.310(6) will not prevent the finding of secondary service-connection. In cases where the MST played a role in aggravating symptoms, MST will receive a presumptive allocation of 75%."

397 Michelle A. Finkel, *Traumatic Injuries Caused by Hazing*, *in* THE HAZING READER 171 (Hank Nuwer ed., 2004).

398 *Id.*

many commanders to permit it in different forms despite strict prohibitions.[399]

The military branches have adopted specific definitions for hazing, such as "any conduct [in the Army] whereby one military member or employee, regardless of Service or rank, unnecessarily causes another military member or employee, regardless of Service or rank, to suffer or be exposed to an activity that is cruel, abusive, oppressive, or harmful."[400] Army Regulation 600-20 further provides a non-exhaustive list of specific hazing behaviors, including any form of initiation, "rite of passage," or congratulatory act that involves:

- physically striking another in order to inflict pain;
- piercing another's skin in any manner;
- forcing or requiring the consumption of excessive amounts of food, alcohol, drugs, or other substances; or
- encouraging another to engage in illegal, harmful, demeaning or dangerous acts.[401]

The Regulation is clear, however, that "[h]azing need not involve physical contact among or between military members or employees; it can be verbal or psychological in nature."[402] To this end, many of the BVA cases involving hazing describe brutality at the hands of drill instructors or peers during recruit or basic training, such as physical beatings during "blanket parties,"[403] "belt-lines" in which trainees lashed each other with belts as they moved through a gauntlet of peers, incidents in which they were made to stand at attention until they passed out, or ordeals where they were ordered to roll a grain of sand across a room with their noses.[404] Sometimes, the abuse includes forcible confinement to

399 Hank Nuwer, *Military Hazing, in* THE HAZING READER, 141, 143 ("[B]ecause hazing is perceived by many soldiers to build trust, to continue tradition, and to instill discipline, it shows little evidence of disappearing altogether.").

400 U.S. DEP'T OF ARMY, REG. 600-20, ARMY COMMAND POLICY para. 4-20*a*, at 28 (Sept. 20, 2012) (Rapid Action Rev.).

401 *Id.* at para. 4-20*a*(1).

402 *Id.*

403 Name Redacted, No. 97-01 102, 2009 WL 3963025 (B.V.A. Sept. 28, 2009).

404 Name Redacted, No. 04-00 235, 2008 WL 5513032 (B.V.A. Nov. 17, 2008) (recounting incidents at Paris Island Marine Corps Base recruit training and a resulting claim of PTSD which included being witness to trainee suicides as a result of such treatment).

restricted spaces such as a tank[405] or torpedo tube[406] for long periods of time. Other cases involve "rituals," such as being "involuntarily injected with drugs with shared hypodermic needles,"[407] or being "made to hang upside-down in a wall locker" while a member of an Army Ranger Battalion.[408] Yet other hazing events revolve around the celebrations of promotions or completion of schools, such as the receipt of one's "blood stripe," which can often involve kicks or punches by several senior personnel.[409]

Germane to this Article, perpetrators often incorporate sexual components into hazing conduct in order to attain a sufficient degree of humiliation.[410] These sexual hazing acts can range from forcing a service member to disrobe in the presence of a superior,[411] placing naked initiates close to or in physical contact with others who are naked or clothed,[412] tying or attaching weighted objects to, pulling, forcefully grabbing, or biting the penis, testicles, or breasts,[413] inserting objects into the vagina, penis, or anus,[414] and performing a full range

405 Name Redacted, No. 96-48 854, 1998 WL 35203581 (B.V.A. Mar. 16, 1998) (discussing a two-day period of being confined inside a tank by peers).

406 Name Redacted, No. 98-09 065, 1999 WL 33866060 (B.V.A. Sept. 27, 1999).

407 Name Redacted, No. 04-41 680, 2008 WL 4315475 (B.V.A. Feb. 14, 2008).

408 Name Redacted, No. 07-03 100, 2012 WL 6557415 (B.V.A. Oct. 16, 2012).

409 Name Redacted, No. 04-36 718, 2009 WL 3948540 (B.V.A. Sept. 10, 2009) (addressing a veteran who was kneed in both knees by several non-commissioned officers upon his promotion to E-4).

410 Finkel, *supra* note 397, at 176 (describing sexual assaults perpetrated during the course of hazing).

411 *See, e.g.*, Name Redacted, No. 04-00 235, 2010 BVA LEXIS 47717, at *10 (B.V.A. Nov. 9, 2010) (relating the traumatizing experience of being stripped naked by having his clothes "ripped off by a sergeant").

412 Finkel, *supra* note 397, at 176 (discussing common hazing practices involving targets "coerced into unwanted close proximity with a naked individual").

413 Consider the case of a seaman who was stripped and held down as other sailors forced grease into his anus in a ritual "everyone had to go through." Name Redacted, No. 10-04 579, 2011 WL 4145800 (B.V.A. July 21, 2011). In another case, while aboard ship, a seaman was "aroused from his sleep," blinded with grease, and "led . . . about his area of the ship" by a sailor who was grasping his testicles. Name Redacted, No. 03-34 391, 2006 WL 4441396 (B.V.A. Mar. 30, 2006). Interestingly, here, the medical examiner ruled out PTSD on the basis that "it was much less likely that an individual would develop chronic PTSD from a single isolated incident." *Id.* Notably, this hazing event was not recognized as a sexual assault. *Id.* Contrast this with a different BVA decision in which the former sailor's claim was recognized as a hazing-related sexual assault when "fellow sailors squeezed his testicles until he passed out." Name Redacted, No. 04-190 400, 2006 WL 4435190 (B.V.A. Dec. 4, 2006).

414 For example, a veteran described his initiation into the Navy's "Turtle Club." Upon arriving at his first duty station as a Naval photographer, a number of service members approached him and "asked if he was a

of sexual acts including rape by multiple perpetrators.[415] In the military context, many of these sexual acts often take place with other physically assaultive painful behavior, such as senior cadets forcing United States Military Academy Plebes to "slid[e] down a splinter-filled board while naked."[416] Contrary to the military branches, the VA has not cognized hazing in an operational manner for purposes of claims adjudication, such that proof of hazing alone provides no special consideration or analytical framework. In approximately 188 BVA opinions decided between the years of 1992 and 2013, seemingly none have defined it as a stand-alone term.[417] In the BVA decisions, hazing is usually mentioned in the context of humiliating or abusive treatment by a superior(s) and, when perpetrated in the physical or verbal form, has been analyzed under the standard for personal assault.[418] Without careful attention, not only VA, but many veterans themselves may fail to recognize the sexual component of their abuse. In a 2011 BVA opinion, a soldier explained that he was forced to take cold showers, naked and presumably in the full observation of his ridiculing superior, for up to one-and-a-half hours at a time.[419] The claim was raised and adjudicated as a personal assault involving "hazing," but not as a claim involving military sexual trauma, even though it could easily be cognized as such.[420] In another telling case, it appears that the BVA had difficulty recognizing hazing conduct as sexual trauma when the facts involved a sailor who was held down and slapped on the belly until it became red (i.e.,

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member of the "Turtle Club." Upon his stating that he wasn't, the sailors removed his pants and bit his buttocks until he bled as he was held suspended in the air. Name Redacted, No. 00-24 084, 2009 WL 5505162 (B.V.A. Nov. 19, 2009). In support of his claim for PTSD based on this and other hazing incidents, the same veteran provided evidence in the form of photographs of a group of individuals holding down a service member as another poured powder onto his buttocks. *Id.*; *see also* Name Redacted, No. 08-15 813, 2010 WL 2480353 (B.V.A. Apr. 28, 2010) (describing a hazing incident in which a sailor was summoned to a secluded area where six of his fellow servicemembers "proceeded to bind his knees and legs with chains, hang him upside down, beat him, spray him with spray paint, and sodomize him with a grease gun"); Nuwer, *supra* note 399, at 141, 142 (noting similar accounts of forcible sodomy with objects as commonplace accounts of hazing).

415 Finkel, *supra* note 397, at 176 ("Being 'sexed in' is a common practice . . . requiring initiates to have sexual relations with existing members in order to join.").

416 HUNTER, *supra* note 33, at 48.

417 Search at U.S. Dep't of Veterans Affairs, *Board of Veterans' Appeals Decision Search*, DEP'T OF VETERANS AFFAIRS, http://www.index.va.gov/search/va/bva_search (conducted on July 5, 2013) (using the keyword "hazing" and examining the results of the decisions produced by the system). Some of these cases may involve "hazing" conducted during optical procedures, which would not fall under this category.

418 *Id.*

419 Name Redacted, No. 09-40 912, 2011 BVA LEXIS 14643, at *4 (B.V.A. Apr. 14, 2011).

420 *Id.*

"pink belly"), after which "one fellow dropped his pants and underwear and squatted over [the claimant's] face."[421] The scholarship on hazing describes such acts in the context of sexual assault.[422] Such examples highlight how, for veterans benefits adjudication purposes, it is vital to identify sexual components of hazing and to ensure that veterans claim them as MST and obtain the benefits of additional presumptions in their favor.

E. Unique Hazing-Specific Psychological Reactions

1. Greater Reluctance to Report

The very existence of hazing acts, even without sexual components, is important for two additional reasons related to MST. Scholarship on the effects of hazing reveals that there are hazing-specific psychological reactions that may influence later behavior in response to sexual assault. Where hazing is perpetrated on multiple individuals in a group, there is far more pressure to endure the acts and forego reporting them to remain in the good graces of the group or avoid retaliation.[423] In a poignant example, a veteran who was attending training at Hunter Army Airfield while two months pregnant felt compelled to participate in "friendly hazing," despite her medical needs, given the fact that all trainees there endured hazing in some form.[424] Sadly, this resulted in a miscarriage when she ruptured cysts while she was "low crawling on the floor with a broom in her hands."[425] This compelling and overriding need to please and fit in with the group also consistently results in victims declining to seek necessary medical attention and concealing the true reasons for

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421 Name Redacted, No. 09-35 775, 2013 WL 2105263 (B.V.A. Mar. 25, 2013) After the ordeal, the perpetrators "said that this was his welcome to the First Division on the *USS Kennebec*." *Id.* The BVA remanded the case to determine whether this hazing incident constituted the "sexual" trauma to which a medical professional had referred. *Id.*

422 Finkel, *supra* note 397, at 176 (describing as an act of "sexual assault" the hazing ritual whereby targets may have to endure members' buttocks being shoved in their faces—a practice called 'butting'").

423 Finkel, *supra* note 397, at 178 ("Individuals participate as initiates in hazing activities because they wish to be accepted, well liked, and successful. Furthermore, victims may fear even more deleterious injuries if they do not comply with the hazing activities, including severe harassment or worse physical violence."); *see also* Hoyt et al., *supra* note 4, at 32, 43 (describing a ubiquitous "code of silence" that normally accompanies hazing victimization).

424 Name Redacted, No. 09-46 017, 2012 WL 3266049 (B.V.A. June 1, 2012) (observing how "her squad leader knew she was pregnant but she was still 'initiated/hazed' when she arrived to show that she was one of the team").

425 *Id.*

their emergency/unscheduled medical visits.[426]

The VA apparently does not provide training on these unique psychological reactions, which has unfortunately resulted in the ironic use against the veteran during adjudication of evidence that would actually support the claim. In one 2008 opinion, a sailor claimed that he was anally penetrated in the shower while aboard a ship.[427] In his past experience in high school, he had been a party to "incidents of hazing including the use of a hotdog (but no penetration)."[428] Accordingly, the veteran "did not report the assault to his superiors because he did not know whether the assault was part of an 'initiation or hazing.'"[429] Absent expert evaluation of these points, the BVA adopted a standard of objective reasonableness and found this as a basis to discredit his claim:

> [R]egarding this current assertion that he thought the claimed attack was an initiation or hazing which was the reason that he did not complain to his superiors, it would seem that a sexual assault is so traumatic that it could not be mistaken for "hazing" by any reasonable person . . . . The Board finds that the reasoning for why he did not report it, because he thought that it was an initiation or hazing activity, is an *incredible assertion by its nature*.[430]

While BVA opinions and reasoning have no precedential weight, this one highlights the necessity of educating adjudicators and the BVA on common reactions to hazing and providing expert evaluation in this area specifically. In this case, the veteran had raised his confusion over the interpretation of the assault as a basis for why he had not reported it. He did this for the first time during his adjudication hearing. Another problem highlighted by this sad case is the manner in which the BVA used this fact against him, finding his account

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426 Finkel, *supra* note 397, at 173:

> [W]hether or not [hazing] victims sought medical care was related to the severity of injury. Thus, victims of less severe injuries may not present to medical personnel. Conversely, some patients may be presenting but disguising the etiology of their injuries, resulting in an underreporting of patients who are victims of hazing-related practices presenting to health care providers.

427 Name Redacted, No. 06-33 913, 2008 BVA LEXIS 30404 (B.V.A. Sept. 10, 2008).

428 *Id.* at *19.

429 *Id.*

430 *Id.* at *44–45 (emphasis added).

to be inconsistent since he had never mentioned hazing in his prior evaluations leading up to the hearing.[431] On this basis, claimants and mental health evaluators should also address reasons why hazing is mentioned later in time if it did not appear in previous filings for the sought benefits.

Nonsexual hazing incidents can also influence perceptions of later incidents of MST. Researchers have recognized that when the degrading and humiliating experience occurs on an ongoing basis, victims often come to rationalize their abuse in a permissive manner, believing that it will make them stronger and may even save their lives in combat scenarios.[432] Note the comments of Officer Candidate School hazing survivor Tom Hohan, who saw his daily hazing rituals this way: "It helped me survive [in Vietnam]. OCS and all the hazing steeled me, taught me how to react and function . . . . It was a very intense part of my training and it taught me I could survive."[433] For this reason, when a veteran has been sexually assaulted in an environment where he or she has experienced hazing, whether or not the MST comes from the hazing perpetrator, proof of prior nonsexual hazing incidents may have important corroborating value because it adds factors that have a bearing on the manner in which the survivor conceptualizes his or her sexual traumatization.

2. Serious Effects of Sexual Identity Challenges

A "sexual identity challenge" is a particular form of sexually harassing behavior that calls into question the target's adoption of prevailing gender roles in society, usually that the male target is not masculine enough and the female target is not feminine enough.[434] As explored below, it can also involve acts that force the hazing target to adopt the dress, mannerism, or gender expectations of the opposite sex. Sadly, these challenges have been

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431 *Id.* at *44.

432 Finkel, *supra* note 397, at 178 (omitting internal citations):

> [P]rolonged hazing can lead to a feeling of hopelessness or to the idea that after so much harassment, it would be foolish to "quit." Initiates may pathologically take pride in being able to endure such abusive circumstances. They may also see their participation in hazing as an investment in a more powerful and satisfying social future.

433 Nuwer, *supra* note 399, at 141, 145 (citing Vietnam veteran Tom Hohan).

434 Maureen Murdoch et al., *Functioning and Psychiatric Symptoms Among Military Men and Women Exposed to Sexual Stressors*, 172 MIL. MED. 718, 719 (2007) ("Sexual identity challenges involve shaming comments about the target's supposedly inadequate masculinity/femininity or sexual orientation, as well as pressure to meet hypermasculine behavior norms.").

neglected in the research on military sexual harassment.[435] Within the military, sexual identity challenges occur among both sexes, but are the most prevalent form of sexual harassment among men.[436] Aside from being more common among military men, males often find gender challenges more upsetting than other types of sexual harassment.[437] Prior to the repeal of the Don't Ask, Don't Tell policy in 2011, when homosexual orientation was a basis for involuntary separation from the service or criminal prosecution based on certain homosexual acts,[438] gender challenges often related in some way to homosexuality because of the additional stress they generated.[439] For example, "[t]he most common form of harassment of women in the military is being accused of being a lesbian and demanding that she prove she is not by having sex with the man making the accusation."[440] For males, gender challenges involving homosexuality are most prevalent in the context of hazing, and they likely account for the observation that "males and females view hazing differently."[441]

Commonly, upon crossing the equator in a ship for the first time, the "crossing the line" ritual requires male sailors to "dress like women, act as if they are having sex with one another . . . simulate oral sex by sucking on a section of rubber hose that hangs out the front of the pants of one of the veteran sailors, who is dressed as King Neptune."[442] Another example of a gender challenge adjudicated by the BVA involves a Marine recruit's ordeal at boot camp in which a drill instructor directed another Marine to paint the target's fingernails pink, douse him with women's perfume, and then parade him in front of each

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435 M. Murdoch et al., *Unreliability and Error in the Military's "Gold Standard" Measure of Sexual Harassment by Education and Gender*, 12 J. TRAUMA & DISSOCIATION (SPECIAL ISSUE) 4, 7 ("[S]everal types of experiences important to [men], such as challenges to one's masculinity, are not captured.").

436 Amy E. Street et al., *Gender Differences in Experiences of Sexual Harassment: Data from a Male-Dominated Environment*, 75 J. CONSULTING & CLINICAL PSYCHOL. 464, 465 (2007) ("[M]en most commonly experience lewd or vulgar comments or negative remarks enforcing traditional gender role stereotypes.").

437 Murdoch et al., *supra* note 435, at 719.

438 Herbert W. Titus, *The Don't Ask, Don't Tell Repeal Act: Breaching the Constitutional Ramparts*, 18 WM. & MARY J. OF WOMEN & L. 115, 116–18 (2011) (describing the development of legislation which led to the repeal of "Don't Ask, Don't Tell" on September 20, 2011).

439 Murdoch et al., *supra* note 435, at 719 ("[S]exual identity challenges may be a particularly salient sexual stressor for military personnel because the Armed Forces [used to] prohibit homosexuality.").

440 HUNTER, *supra* note 33, at 102.

441 Nuwer, *supra* note 399, at 141, 145 (noting the research of sociologist Lionel Tiger).

442 HUNTER, *supra* note 33, at 50.

member of the platoon to smell his perfume as their sex object.[443] While the veteran's claim was ultimately denied on the grounds that he could not demonstrate sufficient aggravation and his major depressive disorder resulted more from a "contentious divorce and custody battle over his two daughters," his experience represents a classic gender challenge in the military setting as well as its potential for lifelong deleterious effects on health.[444]

Although "sexual stress among men has received little attention,"[445] research has shown that military men may be *more susceptible* to the mental health effects of verbal sexual harassment than military women.[446] Additionally, when the victimization is physical, "[m]ale rape, more so than any other trauma, leads to the highest probability for the development of [PTSD]."[447] Studies show that "[a]t baseline, men . . . reported significantly more trauma symptoms compared with women" who suffered MST.[448] Hazing likely accounts for much of this outcome. The main reason for this gender differential deals with the fact that such challenges directed at men perpetrated in the verbal, physical, or hybrid form often may result in "confusion concerning sexual identity, masculinity, and sexual orientation after an assault."[449] The service member is often plagued by concerns over whether he was targeted because he was perceived as too feminine or that he might actually be gay or bisexual,[450] which ties directly into societal rape myths about males deserving to be sexually abused when they are or act gay.[451] When a case involves MST

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443 Name Redacted, No. 02-10 748, 2008 BVA LEXIS 5209, at *9 (B.V.A. Feb. 14, 2008).

444 *Id.* at *16.

445 Murdoch et al., *supra* note 454, at 718.

446 *Id.* at 4, 14 ("[E]merging data using other sexual harassment measures suggest that men sexually harassed in the military are at least as adversely impacted by such experiences as women, if not more so.").

447 Jessica A. Turchik & Katie M. Edwards, *Myths About Male Rape: A Literature Review*, 13 PSYCHOL. OF MEN & MASCULINITY 211, 215 (2011).

448 O'Brien et al., *supra* note 362, at 253; *see also* Hoyt et al., *supra* note 4, at 32, 33 ("Psychological symptoms also appear to be more persistent and treatment resistant after MST in men than in women."); Valdez et al., *supra* note 128, at 20, 29 ("Some evidence suggests that males are more vulnerable than females to the negative mental health consequences of MST.").

449 Turchik & Wilson, *supra* note 5, at 269.

450 *Id.* (noting how "heterosexual victims may feel confused about their sexuality and masculinity, especially if their body sexually responded during the assault").

451 Michelle Davies, *Male Sexual Assault Victims: A Selective Review of the Literature and Implications for Support Services*, 7 AGGRESSION & VIOLENT BEHAV. 203, 204 (2002) ("Male victims use male rape myths as a way to blame themselves for the assault."); *id.* at 208 (observing how the internalization of the myth that "all

based on gender challenges, veterans and advocates should ensure that their claims provide sufficient discussion of these points. Very often, the male veteran will not associate such abuse with sexual harassment, even though it has such deleterious effects.[452] If the nature of the abuse is obscured to the veteran because it occurred in the context of hazing, then it will more likely be obscured to the mental health evaluator without proper exploration of the context of military experiences.

3. Physical Corroboration for Masked Hazing Events

Most hazing victims, under additional pressures to conceal the acts, usually from desire to remain in the good graces of the organization, will not report medical complications resulting from these acts.[453] If physical problems are dire, they will often attribute their injuries to different, more innocuous causes.[454] In the field of emergency medicine, physicians have begun to develop methods of identifying masked hazing incidents, which can also be of significant use to claimants wishing to corroborate past hazing events in the military setting. In her extensive review of hazing-related trauma, emergency physician Michelle A. Finkel developed the following "Summary List of Hazing Practices, Mechanisms, and Injuries" to assist emergency room doctors in detecting concealed hazing based on the nature of associated injuries. With permission of Indiana University Press, we reproduce the Summary below in *Figure Three*:

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men who are raped are gay" leads many "heterosexual victims [to] question or become confused about their sexual orientation post-rape"); Turchik & Edwards, *supra* note 447, at 211–12 (discussing nine prevalent male rape myths, including that "homosexual and bisexual individuals deserve to be sexually assaulted because they are immoral and deviant"). After analyzing the MST grants within the VA for males, as opposed to females, it is clear that "VA grants the PTSD benefits of male MST survivors at a significantly lower rate than it grants PTSD benefit claims of female MST survivors." AM. CIVIL LIBERITIES UNION & SERVICE WOMEN'S ACTION NETWORK, *supra* note 57, at 16. Male rape myths may explain this outcome among adjudicators as well.

452 Street et al., *supra* note 436, at 472 ("The use of clear, behaviorally worded questions that avoid the term *sexual harassment* are more effective in addressing males' history of harassment because males are less likely to define their own experiences as sexual harassment.").

453 Finkel, *supra* note 397, at 173.

454 *Id.*

Summary List of Hazing Practices, Mechanisms, and Injuries

Hazing practices	Mechanism	Injuries
Alcohol, binge drinking	Acute alcohol intoxication	Aspiration, alcoholic coma, hematemesis, injuries associated with concomitant hazing practices
Beating/paddling/ whipping/striking	Blunt trauma	Intra-cranial, -thoracic, -abdominal; extremity
Blood-pinning	Penetrating trauma to chest	Superficial chest trauma
Branding, tattooing/ cigarette burning, burning	Burns	1st-, 2nd-, 3rd-degree burns; oropharyngeal and esophageal burns
Calisthenics	Heat-related Cardiac	Syncope, vomiting, end-organ damage, including seizure and coma Ischemia in patients with underlying heart disease
Confinement in a restricted area	Heat-related Hypoxia	Syncope, vomiting, end-organ damage Multi-organ system failure, hypoxic brain damage
Consumption of nonfood substances	Toxicity to GI tract	GI distress
Drowning, near-drowning	Hypoxia	Multi-organ system failure, hypoxic brain damage
Falls	Blunt trauma	Spinal cord/c-spine; intra-cranial, -thoracic, -abdominal; extremity
Immersion in noxious substances	Heat-or cold-related	Burns, cold-exposure, dermatitis

Psychological abuse	Verbal humiliation, coercion into performing demeaning acts, forced sleep deprivation	Depression, post-traumatic stress, poor self-esteem
Sexual assaults	Blunt trauma to mouth, vagina, [penis,] anus	Anal, oral, vaginal[, penile] trauma; HIV, hepatitis C and other STDs; unwanted pregnancy

Fig. Three—Potential Indicators of Concealed Hazing Trauma in Medical Records[455]

The above hazing indicators may be apparent in medical documentation submitted with a claim and should be addressed by medical examiners as substantiation that hazing occurred, along with other evidence supporting the claim. Perhaps this could have aided the veteran who claimed PTSD as a result of a hazing incident in which "three [known and named] fellow sailors . . . put shaving cream on his head and testicles and harassed him by grabbing his buttocks and taunted him sexually. He tried to fight and one of them grabbed his penis and twisted it until he passed out."[456] Despite medical records revealing care for testicular trauma in the same general timeframe, the BVA denied the claim based on the contrary information he provided at the time, in which he attributed the injury to a fight with an unnamed person and was "kicked in the testicles."[457] Even where these indicators do not involve different acts of MST, they may still be related as evidence supporting the claimant's later reaction to MST.

4. Raising Hazing as an Alternative Basis for Service-Connection

In some BVA opinions, it also appears that adjudicators can potentially be more accommodating to hazing claims than claims related to MST, specifically sexual harassment, as the basis for PTSD service-connection. A notable BVA opinion involving hazing addressed an Army cadet who had resigned from the United States Military Academy after

455 *Id.* at 171, 181 tbl. 12.1 ("Summary List of Hazing Practices, Mechanisms, and Injuries"). This chart originally appeared as Table 12.1 in Dr. Michelle A. Finkel's chapter, *Traumatic Injuries Caused by Hazing*, which appeared in THE HAZING READER 171, 181 (Hank Nuwer ed., 2004). Reprinted with permission of Indiana University Press.

456 Name Redacted, No. 04-190400, 2006 BVA LEXIS 153338, *11 (B.V.A. Dec. 4, 2006).

457 *Id.* at *9–10.

a year and claimed that he was hazed so routinely about his small physical size that it accounted for his current diagnoses of PTSD and depression, decades later.[458] Despite the fact that there had been some question over whether "complete humiliation based solely on his size" could even qualify as a sufficient stressor for Axis 1 in the PTSD diagnosis, the Veterans Law Judge granted service-connection on appeal, solely on the basis of ongoing nonphysical hazing.[459] The award of benefits on such thin information suggests that hazing may not invoke the same societal rape myths and other biases inherent in sexual assault claims. The opinion was clearly lacking any of the common methods that adjudicators and evaluators have used to attack the basis for more invasive claims. This highlights how any acts of hazing involving sexual components should be raised as personal assault, separate from MST, in addition to hazing as a form of MST. The veteran should support these acts by presenting the accounts of persons who witnessed the veteran's abuse and those who themselves suffered within the same unit. Most importantly, on the basis of the sections above, hazing should not exist as a word on a page, but a concept thoroughly explored and addressed by the examining mental health evaluator.

IV. Tools to Empower Survivors of and Responders to MST: The Self-Guided MST Short Form and Developmental Interview Checklist

Perhaps the greatest challenge facing MST claimants is the difficulty of assembling useful evidence close in time to their sexually traumatic experience. In an effort to provide targeted assistance, we have devised some helpful aids. The Self-Guided MST Short Form is a two-page document that covers the most basic questions relating to an MST claim. It is a form that can be completed entirely by the survivor in concert with the accompanying instructions. The goal of the short form is to capture the most vital information in a single place without making the exercise overly complicated. It can and should be made available to all service members independent of their reporting decisions and while they are serving in the military. It can be used effectively to assist in further development of claims along the guidelines we have described in this Article.

A final component within this Article's practitioner's toolkit is a series of introductory letters to potential witnesses who have information relevant to a claimant's case. We have created Letters of Introduction for lay witnesses, physicians, and mental health professionals to help streamline the process of collecting supporting evidence from other persons. Too

458 Name Redacted, No. 10-25 674, 2012 BVA LEXIS 32517, *8 (B.V.A. Oct. 17, 2012).

459 *Id.* at *8–9 (discussing ridicule by upperclassmen, which included events where "he was told that he was a midget and was backed up against a wall while several cadets told him, one-by-one, why he was an inferior individual").

often, claimants are confronted with the dilemma of approaching potential witnesses without a way to determine the type and nature of information to document. They may have to convince reluctant persons to supply information, they may inadvertently interfere with a potential witness's recollection of events, or they may simply ask a potential witness to include irrelevant details or less probative facts. The three variations of letters each provide examples of the type of information that is most valuable for the purpose of successful MST claims adjudication. All may be found at Appendices G-I.

The MST Survivor Short-Form for Rape, Sexual Assault, and Sexual Harassment

YOUR NAME AND GENDER: _____

1. SERVICE BRANCH:

2. MILITARY OCCUPATIONAL SPECIALTY:

3. DESCRIPTION OF TRAUMATIC EVENT(S): (Describe each event separately. List verbal harassment as a separate event. Also list prior attempted physical or sexual touching as a separate event. List any retaliatory treatment, stalking or post-event harassment as a separate event(s).) Provide a new number for each event).

4. PEOPLE WHO WATCHED OR HEARD THE TRAUMATIC EVENT(S) OR THE EVENTS LEADING UP TO THEM: (For each event listed above, use this space to describe witnesses to the traumatic event or the lead-up to the traumatic event, and the circumstances under which they were in a position to see or hear such information).

5. DATE(S) FOR EACH EVENT: (List dates for each number above within two-month window).

6. LOCATION(S): (Try to be as specific as possible, such as address, building number, intersection of streets, or identifiable locations that were closest to the location if the address is unknown).

7. UNIT(S) OF ASSIGNMENT: (List different units with the corresponding number for each event if units of assignment changed).

8. DUTY STATUS DURING INCIDENT(S): Regular / Reserve / National Guard / Active Duty / Active Duty Training / Inactive Duty Training / Other

9. INFORMATION ABOUT THE PERPETRATOR(S): (If there were multiple perpetrators, list each one separately, if known, along with the corresponding event number).

10. ADMISSION OR APOLOGY OF THE PERPETRATOR: (For each event, use the space below to indicate any apology from or admission by the perpetrator relating to his or her traumatic conduct. Be sure to indicate the date, location, and circumstances of the communication, and any witnesses who may have heard it).

11. OTHER PERSONS TRAUMATIZED BY THE SAME PERPETRATOR(S): (For each perpetrator, use the space below to describe whether you learned of any persons (military or civilian) who were sexually traumatized by the same perpetrator(s). Indicate when you learned this information, from whom you learned it, and whether there was any reporting or response to the other person's experience).

12. TRAUMATIC EVENTS OCCURRING IN A HOSTILE FIRE ZONE? (For each traumatic event, indicate whether it occurred during deployment to a hostile fire zone). YES / NO

13. MEDICAL TREATMENT SOUGHT? (For each traumatic event, indicate the type of medical care you requested (Military / Civilian / Both). This includes an attempt to receive mental health treatment or medical treatment, even if you were turned away. It includes reporting to sick call or going to a local emergency room. An attempt to seek medical care counts, even if you did not share information about the cause of the trauma).

MENTAL HEALTH TREATMENT REQUESTED ONLY, WITHOUT TREATMENT:
MENTAL HEALTH TREATMENT OBTAINED:
MEDICAL TREATMENT REQUESTED ONLY, WITHOUT TREATMENT:
MEDICAL TREATMENT OBTAINED:
DID YOU DISCLOSE THE NATURE OF THE SEXUAL TRAUMA?

- If you obtained medical treatment, have provider complete Disability Benefits Questionnaire.

14. REPORTED TO AUTHORITIES? (For each traumatic event listed, indicate whether you informed an authority of the nature of the sexual trauma. For the purposes of this form, an authority is a person who was acting in an official capacity when you told them. An

authority can be a military or civilian law enforcement officer, a member of the Judge Advocate General's Corps, a mental health provider, a chaplain, a senior ranking person within your chain of command, a Sexual Assault Response Coordinator (SARC) or Victim Advocate, or other persons normally suggested as people who can respond to sexual trauma).

YES / NO MILITARY / CIVILIAN / JOINT / BOTH

- If YES, try to describe exactly what you told each authority and how each authority responded to you. Indicate whether you made a written statement, whether it was by e-mail or by handwriting. You should list each authority you told, even if you did not share all of the information with them or even if you shared different information with them.

- Recover and print each e-mail or handwritten statement you wrote and attach it to this Short Form.

- If there were any other witnesses present who heard you share your experiences with the trusted person, indicate their names, where they were physically located when you described the situation, and anything they did to show you that they heard and understood what you related to the trusted person (this includes, nodding, making comments, or other expressions in response).

- Indicate the result of each statement you made:

15. REPORTED TO ANYONE ELSE? (For each traumatic event listed, indicate whether you informed a non-official person, such as a fellow service member, a friend, a relative, or someone else that you trusted).

- If YES, try to describe exactly what you told each person and how each person responded to you. You should list each person you told, even if you did not share all of the information with them or even if you shared different information with them.

- Recover and print each e-mail or handwritten statement you wrote and attach it to this Short Form.

- If there were any other witnesses present who heard you share your experiences with the trusted person, indicate their names, where they were physically located when you described the situation, and anything they did to show you that they heard and understood what you related to the trusted person (this includes, nodding, making comments, or other expressions in response)

- If YES, for each incident, please submit a signed, dated, written statement from each person, using the attached Letters of Introduction.

16. YOUR OWN RECORDING OF THE TRAUMATIC EVENT(S): (For each traumatic event described above, indicate whether you made a record of it in any form. This includes diary or journal entries, blog posts, website entries, tweets, YouTube videos, recordings, short stories, tape recordings, voice messages, e-mails, or other accounts of what happened, whether you shared them or not).

17. OTHERS' INDEPENDENT KNOWLEDGE OF TRAUMATIC EVENT(S): (List here any individuals who shared information with you about the traumatic event(s), told others about them, spread rumors about them, or somehow learned about them from a source that was not you. Indicate the date, and location of these events and the circumstances surrounding your knowledge of this information).

18. ADDITIONAL INFORMATION? (For any of the events described above, use the space below to provide additional information that will help the claims adjudicator verify the trauma. Other helpful information might include, for example, descriptions of any events where someone witnessed your flashback to the traumatic experience).

The form above and the inquiries contained in it are meant to expand upon the existing prompts located on VA Form 21-0781a, reprinted at Appendix C. At the most basic level, answers to the above questions will provide a claimant with essential, useful information in a single place and will hopefully eliminate the burdens of attempting to obtain evidence long after the fact when such evidence may no longer exist.

CONCLUSION

The number of incoming VA disability benefits claims is outpacing the VA's ability to adjudicate them, as is evident in the well-publicized debate over the claims backlog. Although the VA has undertaken several efforts over the years to eliminate the claims backlog, as of this writing, it is unclear what effect, if any, these most recent efforts will have on expediting claims processing for the many veterans patiently waiting to have their MST claims reviewed and adjudicated. Similarly, despite the recent developments in controlling case law on the absence of official reports to the chain of command, as evidenced by the Federal Circuit's decision in *AZ v. Shinseki*,[460] these developments still

460 *AZ v. Shinseki*, 731 F.3d 1303 (Fed. Cir. 2013).

fall short of a presumption of causation or a moratorium on the requirement to prove, by a 50% chance or greater, that the sexual assault occurred. These developments also fail to eliminate or mitigate problems associated with cumulative trauma or hazing, as raised in this Article. Hopefully, *AZ* and its progeny provide a new opportunity and motivation to critically examine the impact of other concerning evidentiary standards which impose undue burdens on claimants facing the special hardships of sexual trauma and its aftermath. In this Article, we have provided potential MST claimants with a common sense guide to understand how the adjudication process works and to highlight the kinds of targeted evidence necessary to obtain service-connected disability compensation benefits. While much of this Article has cited to VA appellate decisions, we have adopted this methodology specifically to avoid any appellate litigation for MST claimants. The VA's pro-claimant, veteran-friendly mentality notwithstanding, our sampling of the 2,170 MST-related cases decided between 2002 and 2012 shows that those claimants who were the most successful in getting their claims approved were those who had the ability to show evidence of a current disability, and to provide competent, credible evidence that there was at least a 50% chance or greater that the assault occurred, as well as a relationship between the current disability and the assault.

The overarching message of our Article, as reflected by The MST Survivor Short-Form and Letters of Introduction, is to encourage potential MST claimants to be proactive. This means that potential claimants and their advocates should request complete copies of their service medical records and service personnel records prior to or upon discharge from service. It also means that claimants should endeavor to have medical professionals complete the Disability Benefits Questionnaire[461] and/or The MST Survivor Short-Form. We have also found that those claimants courageous enough to share their story with friends, family members, clergy, and/or medical professionals, who in turn provide statements in support of these claims, are not only better suited to successfully navigate the disability compensation adjudication system, but also to get the care and counseling services to which they are entitled and which play an integral role in the recovery process. In fact, we recommend that potential claimants seek treatment from an MST or women's trauma VA program prior to or during their period of application for VA disability compensation benefits because (1) trauma-focused treatment provides the best chances of meaningful treatment for MST survivors;[462] and (2) because the professionals at these centers can assist

461 Copies of the disability benefits questionnaires used by VA examiners for PTSD and mental disorders other than PTSD are available at http://www.benefits.va.gov/compensation/dbq_ListByDBQFormName.asp (last visited Mar. 29, 2014).

462 *See, e.g.*, Williams & Bernstein, *supra* note 36, at 143 ("[A] trauma-informed system uses the understanding of the vulnerabilities of trauma survivors and avoids inadvertent retraumatization.").

in providing high-quality medical opinions in support of the claim based on their extensive knowledge and experience.[463]

Our recommendations may not ultimately resolve many of the major challenges facing MST survivors. There will be survivors who do not want to endure the process of applying for benefits, despite the potential for increased financing and freedom to obtain treatment from a source of their own choosing. For example, some survivors equate disability compensation with payment for being traumatized,[464] and others may not feel worthy of obtaining care or compensation based on intense shame.[465] Likewise, even with targeted evidence that *should*, for all intents and purposes, substantiate an MST disability claim, the systemic problems we have discussed point to the ever-present potential for personal bias, varied preferences for particular types of evidence, and inconsistent standards to influence adjudicators' decisions. Thus, even when supported by The MST Survivor Short Form, and responsive documentation and testimony, there will surely be denials of fully meritorious claims across the different Regional Offices. While our suggested approach cannot solve every problem in the VA system and perhaps unfairly thrusts responsibilities on survivors

463 In Name Redacted, No. 00-20 684, 2002 BVA LEXIS 24704, at *16–17 (B.V.A. Oct. 24, 2002), the grant of benefits at the BVA was due in great part to the statistical information that an experienced physician provided about MST survivors' experiences in general, even though the case presented cumulative trauma issues:

> It was reported that she, like many veterans and non-veterans, had failed to report sexual traumas (rapes) perpetrated on her during service. Considering that the majority of rape victims did not report their sexual trauma to the police (only 10 to 25 percent of rapes were actually reported), that aspect of the veteran's case was not unusual. It was not surprising that the VA had been unable to locate any police report of the incidents. Moreover, the trauma was seldom shared with anyone close to the victim due to the intense guilt and shame felt by the victim as the result of the sexual trauma. The veteran had indicated that it took approximately 2 years of psychotherapy before she was able to completely discuss her sexual traumas while she was in service. Even though she had been the victim of sexual trauma before entrance onto active duty, the additional sexual traumas which she suffered during service appeared to have significantly exacerbated her PTSD. She had used alcohol in the past to self-medicate herself against the distressing symptoms of her PTSD (flashbacks, intrusive thoughts and nightmares).

Normally, these are some of the very facts that adjudicators use to deny claims—without the benefit of a medical examiner with a proper knowledge base. Specialized VA sexual trauma treatment programs contain precisely this type of knowledge.

464 Sayer et al., *supra* note 20, at 704 (sharing the feelings of an MST survivor, "It still makes me feel funny because, point blank, I felt like a whore. I [would be] getting paid for being raped. How many people out there does that happen to?").

465 Mattocks et al., *supra* note 15, at 543 (discussing reasons for avoiding needed VA care).

when they innocently suffered harm at the hands of abusers and institutions, it ensures that those who do file claims are in a better position to succeed and to address common shortfalls that remain elusive to most applicants. Moreover, it recognizes the vital role of disability compensation for MST survivors specifically.

In recognition of the all-too-common experience of MST survivors, who have often been de-validated and disbelieved at each stage of the reporting process—if there was a report—we cannot underscore enough the "symbolic" value of service-connection and VA disability compensation for an MST-related condition. As evident in the studies of Dr. Nina Sayer and her colleagues, one of the primary benefits of obtaining service-connection disability for a veteran of the U.S. Armed Forces is that "it provided them with official recognition and validation of their traumatic experiences."[466] Put differently, pursuits to obtain VA benefits for MST have been equated to "the second battle" in which "[b]etrayed once by their fellow soldiers, survivors of MST [can be] betrayed again by a disability compensation system that makes unreasonable evidentiary demands and often unjustly denies the benefits they need."[467] In the final analysis, through the compensation process, the VA is uniquely positioned to do something that the immediate chain of command, the military in general, and law enforcement were not capable of doing. Along related lines, it is as noteworthy for us to emphasize the potential that compensation—beyond merely treatment—has the power to dramatically improve the survivor's quality of life. First,

> [u]nlike U.S. Worker's Compensation benefits, VA benefits are not limited in either the length of time or the total amount paid. Unlike U.S. Social Security disability insurance, VA disability benefits are not automatically discontinued if the recipient returns to work, or reduced to offset other income.[468]

Second, considering how many female and male MST survivors do not feel comfortable obtaining healthcare services from the VA at VA hospitals,[469] disability compensation provides them with the means to obtain care from alternative providers with whom they

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466 Sayer et al., *supra* note 20, at 700.

467 AM. CIV. LIB. UNION & SERVICE WOMEN'S ACTION NETWORK, *supra* note 57, at 1, 4.

468 *Id.* at 699.

469 *See, e.g.*, Ghahramanlou-Holloway et al., *supra* note 5, at 5 (discussing various reasons for women avoiding treatment from the VA).

feel more comfortable.[470]

Considering how difficult it is to file for and obtain benefits related to MST,[471] the "small number" of claimants who apply,[472] the re-traumatization inherent in the process,[473] and the fact that each applicant who has the courage to come forward and apply potentially represents *many more* who do not,[474] the 68% rate of MST-benefit denials between 2008 and 2010 is alarming and represents a failure to meet the most basic needs of a population with the greatest life challenges.[475] The inability of the VA to provide necessary compensation and comprehensive services to these survivors contributes, in no small way, to the increased rates of homelessness among female veterans,[476] as well as the fact that [f]emale veterans

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470 *Id.* ("A significant portion of women veterans choosing to seek treatment from non-VA settings report feeling some stigma going to the local VA and/or feeling unwelcomed at the VA"); *see also* AM. CIV. LIB. UNION & SERVICE WOMEN'S ACTION NETWORK, *supra* note 57, at 3 ("[C]are without compensation is not enough for MST survivors whose debilitating mental health conditions prevent them from building fully productive careers after their service.").

471 *See, e.g.*, Sayer et al., *supra* note 21, at 704 (sharing the manner in which an MST survivor equated VA compensation with payment for being sexually assaulted and her speculation that other MST survivors thought of compensation in the same way); *see also* Holloway et al., *supra* note 5, at 5 (describing a recent study in which "over 40% of women veterans reported needing psychological services but not getting them" and providing a number of reasons why women veterans choose to forego applications for VA benefits). As Amy Street and her colleagues explain, "[s]exually traumatized veterans may . . . be reluctant to seek disability compensation related to their mental difficulties given the accurate perception that veterans who experienced sexual trauma are less likely to receive compensation than veterans with similar mental health difficulties that are related to combat trauma." Street et al., *supra* note 33, at 131, 139–40.

472 Sayer et al., *supra* note 20, at 700 (accounting for a small number of VA applicants).

473 *See, e.g.*, Sandberg et al., *supra* note 13, at 466 (describing how merely being asked to recall issues related to MST caused a number of veterans to become unexpectedly upset and even to regret their participation in a survey addressing these issues).

474 *See, e.g.*, HUNTER, *supra* note 33, at 167 (sharing estimates that the number of sexual assaults is, in actuality, "two to three times greater than the number reported").

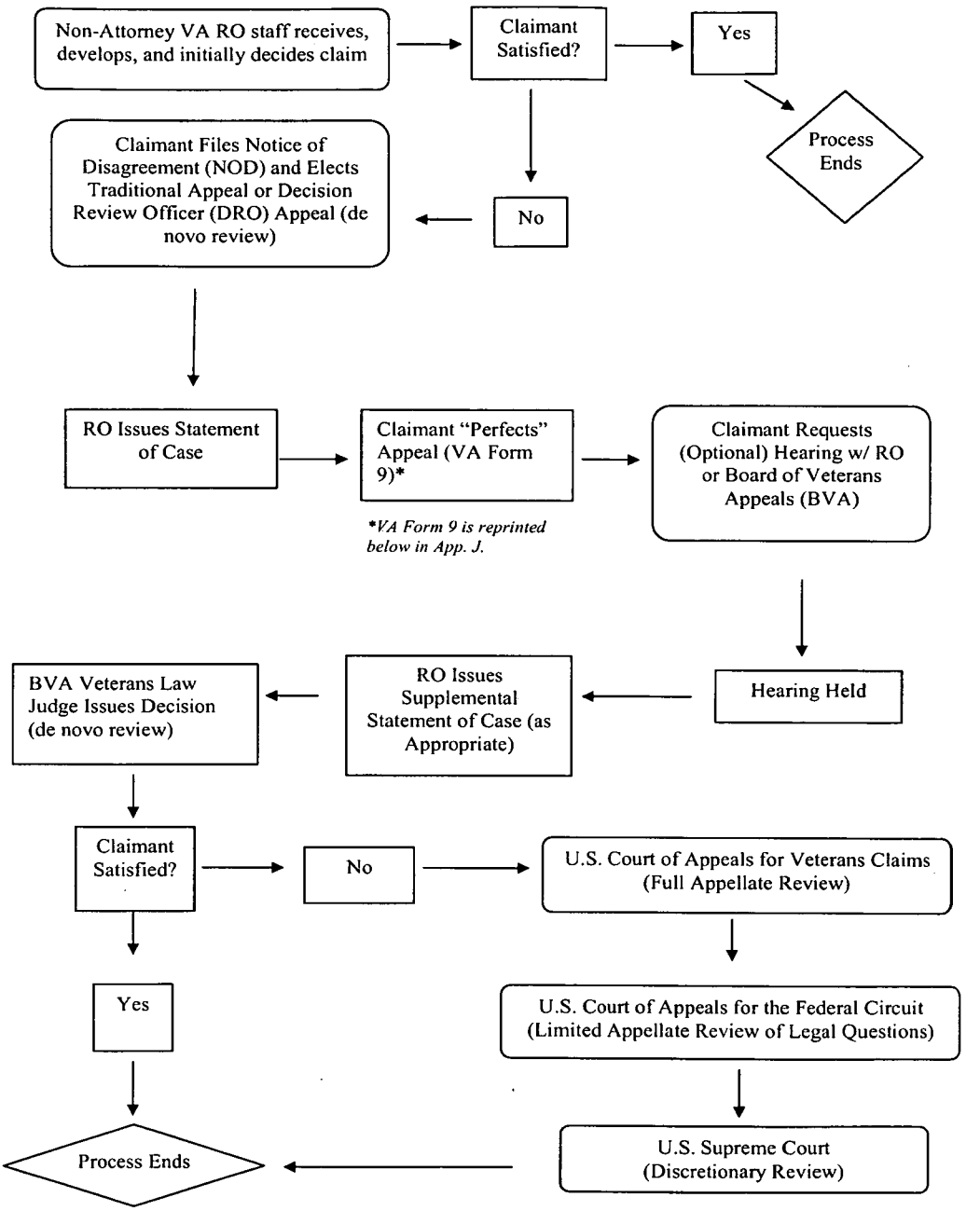
475 Goldberg, *supra* note 18. Even though data from 2010 to 2012 suggest a small rise in the number of MST claims that are approved, nearly half were denied in 2012, at levels which raised serious concerns about the consistency of adjudication standards across regional offices. AM. CIV. LIB. UNION & SERVICE WOMEN'S ACTION NETWORK, *supra* note 57, at 5, 12 (reporting 44.6% and 56.8% MST claim grants in 2011 and 2010 respectively and concluding that "the chances of success of a veteran's [MST] claim may have been—and still may be—significantly impacted by which regional office he or she applied to and when he or she applied").

476 *See, e.g.*, LIBBY PERL, CONGRESSIONAL RESEARCH SERVICE: VETERANS AND HOMELESSNESS 40 & 13 (Feb. 4, 2013) (linking MST to increased rates of homelessness among veterans and reporting that, "[o]verall, women veterans are 2.1 times more likely to be homeless than their nonveteran counterparts.").

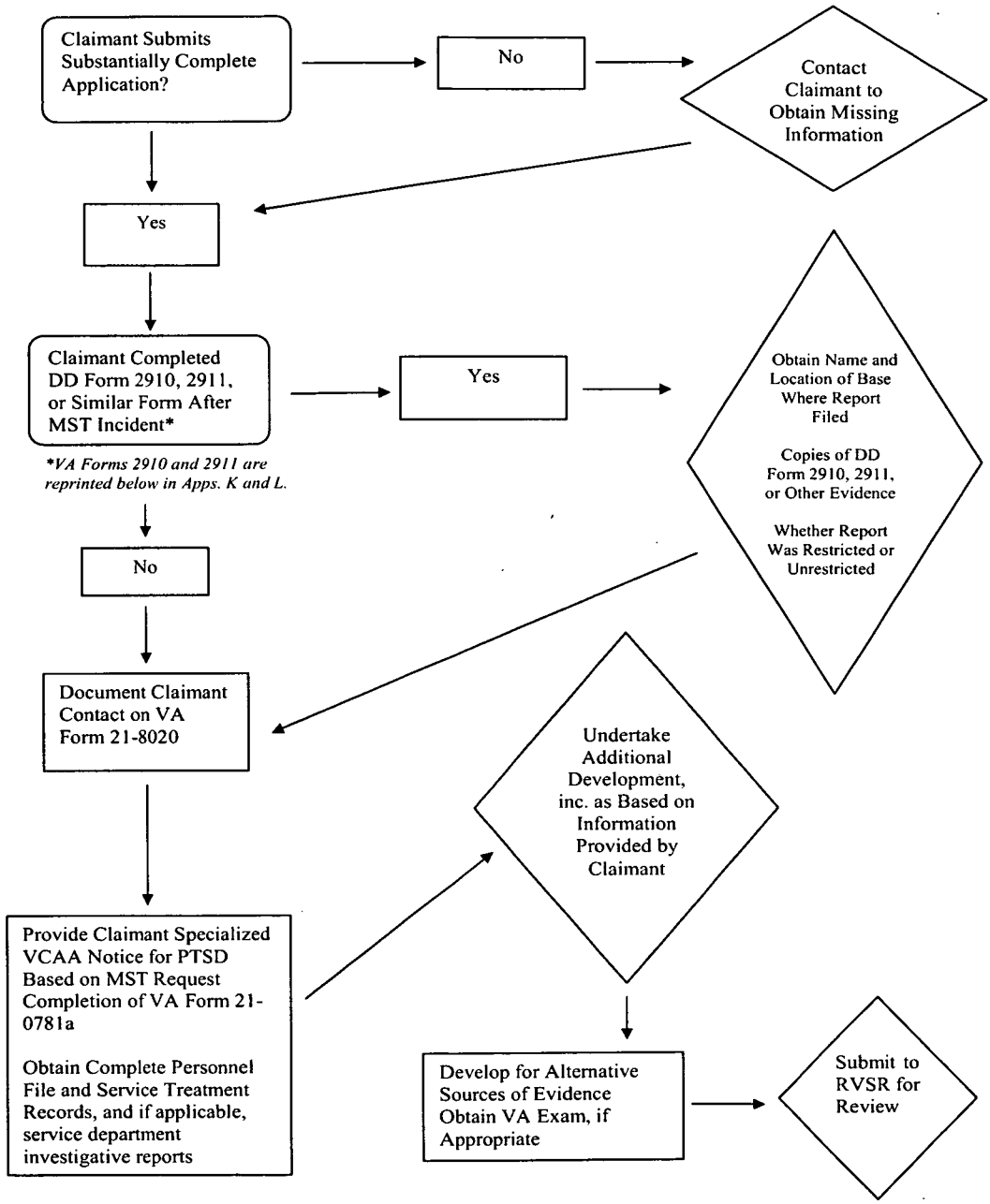
are 79% more likely to die by suicide than civilian women."[477] It is our sincere hope that the instant Article provides immediate improvements in maximizing VA benefits for MST survivors as we await long-term policy, legislative, and judicial solutions.

477 Ghahramanlou-Holloway et al., *supra* note 5, at 3; *see also* Alina Surís et al., *Predictors of Suicidal Ideation in Veterans With PTSD Related Military Sexual Trauma*, 24 J. TRAUMATIC STRESS 605, 605 (2011) (observing that an "increased likelihood of suicide/intentional self-injury has been reported among both female and male veterans who screened positive for sexual trauma").

APPENDIX A: VA DISABILITY APPEALS PROCESS FLOW-CHART



APPENDIX B: THE MST CLAIMS DEVELOPMENT PROCESS FLOW-CHART



APPENDIX C

This form is part of the public domain. *See* 17 U.S.C. § 105.

OMB Approved No. 2900-0659
Respondent Burden: 1 hour 10 minutes

Department of Veterans Affairs

VA DATE STAMP
DO NOT WRITE IN THIS SPACE

STATEMENT IN SUPPORT OF CLAIM FOR SERVICE CONNECTION FOR POST-TRAUMATIC STRESS DISORDER (PTSD) SECONDARY TO PERSONAL ASSAULT

INSTRUCTIONS: List the stressful incident or incidents that occurred in service that you feel contributed to your current condition. For each incident, provide a description of what happened, the date, the geographic location, your unit assignment and dates of assignment. Please complete the form in detail and be as specific as possible so that research of military records and other sources you identify can be thoroughly conducted. If more space is needed, attach a separate sheet, indicating the item number to which the answers apply.

1. NAME OF VETERAN *(First, Middle, Last)*	2. VA FILE NO.

STRESSFUL INCIDENT NO. 1

3A. DATE INCIDENT OCCURRED *(Mo., day, yr.)*	3B. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*

3C. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*	3D. DATES OF UNIT ASSIGNMENT *(Mo., day, yr.)*	
	FROM	TO

3E. DESCRIPTION OF THE INCIDENT

4. OTHER SOURCES OF INFORMATION: Identify any other sources (military or non-military) that may provide information concerning the incident. If you reported the incident to military or civilian authorities or sought help from a rape crisis center, counseling facility, or health clinic, etc., please provide the names and addresses and we will assist you in getting the information. If the source provided treatment and you would like us to obtain the treatment records, complete VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA), for each provider. If you confided in roommates, family members, chaplains, clergy, or fellow service persons, you may want to ask them for a statement concerning their knowledge of the incident. These statements will help us in deciding your claim. Other sources of information also include personal diaries or journals.

NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS

VA FORM JAN 2014 **21-0781a** SUPERSEDES VA FORM 21-0781A, JUN 2012, WHICH WILL NOT BE USED. PAGE 1

STRESSFUL INCIDENT NO. 2			
5A. DATE INCIDENT OCCURRED *(Mo., day, yr.)*	5B. LOCATION OF INCIDENT *(City, State, Country, Province, landmark or military installation)*		
5C. UNIT ASSIGNMENT DURING INCIDENT *(Such as, DIVISION, WING, BATTALION, CAVALRY, SHIP)*		5D. DATES OF UNIT ASSIGNMENT *(Mo., day, yr.)*	
		FROM	TO
5E. DESCRIPTION OF THE INCIDENT			

6. OTHER SOURCES OF INFORMATION: Identify any other sources (military or non-military) that may provide information concerning the incident. If you reported the incident to military or civilian authorities or sought help from a rape crisis center, counseling facility, or health clinic, etc., please provide the names and addresses and we will assist you in getting the information. If the source provided treatment and you would like us to obtain the treatment records, complete VA Form 21-4142, Authorization and Consent to Release Information to the Department of Veterans Affairs (VA), for each provider. If you confided in roommates, family members, chaplains, clergy, or fellow service persons, you may want to ask them for a statement concerning their knowledge of the incident. These statements will help us in deciding your claim. Other sources of information also include personal diaries or journals.

NAME	ADDRESS
NAME	ADDRESS
NAME	ADDRESS

7. Please provide in the space below any other information that you feel is important for us to know that may help your claim. Let us know if you experienced any of the following or other behavior changes following the incident(s):

- visits to a medical or counseling clinic or dispensary without a specific diagnosis or specific ailment
- sudden requests for a change in occupational series or duty assignment
- increased use of leave without an apparent reason
- changes in performance and performance evaluations
- episodes of depression, panic attacks, or anxiety without an identifiable cause
- increased or decreased use of prescription medications
- increased use of over-the-counter medications
- substance abuse such as alcohol or drugs
- increased disregard for military or civilian authority
- obsessive behavior such as overeating or undereating
- pregnancy tests around the time of the incident
- tests for HIV or sexually transmitted diseases
- unexplained economic or social behavior changes
- breakup of a primary relationship

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

8. SIGNATURE	9. DATE	10. TELEPHONE NUMBERS *(Include Area Code)*	
		DAYTIME	EVENING

PENALTY - The law provides severe penalties which include fine or imprisonment or both, for the willful submission of any statement or evidence of a material fact, knowing it is false, or fraudulent acceptance of any payment to which you are not entitled.

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, the requested information is necessary to obtain supporting evidence of stressful incidents in service. If the information is not furnished completely or accurately, VA will not be able to thoroughly research your military records and other sources for supporting evidence. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: We need this information in order to assist you in supporting your claim for post-traumatic stress disorder (38 U.S.C. 5107 (a)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 1 hour and 10 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

APPENDIX D

This form is part of the public domain. *See* 17 U.S.C. § 105.

OMB Control No. 2900-0001
Respondent Burden: 5 minutes

Department of Veterans Affairs

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO THE DEPARTMENT OF VETERANS AFFAIRS (VA)

RESPONDENT BURDEN: We need this information to obtain your treatment records. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at http://reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, CALL VA TOLL-FREE AT 1-800-827-1000 (TDD 1-800-829-4833 FOR HEARING IMPAIRED).

SECTION I - VETERAN/CLAIMANT IDENTIFICATION

1. LAST NAME - FIRST NAME - MIDDLE NAME OF VETERAN *(Type or print)*	2. DATE OF BIRTH (MM,DD,YYYY)	3. VETERAN'S VA FILE NUMBER
4. CLAIMANT'S NAME *(If other than veteran)* LAST NAME, FIRST, MIDDLE		5. VETERAN'S SOCIAL SECURITY NUMBER
6. RELATIONSHIP OF CLAIMANT TO VETERAN		7. CLAIMANT'S SOCIAL SECURITY NUMBER

SECTION II - SOURCE OF PERTINENT INFORMATION (Please use a separate form for each source)

8A. LIST THE SOURCE OF INFORMATION OR PROVIDER OF MEDICAL TREATMENT FOR YOUR CLAIMED CONDITION(S) *(Include the first and last name, complete address, and telephone number)*	8B. DATE(S) OF TREATMENT: *(Include the time period (month and year) for which the provider in Item 8A treated you for your currently claimed condition(s)*	8C. LIST THE DISABILITY(IES) FOR WHICH YOU FILED YOUR CURRENT CLAIM AND THAT WERE TREATED BY THE PROVIDER IN ITEM 8A
	NOTE - "Treatment" includes office visits, hospitalizations, telephone consultations, etc.	
Source of Information (other than medical treatment provider):		
First Name and Last Name of Medical Treatment Provider:		
Complete Address and Telephone Number of Source of Information or Medical Treatment Provider:		

9. COMMENTS:

YOU MUST SIGN AND DATE THIS FORM ON PAGE 2 AND CHECK THE APPROPRIATE BLOCK IN ITEM 10C.

VA FORM FEB 2012 **21-4142** Existing stocks of the VA Form 21-4142, JAN 2011, will be used. PAGE 1

SECTION III - CONSENT TO RELEASE INFORMATION

READ ALL PARAGRAPHS CAREFULLY BEFORE SIGNING. YOU MUST CHECK THE APPROPRIATE STATEMENT UNDERLINED IN PARENTHESES IN PARAGRAPH 10C.

10A. **Privacy Act Notice:** The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28 Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary. However, if the information including your Social Security Number (SSN) is not furnished completely or accurately, the health care provider to which this authorization is addressed may not be able to identify and locate your records, and provide a copy to VA. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect.

10B. I, the undersigned, hereby authorize the hospital, physician or other health care provider or health plan shown in Item 8A to release any information that may have been obtained in connection with a physical, psychological or psychiatric examination or treatment, with the understanding that VA will use this information in determining my eligibility to veterans benefits I have claimed. I understand that the health care provider or health plan identified in Item 8A who is being asked to provide the Veterans Benefits Administration with records under this authorization may not require me to execute this authorization before it will, or will continue to, provide me with treatment, payment for health care, enrollment in a health plan, or eligibility for benefits provided by it. I understand that once my health care provider sends this information to VA under this authorization, the information will no longer be protected by the HIPAA Privacy Rule, but will be protected by the Federal Privacy Act, 5 USC 552a, and VA may disclose this information as authorized by law. I also understand that I may revoke this authorization, at anytime (except to the extent that the health care provider has already released information to VA under this authorization) by notifying the health care provider shown in Item 8A. Please contact the VA Regional Office handling your claim or the Board of Veterans' Appeals, if an appeal is pending, regarding such action. If you do not revoke this authorization, it will automatically end 180 days from the date you sign and date the form (Item 10C).

10C. I ☐ (AUTHORIZE) ☐ (DO NOT AUTHORIZE) the source shown in Item 8A to release or disclose any information or records relating to the diagnosis, treatment or other therapy for the condition(s) of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), sickle cell anemia or psychotherapy notes. IF MY CONSENT TO THIS INFORMATION IS LIMITED, THE LIMITATION IS WRITTEN HERE:

11A. SIGNATURE OF VETERAN/CLAIMANT OR LEGAL REPRESENTATIVE	11B. RELATIONSHIP TO VETERAN/CLAIMANT *(If other than self, please provide full name, title, organization, city, State and ZIP Code. All court appointments must include docket number, county and State)*	11C. DATE

11D. MAILING ADDRESS *(Number and Street or rural route, city, or P.O. State and ZIP Code)*	11E. TELEPHONE NUMBER *(Include Area Code)*

The signature and address of a person who either knows the person signing this form or is satisfied as to that person's identity is requested below. This is not required by VA but may be required by the source of the information.

12A. SIGNATURE OF WITNESS	12B. DATE

12C. MAILING ADDRESS OF WITNESS

APPENDIX E

In addition to the alternate sources listed in 38 C.F.R. § 3.304(f)(5), a non-exhaustive list of behavior change markers includes the following:

- visits to a medical or counseling clinic without a specific diagnosis or ailment;
- sudden requests for a change in occupational series or duty assignment without other justification;
- increased use or abuse of leave without apparent reason;
- changes in performance or performance evaluations (either a decline or unusual increase);
- episodes of depression, panic attacks, or anxiety without identifiable causes;
- increased or decreased use of prescription or over-the-counter medications;
- substance abuse such as of alcohol or drugs;
- use of pregnancy tests or tests for sexually transmitted diseases around the time of the incident;
- increased disregard for military or civilian authority;
- obsessive behavior such as over- or under-eating;
- unexplained social or economic changes such as not paying bills on time, uncharacteristic requests to borrow money, withdrawal from friends and social activities following traumatic event;
- breakup of a primary relationship;
- treatment for physical injuries around the time of the incident, but not reported as a result of the incident;
- a quick decision to marry an individual; or
- getting pregnant and leaving service.[478]

Opportunities for marker spotting within a claims file are nearly endless. However, some practical examples are in order. Consider the following:

- Claimant reports being sexually assaulted and allegations are investigated (and perhaps the perpetrator is prosecuted in service);
- Claimant reports to sick call telling a male medic that she wants a female medic or referral to gynecology clinic;

478 *See Rating Job Aids, supra* note 134; VA DISABILITY APM, *supra* note 83, Part III, subpart iv, Ch. 4, Section H.

- Claimant disciplined for failure to report for duty or drinking on duty, arrested for being drunk and disorderly following the claimed assault, and/or referred for participation in a substance abuse treatment program;
- Claimant visits chaplain who thereafter advocates for an expeditious discharge from service;
- Claimant seen for psychological counseling for emotional outbursts or depression, requests testing, or receives treatment for urinary tract infections or sexually transmitted diseases around the time of the claimed assault;
- In-service PTSD diagnosis;
- Claimant treated for physical injuries such as black eye, broken bones, anal injuries, or lacerations and bruises around the time of the claimed assault;
- Claimant requests pregnancy test approximately two to three months after claimed assault (or gives birth or miscarries approximately nine months after);
- Claimant's parents or siblings provide statements that the claimant reported being sexually assaulted after the incident occurred;
- Claimant's roommate or fellow service buddy provides statements regarding claimant's unexplained use of leave, performance decline (or overcompensation), and/or socially avoidant behavior;
- Claimant requests separation from service, but complete summary of visit not included in records, separation from service based on immaturity, poor communication skills, or an inability to pass physical training tests (despite being an accomplished soldier), or ongoing disciplinary problems (without prior evidence of disciplinary problems).[479]

479 *See Rating Job Aids, MST Trainee Guide, supra* note 134; *Markers and Claims Development, supra* note 174.

APPENDIX F

This appendix contains excerpts from the BVA's remand order to a mental health evaluator, applying the current standards for determining *Allen* aggravation to a claim which involved both a rape perpetrated at the age of 13 and a later rape occurring during military service. The stepwise progression, which includes mention of specific thresholds for analysis should be useful in assisting evaluators in approaching similar cases involving MST. There is notably, however, no specific methodology provided for the manner in which to assess a pre-aggravation baseline, as required by the 2006 amendment.[480]

> 1. Schedule the Veteran for a VA mental disorders examination to determine the causation or etiology of her current PTSD and/or any other current psychiatric diagnoses, as well as to determine whether the Veteran has a chemical dependency that is secondary to any diagnosed psychiatric disorder. Any and all indicated evaluations, studies, and tests deemed necessary by the examiner should be accomplished, and a complete rationale for any opinion expressed should be provided. The relevant documents in the claims file should be made available to the examiner for review of the history in conjunction with the examination, and the examination report should reflect that such review was accomplished.
>
> a. The examiner should first identify any and all current psychiatric disorders (diagnoses), commenting specifically on post-service treatment records which document current diagnoses of anxiety disorder with depression and panic attacks and PTSD.
>
> b. Next, the examiner should offer the following opinion: Did the Veteran have a psychiatric disorder that clearly and unmistakably (i.e., obvious and manifest, which is a very high likelihood, much greater than a [50/50] degree of probability) pre-existed her entrance into military service in 1977? If so, what was the nature of such preexisting psychiatric disability? In offering this opinion, the examiner should specifically address the factors of the pre-service divorce of the Veteran's parents, a pre-service rape at the age of thirteen, and substance abuse problems prior to enlistment in service.

---

480 Name Redacted, No. 09-37 499, 2012 WL 2881259 (B.V.A. May 11, 2012).

c. If it is the examiner's opinion that a psychiatric disorder pre-existed the Veteran's entrance into military service, offer the following opinion: Was the preexisting psychiatric disorder clearly and unmistakably not aggravated (not permanently worsened in severity) in service?

d. Alternatively, if it is your opinion that there was aggravation (permanent worsening in severity) during service, what was the pre-existing baseline level of the psychiatric disability prior to such aggravation? The examiner should specifically comment on the notation of excessive worry and nervous trouble at the time of enlistment in 1976, the in-service psychiatric evaluation in June 1980, the psychiatric diagnoses noted on the July 1980 separation examination report, and the multiple post-service treatment records relating the Veteran's current psychiatric troubles to pre-service traumas.

Note: The term "aggravated" in this context refers to a permanent worsening of the underlying condition, as contrasted to temporary or intermittent flare-ups of symptomatology which resolve with return to the baseline level of disability.

e. If the examiner concludes that the Veteran's PTSD and/or other current psychiatric disorder(s) did not pre-exist service, the examiner should offer an opinion as to whether it is at least as likely as not (i.e., to at least a 50/50 degree of probability) that any currently diagnosed psychiatric disorder, to include PTSD, was incurred during or caused by active service. The examiner should specifically comment on whether the Veteran's claimed in-service stressors of almost being run over and being raped are sufficient to support a PTSD diagnosis using the DSM-IV criteria, and whether the Veteran's current PTSD was caused by those stressors.

Note: The term "at least as likely as not" does not mean merely within the realm of medical possibility, but rather that the weight of medical evidence both for and against a conclusion is so evenly divided that it is as medically sound to find in favor of causation as it is to find against it.

f. The examiner shoulder offer an opinion as to whether it is at least as likely as not (i.e., to at least a 50/50 degree of probability) that the

Veteran's chemical dependency has been caused by the Veteran's PTSD or other psychiatric disorder (including as a component or symptom of PTSD or other psychiatric disorder). The examiner should provide an explanation for the opinion reached, and should specifically comment on the Veteran's pre-service substance abuse problems, as well as the April 1992 psychiatric evaluation which opined the pre-service rape possibly played a part in the Veteran's substance dependency.

g. The examiner should offer an opinion whether it is at least as likely as not (i.e., to at least a 50/50 degree of probability) that the Veteran's chemical dependency has been aggravated (permanently worsened in severity) by the Veteran's PTSD or other psychiatric disorder (including as a component or symptom of PTSD or other psychiatric disorder). The examiner should provide an explanation for the opinion reached, and should specifically comment on the Veteran's pre-service substance abuse problems, as well as the April 1992 psychiatric evaluation which opines the pre-service rape possibly played a part in the Veteran's substance dependency.

Note: The term "aggravated" in the above context refers to a permanent worsening of the pre-existing or underlying condition, as contrasted to temporary or intermittent flare-ups of symptoms which resolve with return to the previous baseline level of disability.

h. If the examiner opines that the Veteran's chemical dependency was aggravated (permanently worsened in severity) by her PTSD and/or other psychiatric disorder, the examiner should attempt to identify the baseline level of severity of the chemical dependency before the onset of aggravation. The examiner should provide an explanation for the opinion reached.

i. If the opinion and/or supporting rationale cannot be provided without invoking processes relating to guesses or judgment based upon mere conjecture, the examiner should so specify in the report, and explain why any opinion could not be offered. In this regard, if the examiner concludes that there is insufficient information to provide an etiologic opinion without result to mere speculation, the examiner should state whether the inability to provide an opinion is due to a need for further information

(with such needed information identified) or because the limits of medical knowledge have been exhausted regarding the etiology of the Veteran's claimed PTSD and/or other psychiatric disorder.

APPENDIX G
Letter of Introduction
Lay Witness

To Whom It May Concern:

This letter is a request by _____ (the Requestor) for you to help in his/her application for VA disability compensation benefits related to a sexually traumatic incident that occurred while the Requestor was serving in the Armed Forces in some capacity. In the Requestor's own words, the nature of the incident that you may have information about is best described as _____ _____, occurring on or about _____ at the following location: _____.

Please use a separate page to write what you know of the incident described above. You want to be sure to include the following information:

- What did you learn about the incident, in terms of who was involved, what occurred, how it ended, and any other information that will help provide a better understanding of the event?
- How did you first learn of the incident and from whom?
- If you saw the incident take place, or the immediate aftermath of the incident, where were you physically located (distance, place, date, time, location)?
- If you heard from others about the incident, who told you and how long after the incident did you first learn about it?
- How long you knew the requestor at the time you first learned of the incident?
- What was your job or duty description at the time?
- How frequently did you have contact with the Requestor at the time of the incident?
- If you did not witness the incident, but witnessed any change in the requestor's behavior, indicate what you observed in the time before and after the behavior change.
- If you are aware of any other people with first-hand information about the incident described above, please be sure to indicate their names and any information you know about them, in terms of where they worked and lived or where they can be located today.

Please rely on your own recollections when providing these responses.

APPENDIX H
Letter of Introduction
Medical Professional

To Whom It May Concern:

This letter is a request by _____ (the Requestor) for you to help in his/her application for VA disability compensation benefits related to a sexually traumatic incident that occurred while the Requestor was serving in the Armed Forces in some capacity. In the Requestor's own words, the nature of the incident that you may have information about is best described as _____ _____, occurring on or about _____ at the following location: _____.

Please use a separate page to write what you know of the incident described above. You want to be sure to include the following information:

- Describe how long you have been treating the Requestor.
- Describe the nature of medical conditions that you have been treating the Requestor for since you began a provider-patient relationship with the Requestor.
- Describe any medical conditions that you diagnosed or treated the Requestor for which were consistent with the nature and type of sexual trauma indicated above.
- For each physical condition that is consistent with the nature and type of trauma indicated above, please express an opinion as to whether there is a 50% chance or greater that the condition was caused by or due to the sexually traumatic incident described above.
- Provide an explanation for the basis of your observations of the cause and or effect of the sexually traumatic incident on the Requestor's physical condition.

APPENDIX I
Letter of Introduction
Mental Health Professional

To Whom It May Concern:

This letter is a request by _____ (the Requestor) for you to help in his/her application for VA disability compensation benefits related to a sexually traumatic incident that occurred while the Requestor was serving in the Armed Forces in some capacity. In the Requestor's own words, the nature of the incident that you may have information about is best described as _____ _____, occurring on or about _____ at the following location: _____.

Please use a separate page to write what you know of the incident described above. You want to be sure to include the following information:

- Describe how long you have been treating the Requestor.
- Describe the nature of mental health conditions that you have been treating the Requestor for since you began a provider-patient relationship with the Requestor.
- Describe any mental health conditions that you diagnosed or treated the Requestor for which were consistent with the nature and type of sexual trauma indicated above.
- For each mental condition that is consistent with the nature and type of trauma indicated above, please express an opinion as to whether there is a 50% chance or greater that the condition was caused by or due to the sexually traumatic incident described above.
- Provide an explanation for the basis of your observations of the cause and or effect of the sexually traumatic incident on the Requestor's mental condition.

The appendices J to L, below, reprint the forms mentioned within the appellate and Regional Office adjudication flow-charts that appear in Appendices A and B.

APPENDIX J

This form is part of the public domain. *See* 17 U.S.C. § 105.

Form Approved: OMB No. 2900-0085
Respondent Burden: 1 Hour

Department of Veterans Affairs — **APPEAL TO BOARD OF VETERANS' APPEALS**

IMPORTANT: *Read the attached instructions before you fill out this form. VA also encourages you to get assistance from your representative in filling out this form.*

1. NAME OF VETERAN *(Last Name, First Name, Middle Initial)*	2. CLAIM FILE NO. *(Include prefix)*	3. INSURANCE FILE NO., OR LOAN NO.

4. I AM THE:
☐ VETERAN ☐ VETERAN'S WIDOW/ER ☐ VETERAN'S CHILD ☐ VETERAN'S PARENT
☐ OTHER *(Specify)*

5. TELEPHONE NUMBERS		6. MY ADDRESS IS: *(Number & Street or Post Office Box, City, State & ZIP Code)*
A. HOME *(Include Area Code)*	B. WORK *(Include Area Code)*	
7. IF I AM NOT THE VETERAN, MY NAME IS: *(Last Name, First Name, Middle Initial)*		

8. OPTIONAL BVA HEARING

IMPORTANT: *Read the information about this block in paragraph 8 of the attached instructions. This block is used to request a Board of Veterans' Appeals hearing. DO NOT USE THIS FORM TO REQUEST A HEARING BEFORE VA REGIONAL OFFICE PERSONNEL. Check one (and only one) of the following boxes:*

A. ☐ I DO NOT WANT A BVA HEARING.
B. ☐ I WANT A BVA HEARING BY LIVE VIDEOCONFERENCE.
C. ☐ I WANT A BVA HEARING IN WASHINGTON, DC.
D. ☐ I WANT A BVA HEARING AT A LOCAL VA OFFICE.*

**Due to travel requirements for BVA personnel, selecting Option D may result in a lengthier waiting period for the hearing than the other options. (This option is also not available at the Washington, DC, or Baltimore, MD, Regional Offices.)*

9. THESE ARE THE ISSUES I WANT TO APPEAL TO THE BVA: *(Be sure to read the information about this block in paragraph 9 of the attached instructions.)*

A. ☐ I WANT TO APPEAL ALL OF THE ISSUES LISTED ON THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENTS OF THE CASE THAT MY LOCAL VA OFFICE SENT TO ME.
B. ☐ I HAVE READ THE STATEMENT OF THE CASE AND ANY SUPPLEMENTAL STATEMENT OF THE CASE I RECEIVED. I AM ONLY APPEALING THESE ISSUES: *(List below.)*

10. HERE IS WHY I THINK THAT VA DECIDED MY CASE INCORRECTLY: *(Be sure to read the information about this block in paragraph 10 of the attached instructions.)*

(Continue on the back, or attach sheets of paper, if you need more space.)

11. SIGNATURE OF PERSON MAKING THIS APPEAL	12. DATE *(MM DD YYYY)*	13. SIGNATURE OF APPOINTED REPRESENTATIVE, IF ANY *(Not required if signed by appellant. See paragraph 6 of the instructions.)*	14. DATE *(MM DD YYYY)*

VA FORM NOV 2009 9

CONTINUATION SHEET FOR ITEM 10

(Attach additional sheets, if necessary)

2

We are required by law to give you the information in this box. Instructions for filling out the form follow the box.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond to, this collection of information unless it displays a valid Office of Management and Budget (OMB) Control Number. The information requested is approved under OMB Control Number (2900-0085). Public reporting burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection, including suggestions for reducing this burden to: VA Clearance Officer (005R1B), 810 Vermont Ave., NW, Washington, DC 20420. **DO NOT** send requests for benefits to this address.

PRIVACY ACT STATEMENT: Our authority for asking for the information you give to us when you fill out this form is 38 U.S.C. 7105(d)(3), a Federal statute that sets out the requirement for you to file a formal appeal to complete your appeal on a VA benefits determination. You use this form to present your appeal to the Board of Veterans' Appeals (BVA). It is used by VA in processing your appeal and it is used by the BVA in deciding your appeal. Providing this information to VA is voluntary, but if you fail to furnish this information VA will close your appeal and you may lose your right to appeal the benefit determinations you told us you disagreed with. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statue (38 U.S.C. 5701), as implemented by 38 C.F.R. 1.526(a) and 1.576(b), require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. However, the law permits VA to disclose the information you include on this form to people outside of VA in some circumstances. Information about that is given in notices about VA's "systems of records" that are periodically published in the *Federal Register* as required by the Privacy Act of 1974. Examples of situations in which the information included in this form might be released to individuals outside of VA include release to the United States Court of Appeals for Veterans Claims, if you later appeal the BVA's decision in your case to that court; disclosure to a medical expert outside of VA, should VA exercise its statutory authority under 38 U.S.C. 5109 or 7109, to ask for an expert medical opinion to help decide your case; disclosure to law enforcement personnel and security guards in order to alert them to the presence of a dangerous person; disclosure to law enforcement agencies should the information indicate that there has been a violation of law; disclosure to a congressional office in order to answer an inquiry from the congressional office made at your request; and disclosure to Federal government personnel who have the duty of inspecting VA's records to make sure that they are being properly maintained. See the *Federal Register* notices described above for further details.

INSTRUCTIONS

1. CONSIDER GETTING ASSISTANCE: We have tried to give you the general information most people need to complete this form in these instructions, but the law about veterans' benefits can be complicated. If you have a representative, we encourage you to work with your representative in completing this form. If you do not have a representative, we urge you to consider getting one. Most people who appeal to the Board of Veterans' Appeals (BVA) do get a representative. Veterans' Service Organizations (VSOs) will represent you at no charge and most people (more than 80 percent) are represented by VSOs. Under certain circumstances, you may pay a lawyer or "agent" to represent you. (See the references in paragraph 9.) Your local VA office can provide you with information about VSOs who are willing to represent you and forms that you will need to complete to appoint either a VSO or an attorney to represent you. Your local bar association may be able to provide you with the names of attorneys who specialize in veterans' law. VA has an 800 number that you can call for assistance: 1-800-827-1000. There are also a few agents recognized by VA who can represent claimants.

2. WHAT IS THIS FORM FOR? You told your local VA office that you disagreed with some decision it made on your claim for VA benefits, called filing a "Notice of Disagreement." That office then mailed you a "Statement of the Case" (SOC) that told you why and how it came to the decision that it did. After you have read the SOC, you must decide if you want to go ahead and complete your appeal so that the BVA will review your case. If you do, you or your representative must fill out this form and file it with VA. "Filing" means delivering the completed form to VA in person or by mailing it to VA. Paragraph 4 tells you how much time you have to file this form and paragraph 7 tells you where you file it.

When we refer to "your local VA office" in these instructions, we mean the VA Regional Office that sent you the "Statement of the Case" or, if you have moved out of the area served by that office, the VA Regional Office that now has your VA records.

3. DO I HAVE TO FILL OUT THIS FORM AND FILE IT? Fill out this form and file it with VA *if* you want to complete your appeal. If you do not, VA will close your appeal without sending it to the BVA for a decision. If you decide that you no longer want to appeal after you have read the SOC, you don't have to do anything.

4. HOW LONG DO I HAVE TO COMPLETE THIS FORM AND FILE IT? Under current law, there are three different ways to calculate how much time you have to complete and file this form. The one that applies to you is the one that gives you the *most* time

(a) You have one year from the day your local VA office mailed you the notice of the decision you are appealing.

(b) You have 60 days from the day that your local VA office mailed you the SOC.

(c) Your local VA office may have sent you an update to the SOC, called a "Supplemental Statement of the Case" (SSOC). If that SSOC was provided to you in response to evidence you or your representative submitted within the one-year period described in paragraph 4(a) of these instructions, above, and if you have not already filed this form, then you have at least 60 days from the time your local VA office mailed you the SSOC to file it even though the one-year period has already expired. *See* 38 C.F.R. 20.302(b)(2).

There is one special kind of case, called a "simulataneously contested claim," where you have 30 days to file this form instead of the longer time periods described above. A "simultaneously contested claim" is a case where two different people are asking for the

same kind of VA benefit and one will either lose, or get less, if the other wins. If you are not sure whether this special exception applies, ask your representative or call your local VA office.

If you have *any* questions about the filing deadline in your case, ask your representative or your local VA office. **Filing on time is very important. Failing to file on time could result in you losing your right to appeal.**

5. WHAT IF I NEED MORE TIME? If you need more time to complete this form and file it, write to your local VA office, explaining why you need more time. *You must file your request for more time with your local VA office before the normal time for filing this form runs out.* If you file by mail, VA will use the postmark date to decide whether you filed the form, or the request for more time to file it, on time.

6. WHAT KIND OF INFORMATION DO I NEED TO INCLUDE WHEN I FILL OUT THE FORM? While most of the form is easy to understand, we will go through the blocks where you might need some additional information.

Block 3. If your appeal involves an insurance claim or some issue related to a VA home loan, enter your VA insurance or VA loan number here. For most kinds of cases, you will leave this block blank.

Blocks 4-7. These blocks are for information about the person who is filing this appeal. If you are a representative filling out this form for the person filing the appeal, fill in the information about that person, not yourself. Block 7 can be left blank if the person filing the appeal is the veteran.

Block 8. It is very important for you to check one, *and only one*, of the boxes in Block 8. This lets us know whether or not you want to appear at a BVA hearing and, if so, where you want to appear. Please keep in mind that a BVA hearing is entirely optional, and it is not necessary for you to have a hearing for BVA to decide your appeal. *If you do not check any of the boxes, BVA will assume that you DO NOT want a BVA hearing and your case will be decided taking into consideration the arguments already made, including your explanation on this form as to why you think VA decided your case incorrectly.*

If you ask for a BVA hearing, you and your representative (if you have one) can tell us why you think the BVA should act favorably on your appeal (present argument). You can also tell us about the facts behind your claim and you can bring others (witnesses) to the hearing who have information to give the BVA about your case. At your option, you can submit more evidence at a hearing requested on this form. If you do ask for a BVA hearing, it can be very helpful to have a representative assist you at the hearing.

The purpose of a hearing is to receive argument and testimony relevant and material to the issue or issues in your case that are on appeal. Hearings conducted by the Board are nonadversarial in nature. Parties to a hearing are permitted to ask questions, including follow-up questions, but cross-examination is not allowed. While the types of questions that may be asked are not limited by the legal rules of evidence that typically apply in an adversarial trial setting, reasonable bounds of relevancy and materiality still must be maintained.

Here is specific information about each of the check boxes in Block 8:

Box A: Check Box A if you decide that you *do not* want a BVA hearing. It is *not* necessary for you to have a hearing for BVA to decide your appeal, and you will not be penalized if you choose this option. If you feel that you have already sent VA everything that the BVA will need to decide your case, including making all desired arguments in support of your appeal, then there is no need for a hearing to be held. In addition, a hearing is not needed if the only thing you would like to do is submit additional evidence in support of your appeal. Instead, you may submit such additional evidence, or at a minimum notify VA of its existence and request that it be obtained, without a hearing being held. *If you check this box, do not check any of the other boxes in Block 8.*

Box B: Check Box B if you want to appear at a live BVA videoconference hearing. This option allows you to have a hearing by way of videoconferencing where you will be at the local VA office and the Veterans Law Judge hearing your case will be at the BVA's offices in Washington, DC. Videoconferencing allows the Veterans Law Judge holding the hearing to see and hear you, your representative and witnesses (if any). You will also be able to see and hear the Veterans Law Judge. *Please note that a live videoconference hearing can often be scheduled more quickly than a BVA hearing where all participants (including the Veterans Law Judge) are physically present together at the local VA office.*

Box C: Check Box C if you want to appear for a hearing at the BVA's offices in Washington, DC. If you choose this option, please note that VA *cannot* pay any expenses that you (or your representative or witnesses) incur in connection with attending the hearing. Having your BVA hearing by live videoconference (Box B) is usually less expensive for you, because you will not incur expenses associated with travel to Washington, DC.

Box D: Check Box D if you want a BVA hearing at your local VA office. If you select this option, both you and the Veterans Law Judge assigned to hear your case will be physically present together at the local VA office. *Please note that because Veterans Law Judges conduct this type of hearing only on special trips, it often takes more time to schedule these hearings than a live videoconference hearing (Box B). You can check with your local VA office for an estimate of how long it may take before your case could be scheduled for a BVA hearing at that local VA office.*

HEARINGS BEFORE VA REGIONAL OFFICE PERSONNEL: A hearing before VA regional office personnel, instead of before a member of the BVA, is not a BVA hearing. You can request a hearing before VA regional office personnel by writing directly to the regional office. DO NOT use this form to request that kind of hearing. If you do, it will delay your appeal. You should also know that requesting a hearing before VA regional office personnel does not extend the time for filing this form.

Block 9. This is the block where you tell us exactly *what* you are appealing. You do this by identifying the "issues" you are appealing. Your local VA office has tried to accurately identify the issues and has listed them on the SOC and any SSOC it sent you. Save what you want to tell us about *why* you are appealing for the next block (Block 10).

If you think that your local VA office has correctly identified the issues you are appealing and, after reading the SOC and any SSOC you received, you still want to appeal its decisions on *all* those issues, check the first box in Block 9. *Do not check the second box if you check the first box.*

Check the second check box in Block 9 if you only want to continue your appeal on some of the issues listed on the SOC and any SSOC you received. List the specific issues you want to appeal in the space under the second box. While you should not use this form to file a new claim or to appeal new issues for the first time, you can also use this space to call the BVA's attention to issues, if any, you told your local VA office in your Notice of Disagreement you wanted to appeal that are not included in the SOC or a SSOC. If you want to file a new claim, or appeal new issues (file a new Notice of Disagreement), do that in separate correspondence.

Block 10. Use this block to tell us why you disagree with the decision made by your local VA office. Tie your arguments to the issues you identified in Block 9. Tell us what facts you think VA got wrong and/or how you think VA misapplied the law in your case. Try to be specific. If you are appealing a rating percentage your local VA office assigned for one or more of your service-connected disabilities, tell us *for each service-connected disability rating you have appealed* what rating would satisfy your appeal. (The SOC, or SSOC, includes information about what disability percentages can be assigned for each disability under VA's "Rating Schedule.") You may want to refer to the specific items of evidence that you feel support your appeal, but you do not have to describe all of the evidence you have submitted. The BVA will have your complete file when it considers your case. You should not attach copies of things you have already sent to VA.

In completing this block, please also let us know if there is any additional evidence that you feel needs to be obtained to support your appeal. You may either submit this evidence along with this response, or at a minimum notify VA of its existence so that the evidence can be obtained on your behalf.

If you need more space to complete Block 10, you can continue it on the back of the form and/or you can attach sheets of paper to the form. If you want to complete this part of the form using a computer word-processor, you may do so. Just attach the sheets from your printer to the form and write "see attachment" in Block 10.

Block 11. This form can be signed and filed by *either* the person appealing the local VA decision, or by his or her representative. Sign the form in Block 11 if you are the person appealing, or if you are a guardian or other properly appointed fiduciary filing this appeal for someone else. In cases where an incompetent person has no fiduciary, or the fiduciary has not acted, that person's "next friend," such as a family member, can sign and file this form. If the representative is filing this form, this block can be left blank. Regardless of who signs the form, we encourage you to have your representative check it over before it is filed. Place the date you sign in Block 12.

Block 13. If you are a representative filing this form for the appellant, sign here. Otherwise, leave this block blank. If you are an accredited representative of a Veterans' Service Organization (VSO), also insert the name of the VSO in this block. Note that signing this form will not serve to appoint you as the appellant's representative. Contact your local VA office if you need information on appointment. Place the date you sign in Block 14.

7. WHERE DO I FILE THE FORM ONCE I HAVE COMPLETED IT? When you have completed the form, signed and dated it, send it to the VA office that has your records. Unless you have recently moved outside the area that it serves, this is the office whose address is at the top of the letter VA sent you with the SOC.

8. OTHER SOURCES OF INFORMATION: You can find a "plain language" booklet that describes the VA appeals process called "How Do I Appeal" on the Internet at: http://www.va.gov/vbs/bva/pamphlet.htm. The booklet may also be requested by writing to: Mail Processing Section (014), Board of Veterans' Appeals, 810 Vermont Avenue, NW, Washington, DC 20420. You can also find the formal rules for appealing to the BVA in the BVA's Rules of Practice at title 38, Code of Federal Regulations, Part 20. A complete copy of the Code of Federal Regulations is available on the Internet at: http://www.gpoaccess.gov/cfr/index.html. A printed copy of the Code of Federal Regulations may also be available at your local law library. More general information about VA benefit programs and eligibility can be found on the Internet at: http://www.va.gov.

9. SPECIAL NOTE FOR ATTORNEYS AND VA ACCREDITED AGENTS. There are statutory and regulatory restrictions on the payment of your fees and expenses and requirements for filing copies of your fee agreement with your client with VA. *See* 38 U.S.C. 5904 and 38 C.F.R. 14.636-.637.

NOTE: Please separate these instructions from the form before you file it with VA. We suggest that you keep these instructions with your other papers about your appeal for future reference.

APPENDIX K

This form is part of the public domain. *See* 17 U.S.C. § 105.

VICTIM REPORTING PREFERENCE STATEMENT

(Read Privacy Act Statement before completing this form.)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 113 note, Department of Defense Policy and Procedures on Prevention and Response to Sexual Assaults Involving Members of the Armed Forces; 10 U.S.C. 136; 32 U.S.C.; DoD Directive 6495.01; DoD Instruction 6495.02; 10 U.S.C. 3013; Army Regulation 600-20, Chapter 8; 10 U.S.C. 5013; Secretary of the Navy Instruction 1752.4A: Marine Corps Order 1752.5A; 10 U.S.C. 8013; Air Force Instruction 36-6001; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): Information will be used to document elements of the sexual assault response and/or reporting process and comply with the procedures set up to effectively manage the sexual assault prevention and response program. At the local level, Service SAPR Program Management, Major Command Sexual Assault Response Coordinator(s) (SARCs), Installation and Brigade SARCs use information to ensure that victims are aware of services available and have contact with medical treatment personnel and DoD law enforcement entities. At the DoD level, only de-identified data is used to respond to mandated congressional reporting requirements. The DoD Sexual Assault Prevention and Response Office has access to identified closed case information and de-identified, aggregate open case information for congressional reporting, study, research, and analysis purposes. Collected information is covered by DHRA 06 DoD, Defense Sexual Assault Incident Database (http://dpclo.defense.gov/privacy/SORNs/component/osd/DHRA06DoD.html).

ROUTINE USE(S): The DoD blanket routine uses found at http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.html may apply to this record. Note: Any release made as a blanket routine use will be consistent with the principal purpose of its original collection.

DISCLOSURE: Voluntary. However, if you decide not to provide certain information, it may impede the ability of the SARC to offer the full range of care and support established by the sexual assault prevention and response program. You will not be denied benefits via the Restricted Reporting option. The Social Security Number (SSN) is one of several unique personal identifiers that may be provided. This form will be stored electronically in the Defense Sexual Assault Incident Database (DSAID) for 50 years for Unrestricted Reports.

1. REPORTING PROCESS AND OPTIONS DISCUSSED WITH THE SAPR VA OR SARC	DSAID CASE NUMBER:

a. I, *(full name)* _____ *(Social Security Number)* _____,
had the opportunity to talk with a Sexual Assault Prevention and Response Victim Advocate (SAPR VA) or a Sexual Assault Response Coordinator (SARC) before selecting a reporting option.

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

INITIALS	
	(1) I understand that law enforcement and my command will be notified that I am a victim of sexual assault. An investigation into the crime will be started by an MCIO. I can receive medical treatment, support services, and counseling. I can also choose to have a sexual assault forensic examination if indicated. I will be provided a DD Form 2701 which contains important information about my rights as a victim from the law enforcement or MCIO. I should retain the DD Form 2701. If reporting a sexual assault that occurred prior to or while not performing active service or inactive training, National Guard and Reserve Component members are eligible to receive SAPR support services from a SARC and a SAPR VA and are eligible to file an Unrestricted Report.
	(2) As a service member, I understand that: (a) (Through a separate form) I may request an Expedited Transfer (temporary or permanent) from my installation or to a different location within my installation. My family will be included.
	(b) Depending on the facts of my case, I may request a Military Protective Order (MPO). If a written and/or verbal MPO is issued, my commander will provide me with a copy of the DD Form 2873.
	(c) I also have the option of requesting a Civilian Protective Order (CPO) from civilian courts.
	(3) My Commanding Officer may take appropriate punishment action if there is evidence I committed misconduct around the time of the sexual assault. However, my Commanding Officer is to take into account the sexual assault investigation and circumstances when considering how to address my misconduct.
	(4) If the crime is prosecuted under the UCMJ, any communication with my SARC or SAPR VA are confidential under the "Victim-Victim Advocate Privilege" unless an exception applies.

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

	(1) I understand that I can confidentially receive medical treatment, advocacy services, and counseling. I can also choose to have a sexual assault forensic examination, if indicated. Law enforcement and my command will NOT be notified. My report will NOT cause an investigation of the crime. No action will be taken against the offender(s) as the result of my report. If reporting a sexual assault that occurred prior to or while not performing active service or inactive training, National Guard and Reserve Component members are eligible to receive SAPR support services from a SARC and a SAPR VA and are eligible to file a Restricted Report.
	(2) I understand that there are exceptions to "Restricted Reporting" (see Page 2) and they have been explained to me. If an exception applies, the details of my assault may be revealed.
	(3) I understand the evidence collected from my Sexual Assault Forensic Exam (SAFE) will be stored for 5 years from the date I sign this form. I will be contacted in 1 year by my SARC to discuss my options as they relate to this evidence. If the case is handled in civilian court, civilian law enforcement would handle the SAFE kit storage.
	(4) All state laws, local laws or international agreements that may limit some or all of DoD's Restricted Reporting protections have been explained to me. In the (state, city/county of _____, medical authorities must report the sexual assault to _____.
	(5) I understand that the SARC will provide information that does not reveal my identity, nor that of my offender, to the responsible senior commander. This notification takes place within 24 hours of my "Restricted Report". If I am at a deployed location or there are extenuating circumstances, the notification will be made within 48 hours. Commanders require this information for public safety and other responsibilities.
	(6) I understand that certain protective actions, such as an MPO and/or a CPO against the offender, or an expedited transfer and my victim's rights, will NOT be available to me if I choose Restricted Reporting.
	(7) I understand that speaking to others about my sexual assault may result in the crime being reported to command and law enforcement. This could lead to an investigation. I may keep my report confidential by only talking to those persons covered under the "Restricted Reporting" option (SARC, SAPR VA, or healthcare personnel). Communications with Chaplains and Legal Assistance Attorneys are also privileged and may not be disclosed without my consent.
	(8) I understand that I may change my mind and report this offense at a later time as an "Unrestricted Report", and law enforcement and my command will be notified. However, delays in changing the report from restricted to unrestricted may affect the amount of evidence gathered by an investigation and may impact the ability to hold offender(s) appropriately accountable.

DD FORM 2910, MAY 2013 PREVIOUS EDITION IS OBSOLETE. Adobe Designer 9.0

1.c. RESTRICTED REPORTING *(Continued)*	
INITIALS	(9) If the crime is prosecuted under the UCMJ, any communications with my SARC or SAPR VA are confidential under the "Victim-Victim Advocate Privilege". However, there are exceptions to this privilege that may allow our communications to become evidence in military court. This privilege does not extend to civilian courts proceedings.
d. I also understand that:	
	(1) If I do not choose a reporting option right now or if I refuse to sign this form, the SARC or SAPR VA has no obligation to inform investigators or commanders about my sexual assault. The SARC or SAPR VA may only disclose information about our conversation according to the exceptions to the Victim-Victim Advocate privilege.
	(2) I have the right to decline any or all SAPR services. I may also ask for a different SAPR VA if one is available.
	(3) I have been advised to keep a signed and dated copy of this form for my records. This form may be used in other matters before other agencies (e.g., Department of Veterans Affairs) or for other lawful purposes. **Restricted Reports:** By signing this form I am giving consent that for Restricted Reports, this form will remain with the SARC for 50 years; if not requested, it will be retained, by policy, for 5 years (See block 8 below). **Unrestricted Reports:** By signing this form I am giving consent that for Unrestricted Reports, this form will be stored electronically in DSAID for 50 years.
2. CHOOSE A REPORTING OPTION *(Initial)*	
	a. **I elect Unrestricted Reporting.** I have decided to report that I am a victim of sexual assault to my command, law enforcement, or other military authorities for investigation of this crime. I understand that a Restricted Report is no longer available to me.
	b. **I elect Restricted Reporting.** I have decided to confidentially report that I am a victim of sexual assault. Law enforcement or other military authorities will NOT be notified unless one of the exceptions applies. I understand the information I provide will NOT start an investigation or be used to hold the offender(s) accountable. I understand that I can switch to Unrestricted Reporting at any time.
	RESTRICTED REPORT CASE NUMBER:

3.a. SIGNATURE OF VICTIM	b. DATE *(YYYYMMDD)*	4.a. SIGNATURE OF SARC/SAPR VA	b. DATE *(YYYYMMDD)*

5. I have reconsidered my previous selection of "Restricted Reporting" and am now choosing to make an Unrestricted Report.

a. SIGNATURE OF VICTIM	b. DATE *(YYYYMMDD)*	c. SIGNATURE OF SARC/SAPR VA	d. DATE *(YYYYMMDD)*

EXCEPTIONS TO "RESTRICTED REPORTING"

There are exceptions to Restricted Reporting. This means that sometimes circumstances require that your Restricted Report of sexual assault must be disclosed. The following persons or organizations may be told about your sexual assault report for the following reasons:

1. Command officials or law enforcement when you provide written authorization.
2. Command officials or law enforcement to prevent or lessen a serious and imminent threat. This may be a threat to the health or safety of you or another person. Multiple reports involving the same alleged suspect may also meet this criteria.
3. Disability Evaluation Boards, Medical Evaluation Boards, and the officials participating in the boards. The report may be disclosed to these parties when it is required for fitness for duty or disability retirement determinations. Disclosure is limited to only that information necessary to make a determination for disability processing.
4. SARC, SAPR VA or healthcare personnel when required for the direct supervision of victim services.
5. Military or civilian courts when ordered, or if disclosure is required by Federal or state statute.

Before disclosing any information, SARCs, SAPR VAs and healthcare personnel will first consult with the servicing legal office. The legal office will determine if any of the above exceptions apply, if there is a duty to disclose the information, and who will make the disclosure when required.

6. VICTIM CONSENTED TO TRANSFER OF (RR/UR) CASE DOCUMENTS TO ANOTHER SARC: *(X and complete as applicable)*
☐ Yes ☐ No If yes: Date *(YYYYMMDD)* _____ Location of Transfer: _____

7. VICTIM CONTACTED AT 1-YEAR MARK OF THE RESTRICTED REPORT: *(X and complete as applicable)*
☐ Yes ☐ No If yes: Date *(YYYYMMDD)* _____ If not, document how the SARC attempted to locate the victim:

8.a. VICTIM REQUESTED TO KEEP RESTRICTED REPORT DD FORM 2910 FOR 50 YEARS: *(X one)*
☐ Yes ☐ No

8.b. VICTIM REQUESTED TO KEEP RESTRICTED REPORT DD FORM 2911 FOR 50 YEARS: *(X one)*
☐ Yes ☐ No

9. VICTIM REQUESTED A SECOND COPY OF THE DD FORM 2910: *(X and complete as applicable)*
☐ Yes ☐ No If yes: Date *(YYYYMMDD)* _____

10. VICTIM REQUESTED A COPY OF THE DD FORM 2911 FROM SAFE KIT. I FACILITATED THIS REQUEST: *(X and complete as applicable)*
☐ Yes ☐ No If yes: Date *(YYYYMMDD)* _____

11. I understand that I cannot request an Expedited Transfer, a Military Protective Order, or a Civilian Protective Order through this form. *(X one)*
☐ Yes ☐ No

APPENDIX L

This form is part of the public domain. *See* 17 U.S.C. § 105.

DoD SEXUAL ASSAULT FORENSIC EXAMINATION REPORT

PRIVACY ACT STATEMENT

AUTHORITY: Section 301 of Title 5 U.S.C. and Chapter 55 of Title 10 U.S.C.; DoDD 6495.01, Sexual Assault Prevention and Response (SAPR) Program; and DoDI 6495.02 Sexual Assault Prevention and Response Program Procedures.
PRINCIPAL PURPOSE(S): Information on this form will be used to document the medical/forensic examination of the sexual assault victim. The DD Form 2911 also documents the reporting preference (Restricted or Unrestricted) of the sexual assault victim as part of the sexual assault prevention and response program.
ROUTINE USE(S): None.
DISCLOSURE: Completion of this form is voluntary; however, failure to complete this form with the information requested impedes the effective management of care and support required by the procedures of the sexual assault prevention and response program.

Patient Identification

Sensitive Information Document

PART I (NOTE: Conduct a SAFE for up to one full week following a sexual assault, or longer if circumstances dictate.)

A. GENERAL INFORMATION *(Print or type)*

Name of Medical Facility:

1a. NAME OF PATIENT *(Last, First, Middle Initial)*			b. PATIENT ID NUMBER		
2a. ADDRESS	b. CITY	c. COUNTY	d. STATE	e. ZIP CODE	f. TELEPHONE *(Include Area Code)* (1) Home: (2) Work:

3a. AGE	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. GENDER *(X)*	d. ETHNICITY *(X)*	e. RACE *(X)*
		☐ M ☐ F	☐ (1) Hispanic or Latino ☐ (2) Not Hispanic or Latino	☐ (1) American Indian/ Alaska Native ☐ (2) Asian ☐ (3) Black or African American ☐ (4) White ☐ (5) Native Hawaiian/ Other Pacific Islander

4a. ARRIVAL DATE *(YYYY/MM/DD)*	b. TIME	5a. DISCHARGE DATE *(YYYY/MM/DD)*	b. TIME

B. NOTIFICATION AND AUTHORIZATION:

Location of Assault: ☐ On Installation ☐ Off Installation Jurisdiction: ☐ City ☐ County ☐ Other Civilian or Foreign Assisting Agency:

1a. NAME OF SEXUAL ASSAULT RESPONSE COORDINATOR (SARC) *(Last, First, Middle Initial)*	b. TELEPHONE *(Include Area Code)*

2a. NAME OF SEXUAL ASSAULT FORENSIC EXAMINER *(Last, First, Middle Initial)*	b. RANK	c. TITLE	d. TELEPHONE *(Include Area Code)*

3a. NAME OF VICTIM ADVOCATE (VA) *(Last, First, Middle Initial)*	b. TELEPHONE *(Include Area Code)*

4a. NAME OF MILITARY CRIMINAL INVESTIGATIVE OFFICER (UNRESTRICTED REPORT) *(Last, First, Middle Initial)*	b. TELEPHONE *(Include Area Code)*

c. AGENCY	d. ID NUMBER	e. DATE *(YYYY/MM/DD)*

5a. NAME OF SERVICE DESIGNATED EVIDENCE COLLECTING OFFICER (RESTRICTED REPORT) *(Last, First, Middle Initial)*	b. TELEPHONE *(Include Area Code)*

c. AGENCY	d. ID NUMBER	e. DATE *(YYYY/MM/DD)*	f. TIME	g. RESTRICTED REPORT CONTROL NUMBER *(RRCN)*

C. REPORTING INFORMATION

1. In unrestricted reporting, I understand that Military Medical Treatment Facilities and Healthcare Providers are required by Department of Defense regulations to report sexual assaults to Military Criminal Investigative Organization authorities (e.g., CID, NCIS, AFOSI). Under these circumstances, the report must state the name of the injured person, current whereabouts, and the type and extent of injuries. In Restricted reporting, I understand that Military Medical Treatment Facilities and Healthcare Providers are required by Department of Defense regulations to report sexual assaults to the Sexual Assault Response Coordinator (SARC).	*(Initial)*
2. The Sexual Assault Response Coordinator (SARC) and/or Victim Advocate (VA) have explained the difference between Unrestricted and Restricted Reporting options. I have elected: ☐ **UNRESTRICTED REPORTING** ☐ **RESTRICTED REPORTING (Only applicable to Active Duty, and Reserve and National Guard in active service or inactive duty training)** Note: Military dependents under age 18 who have been sexually assaulted by either parent and/or caregiver are not covered under the sexual assault restricted reporting policy.	*(Initial)*
3. I understand what my options are and do not have questions.	*(Initial)*

D. PATIENT CONSENT

1. I understand that the Sexual Assault Forensic Examination (also known as a "SAFE") that I am about to undergo is optional. When I give my consent, a healthcare professional may examine me to find and collect evidence of an assault. I understand that as part of the examination, the provider can collect specimens to include my hair, urine and/or blood, both now and at a later date, if necessary.	☐ YES ☐ NO *(Initial)*	**Patient Identification**
2. I understand that I may withdraw my consent at any time for any portion of the examination and that it will not impact my right to medical care.	☐ YES ☐ NO	*(Initial)*
3. I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area.	☐ YES ☐ NO	*(Initial)*
4. I understand that samples of my blood and/or urine may need to be tested for drugs as part of my treatment. I also understand that testing for drugs will also show prescriptions, other drugs, and alcohol that I have voluntarily consumed. I understand that illegal drugs or alcohol (if I am under age 21) in my body could be used to show that I engaged in misconduct if I am a Service member. I consent to this testing and the release of the result to law enforcement.	☐ YES ☐ NO	*(Initial)*
5. I understand that some of the information that I provide may be collected for health and forensic purposes and provided to health authorities and other qualified persons for a valid educational or scientific interest and/or epidemiological studies. However, none of my personally identifying data (name, patient identification number, etc.) will be disclosed for these purposes.	☐ YES ☐ NO	*(Initial)*
6. I hereby consent to a sexual assault medical forensic examination (SAFE).	☐ YES ☐ NO	*(Initial)*
7. If I have elected to make an Unrestricted Report, I understand and consent to the release of my records and all evidence collected from this exam to law enforcement.	☐ YES ☐ NO	*(Initial)*
8. If I have elected to make a Restricted Report, I understand that my records and all evidence collected should not be reviewed or tested unless I choose to convert to an Unrestricted Report.	☐ YES ☐ NO	*(Initial)*

9a. PATIENT SIGNATURE	b. DATE *(YYYY/MM/DD)*	c. TIME

10. PATIENT PARENT OR GUARDIAN *(If applicable)*

a. SIGNATURE	b. ADDRESS *(If different from patient) (Include ZIP Code)*	c. DATE *(YYYY/MM/DD)*	d. TIME

11. WITNESS TO PATIENT SIGNATURE

a. SIGNATURE	b. ADDRESS *(Include ZIP Code)*	c. DATE *(YYYY/MM/DD)*	d. TIME

E. PATIENT HISTORY

1a. NAME OF PERSON PROVIDING HISTORY *(Last, First, Middle Initial)*

b. RELATIONSHIP TO PATIENT	c. DATE *(YYYY/MM/DD)*	d. TIME

Patient Identification

2. PERTINENT MEDICAL HISTORY

a. LAST MENSTRUAL PERIOD

b. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? *(If yes, describe)*
☐ No
☐ Yes

c. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? *(If yes, describe)*
☐ No
☐ Yes

d. Any pre-existing physical injuries? *(If yes, describe)*
☐ No
☐ Yes

3. PERTINENT NON-ASSAULT RELATED HISTORY

a. Other non-assault sexual activity within past 5 days? **Do NOT record any other information regarding sexual history on this form.**
☐ No ☐ Yes ☐ Unsure If yes or unsure, complete items b. through f. below. If no, then check the "No" box to the left and proceed to Item 4.

(X and complete as applicable)	No	Yes	Unsure	*(If Yes)*
b. Anal (within past 5 days)?				When?
c. Vaginal (within past 5 days)?				When?
d. Oral (within past 5 days)?				When?
e. Did ejaculation occur?				Where?
f. Was a condom used?				

4. POST-ASSAULT HYGIENE/ACTIVITY ☐ Not Applicable if over 5 days

(X and complete as applicable)	No	Yes		No	Yes
a. Urinated			h. Brushed teeth		
b. Defecated			i. Gargled/mouthwash		
c. Genital or body wipes *(If yes, describe)*			j. Vomited		
			k. Ate or drank		
d. Douched *(If yes, with what)*			l. Used cream/ointment/lotion on body part involved in assault *(If yes, describe)*		
e. Removed/inserted ☐ Tampon ☐ Diaphragm ☐ Nuva ring			m. Changed clothing *(If yes, describe)*		
f. Oral gargle/rinse			n. Changed body piercings *(If yes, describe)*		
g. Bath/shower/wash					

F. ASSAULT HISTORY

1a. DATE OF ASSAULT(S) *(YYYY/MM/DD)*	2. LOCATION AND PERTINENT PHYSICAL SURROUNDINGS
b. TIME	

3. PHYSICAL EFFECTS OF ASSAULT. If injuries are described or if remarkable findings or possible trauma are observed, please photograph.

a. Non-genital injury, pain and/or bleeding (including tenderness). *(If yes, describe.)*
☐ No
☐ Yes

b. Genital/rectal injury, pain and/or bleeding (including tenderness). *(If yes, describe.)*
☐ No
☐ Yes

4. INJURIES INFLICTED UPON THE ASSAILANT(S) DURING ASSAULT? *(If yes, describe injuries, possible locations on the body, and how they were inflicted.)*
☐ No
☐ Yes

5a. NUMBER OF ASSAILANT(S)	b. ASSAILANT(S) RELATIONSHIP TO VICTIM *(Indicate/number all that apply)*
	☐ Stranger ☐ Acquaintance ☐ Relative *(Specify)* _____ ☐ Other *(Specify)* _____

G. PATIENT'S DESCRIPTION OF THE ASSAULT

Please record the patient's description of the assault.
Add additional pages if necessary.

Patient Identification

H. ACTS DESCRIBED BY PATIENT

- Describe any penetration of the genital, anal or oral opening, no matter how slight or brief.
- Type of sexual intercourse (oral, vaginal, anal).
- If more than one assailant, identify by number.

Patient Identification

	No	Yes	Attempted	Unsure	Describe:
1. PENETRATION OF VAGINA BY					
a. Penis					
b. Finger					
c. Object *(If yes, describe the object)*					
2. PENETRATION OF ANUS BY					
a. Penis					
b. Finger					
c. Object *(If yes, describe the object)*					
3. ORAL COPULATION OF GENITALS					
a. Of patient by assailant					
b. Of assailant by patient					
4. ORAL COPULATION OF ANUS					
a. Of patient by assailant					
b. Of assailant by patient					
5. NON-GENITAL ACT(S)					
a. Licking					
b. Kissing					
c. Suction injury					
d. Biting					
e. Strangulation/choking					

6. OTHER ACT(S) *(Describe)*

7. DID EJACULATION OCCUR?	No	Yes	Unsure
(If yes, location(s))			

☐ Mouth ☐ Rectum ☐ Other *(note location(s))*
☐ Vagina ☐ Body surface
☐ Genitals ☐ On clothing
☐ Anus ☐ On bedding

8. CONTRACEPTIVE OR LUBRICANT PRODUCT(S)

	No	Yes	Unsure	Describe Type/Brand, if known:
a. Condom used?				
b. Lubricant used?				
c. Other Contraceptive used?				

I. GENERAL PHYSICAL EXAMINATION

- Record all findings using diagrams, legend, and a consecutive numbering system.
- If injuries are described or if remarkable findings or possible trauma are observed, please photograph.

1a. Weight	b. Blood Pressure	c. Pulse	d. Resp	e. Temp	f. Pulse Oxygen

2a. Exam Started		b. Exam Completed	
Date *(YYYYMMDD)*	Time	Date *(YYYYMMDD)*	Time

Patient Identification

3. Describe general physical appearance. *(Use observations, not conclusions.)*

4. Describe general demeanor. *(Including affect, behavior and orientation. Use observations, not conclusions.)*

5. Describe condition of clothing upon arrival. *(If the patient has not changed after the assault)*

6. Collect outer and underclothing if indicated. ☐ Not Indicated

7. Conduct a physical examination. Use the history obtained earlier to guide your examination and recovery of evidence. ☐ Findings ☐ No Findings Observed

8. Scan the entire body with an Alternate Light Source (such as a Wood's Lamp). Collect dried and moist secretions, stains, and foreign materials from the body. Label box and envelope with the location of the collection. ☐ Findings ☐ No Findings Observed

9. Was there a history of scratching? ☐ No ☐ Yes ☐ Unsure If yes or unsure, collect fingernail clippings. If there is not enough fingernail to clip, then swab fingernails.

10. Was there a history of kissing, licking or sucking parts of the body? ☐ No ☐ Yes ☐ Unsure
If yes or unsure, collect swabs of the body areas that were believed to be contacted by the suspect's mouth. *(Head and genitals are addressed in the next sections.)*

Diagram A

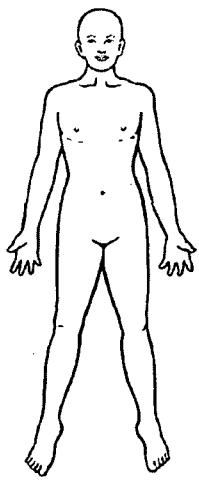
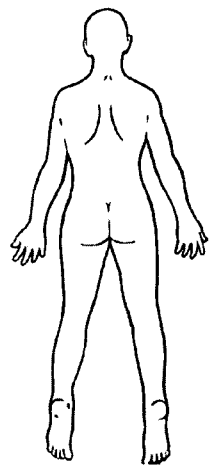


Diagram B



LEGEND: TYPES OF FINDINGS. RECORD ALL CLOTHING AND SPECIMENS COLLECTED IN SECTION O.

AB	Abrasion	**BU**	Burn	**DF**	Deformity	**FB**	Foreign Body	**MS**	Moist Secretion	**PE**	Petechiae	**SW**	Swelling
ALS	Alternate Light Source	**CS**	Control Swab	**DS**	Dry Secretion	**IN**	Induration	**OF**	Other Foreign Materials *(describe)*	**PS**	Potential Saliva	**TB**	Toluidine Blue®
		CT	Contusion (bruise)	**ER**	Erythema (redness)	**IW**	Incised Wound			**SHX**	Sample Per History	**TE**	Tenderness
BI	Bite	**DE**	Debris	**F/H**	Fiber/Hair	**LA**	Laceration	**OI**	Other Injury *(describe)*	**SI**	Suction Injury	**V/S**	Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

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J. HEAD, NECK, THROAT AND ORAL EXAMINATION

- **Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.**
- **If injuries are described or if remarkable findings or possible trauma are observed, please photograph.**

Patient Identification

1. **Examine the face, head, hair, scalp, neck and throat for injury and foreign materials.** ☐ Findings ☐ No Findings Observed
2. **Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, neck, throat and scalp.** ☐ Findings ☐ No Findings Observed
3. **Examine the oral cavity for injury and foreign material** *(If indicated by assault history).* **Collect foreign materials.** Exam done: ☐ Not applicable ☐ Yes ☐ Findings ☐ No Findings Observed
4. **Collect at a minimum 1 external mouth swab and 2 swabs from the oral cavity** *(if indicated by history).*
5. **Collect head hair combing or brushing.**

Diagram C

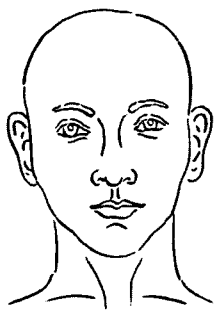


Diagram D

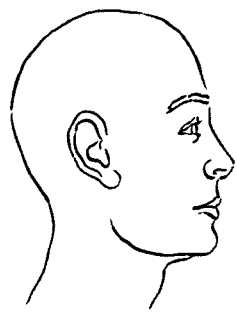


Diagram E

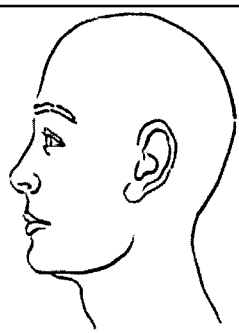
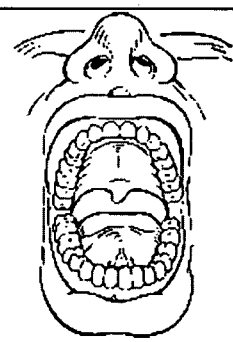


Diagram F



LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.

AB	Abrasion	**BU**	Burn	**DF**	Deformity	**FB**	Foreign Body	**MS**	Moist Secretion	**PE**	Petechiae	**SW**	Swelling
ALS	Alternate Light Source	**CS**	Control Swab	**DS**	Dry Secretion	**IN**	Induration	**OF**	Other Foreign Materials *(describe)*	**PS**	Potential Saliva	**TB**	Toluidine Blue⊖
		CT	Contusion (bruise)	**ER**	Erythema (redness)	**IW**	Incised Wound			**SHX**	Sample Per History	**TE**	Tenderness
BI	Bite	**DE**	Debris	**F/H**	Fiber/Hair	**LA**	Laceration	**OI**	Other Injury *(describe)*	**SI**	Suction Injury	**V/S**	Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

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K. GENITAL EXAMINATION - FEMALE

- **Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.**
- **If injuries are described or if remarkable findings or possible trauma are observed, please photograph.**

1. Examine the inner thighs, external genitalia, and perineal area. If there are findings, describe *(including location)*. *(If available and appropriate, consider the use of toluidine blue dye.)* ☐ Findings ☐ No Findings Observed

- ☐ Abdomen
- ☐ Thighs
- ☐ Perineum
- ☐ Labia majora
- ☐ Labia minora
- ☐ Clitoral hood and surrounding area
- ☐ Perineal/anal tissue/ urethral meatus
- ☐ Hymen
- ☐ Fossa navicularis
- ☐ Posterior fourchette

Patient Identification

2. Scan the area with an Alternate Light Source. Collect dried and moist secretions, stains, and foreign materials. ☐ Findings ☐ No Findings Observed

3. Collect pubic hair combing or brushing. If there is no pubic hair, conduct an external swab of genitalia.

4. Examine the vagina and cervix. If there are findings, describe *(including location)*. *(If available and appropriate, consider the use of toluidine blue dye.)*. ☐ Findings ☐ No Findings Observed

a. Collect the following swabs: 2 pubic mound (if there is no pubic hair), 2 vaginal, and 2 cervical.

5. Examine the buttocks, anus, and perineum.

a. Findings from buttocks, anus, or perineum. If there are findings, describe *(including location) (If available and appropriate, consider use of toluidine blue dye.)*. ☐ Yes ☐ No Findings Observed

b. Collect dried and moist secretions, and foreign materials. ☐ Findings ☐ No Findings Observed

c. Collect 2 swabs of the perineum. d. Collect 2 anal swabs.

6. Conduct a rectal exam (using anoscope if possible) if rectal injury is suspected or if there is any sign of rectal bleeding.

a. Rectal exam done: ☐ Yes ☐ Not applicable
b. Rectal bleeding: ☐ No ☐ Yes
c. Was an anoscopic exam done? ☐ No ☐ Yes
d. If exam was done, what position was used? ☐ Supine Lithotomy ☐ Other *(describe)*
e. If exam was done, describe findings: f. Collect a rectal swab if indicated.

Diagram G

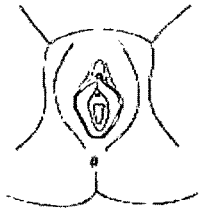


Diagram H

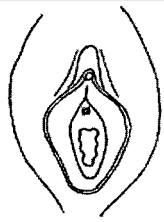
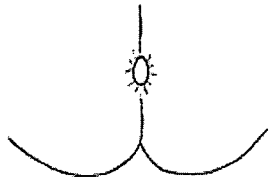


Diagram I

Diagram J



LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.

AB	Abrasion	BU	Burn	DF	Deformity	FB	Foreign Body	MS	Moist Secretion	PE	Petechiae	SW	Swelling
ALS	Alternate Light Source	CS	Control Swab	DS	Dry Secretion	IN	Induration	OF	Other Foreign Materials *(describe)*	PS	Potential Saliva	TB	Toluidine Blue⊙
BI	Bite	CT	Contusion (bruise)	ER	Erythema (redness)	IW	Incised Wound			SHX	Sample Per History	TE	Tenderness
		DE	Debris	F/H	Fiber/Hair	LA	Laceration	OI	Other Injury *(describe)*	SI	Suction Injury	V/S	Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

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L. GENITAL EXAMINATION - MALE

- **Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.**
- **If injuries are described or if remarkable findings or possible trauma are observed, please photograph.**

Patient Identification

1. Examine the inner thighs, external genitalia, and perineal area.
If there are findings, describe *(including location). (If available and appropriate, consider the use of toluidine blue dye.)* ☐ Findings ☐ No Findings Observed

☐ Abdomen ☐ Urethral meatus ☐ Glans
☐ Thighs ☐ Shaft ☐ Testes
☐ Foreskin ☐ Scrotum

2. Circumcised: ☐ No ☐ Yes

3. Scan the area with an Alternate Light Source (such as a Wood's Lamp). Collect dried and moist secretions, stains, and foreign materials. ☐ Findings ☐ No Findings Observed

4. Collect pubic hair combing or brushing. If no pubic hair, conduct external swab at base of penis.

5. If indicated by assault history, collect the following swabs: 2 penile and 2 scrotal.

6. Examine the buttocks and perineum *(if indicated by history).* If there are findings, describe *(including location). (If available and appropriate, consider the use of toluidine blue dye.)*
a. Findings from buttocks, anus, or perineum.
☐ Yes ☐ None Observed
b. Collect dried and moist secretions, and foreign materials.
☐ Findings ☐ No Findings Observed

7. Collect 2 anal swabs.

8. Conduct a rectal exam (using anoscope if possible) if rectal injury is suspected or if there is any sign of rectal bleeding.
a. Rectal exam done? ☐ Yes ☐ No
b. Rectal bleeding: ☐ Yes ☐ None Observed
c. Was an anoscopic exam done? ☐ Yes ☐ No
d. If exam was done, what position was used? ☐ Supine ☐ Other *(describe)*
e. If exam was done, describe findings:

Diagram K

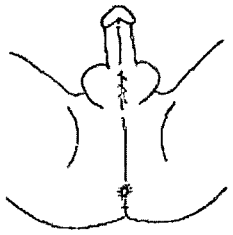


Diagram L

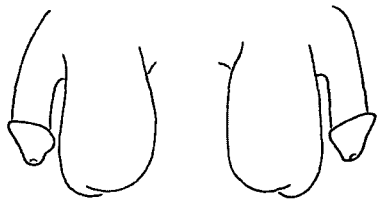


Diagram M

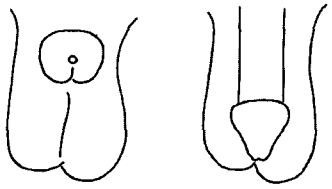
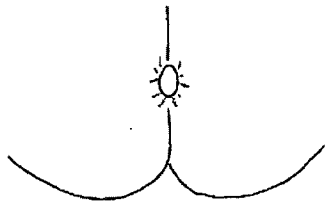


Diagram N



LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.

AB	Abrasion	BU	Burn	DF	Deformity	FB	Foreign Body	MS	Moist Secretion	PE	Petechiae	SW	Swelling
ALS	Alternate Light Source	CS	Control Swab	DS	Dry Secretion	IN	Induration	OF	Other Foreign Materials *(describe)*	PS	Potential Saliva	TB	Toluidine Blue®
		CT	Contusion (bruise)	ER	Erythema (redness)	IW	Incised Wound			SHX	Sample Per History	TE	Tenderness
BI	Bite	DE	Debris	F/H	Fiber/Hair	LA	Laceration	OI	Other Injury *(describe)*	SI	Suction Injury	V/S	Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

M. TOXICOLOGY

Toxicology examples must be collected as soon as possible due to the limited time frame in which they can be collected. If the assault happened within 96 hours of the examination and the answer to any of these questions is Yes or Unsure, use the DoD Toxicology Kit.

1. Loss of memory? *(If yes, describe)* ☐ No ☐ Yes

Patient Identification

2. Lapse of consciousness? *(If yes, describe)* ☐ No ☐ Yes ☐ Unsure

3. Vomited? *(If yes, describe. Include location and number of times.)* ☐ No ☐ Yes

4.a. Voluntary ingestion of alcohol/drugs? ☐ No ☐ Yes ☐ Unsure
If yes: ☐ Alcohol ☐ Drugs

b. Involuntary ingestion of alcohol/drugs? ☐ No ☐ Yes ☐ Unsure
If yes: ☐ Alcohol ☐ Drugs

5. Was a clinical toxicology lab conducted? ☐ No ☐ Yes

6. FOR UNRESTRICTED REPORTS: Was a DoD Toxicology Kit completed? ☐ No ☐ Yes

N. RECORD EXAM METHODS

1. Direct visualization only	☐ No ☐ Yes	5. Toluidine Blue Dye	☐ No ☐ Yes	*(If Other, describe)*
2. Alternate Light Source	☐ No ☐ Yes	6. Anoscopic exam	☐ No ☐ Yes	
3. Digital Camera	☐ No ☐ Yes	7. Vaginal speculum exam	☐ No ☐ Yes	
4. Colposcope or Other Magnifier	☐ No ☐ Yes	8. Other	☐ No ☐ Yes	

O. OBSERVATIONS. Please describe your observations.

P. EVIDENCE COLLECTED				
		No	Yes	Time Completed
1. TOXICOLOGY KIT				
Completed By	Released To			

Patient Identification

2. CLOTHING	No	Yes	Time Completed	Completed By	Released To
a. Undergarments placed in evidence kit					
b. Clothing placed in bags					

3. OTHER:	No	Yes	Time Completed	Completed By	Released To
a. Swabs, suspected blood					
b. Dried secretions					
c. Fiber/loose hairs					
d. Vegetation					
e. Soil/debris					
f. Swabs/suspected semen					
g. Swabs/suspected saliva					
h. Swabs/Alternate Light Source area(s)					
i. Fingernail cuttings					
j. Fingernail scrapings/swabbings					
k. Matted hair cuttings					
l. Pubic hair combings/brushings					
m. Intravaginal foreign body *(If yes, describe)*					
n. Other types *(If yes, describe)*					

4. ORAL, GENITAL, RECTAL SAMPLES	# Swabs	Time Completed	Completed By		# Swabs	Time Completed	Completed By
a. External oral swab(s)				f. Perineal swab(s)			
b. Oral cavity swab(s)				g. Anal swab(s)			
c. Vaginal swab(s)				h. Rectal swab(s)			
d. Cervical swab(s)				i. Other *(If yes, describe)*			
e. Pubic mound swab(s)							

5. REFERENCE SAMPLES	No	Yes	Time Completed	Completed By		No	Yes	Time Completed	Completed By
a. Blood Card					d. Other *(describe)*				
b. Known Head Hair									
c. Known Pubic Hair									

Q. PHOTO DOCUMENTATION METHODS	
1. TYPE OF CAMERA ☐ 35 mm ☐ Polaroid ☐ Digital ☐ Colposcope ☐ Other	
2. DISPOSITION OF FILM/DISK	Patient Identification

3. PHOTO LIST	
Photo Number	Description of Photo

R. OTHER DOCUMENTS INCLUDED - If there are any other documents included with this report, please list:

S. PERSONNEL INVOLVED - Print names.

1. HISTORY TAKEN BY	Telephone (Include Area Code)	2. EXAM PERFORMED BY	Telephone (Include Area Code)
3. SPECIMENS LABELED AND SEALED BY	Telephone (Include Area Code)	4. ASSISTED BY	

T. EVIDENCE DISTRIBUTION

1. TOXICOLOGY KIT GIVEN TO:	2. EVIDENCE KIT AND _____ BAGS GIVEN TO:
3. ITEMS RETURNED TO PATIENT (describe)	4. OTHER (describe) Given to:

U. PERSON RECEIVING EVIDENCE - For Unrestricted Report - MCIO; for Restricted Report - See Service Policy.

1. SIGNATURE	2. PRINTED NAME AND ID NUMBER	
3. AGENCY	4. DATE (YYYYMMDD)	5. TELEPHONE (Include Area Code)

DoD SEXUAL ASSAULT FORENSIC EXAMINATION REPORT

PART II - DoD TOXICOLOGY KIT - FOR UNRESTRICTED REPORTS ONLY

BLOOD AND URINE SPECIMEN COLLECTION INSTRUCTIONS

Notes:
(A) This kit is to be used in conjunction with a DoD Medical Forensic Examination Kit when the patient indicates that there was memory loss, lapse of consciousness, involuntary or voluntary ingestion of drugs or alcohol, or if toxicology testing is otherwise indicated.
(B) Collect **both** blood and urine specimens in all cases.
(C) Urine samples should be collected from the victim as soon as possible due to the short window of detection for many of the drugs (including alcohol) involved in sexual assault.
(D) Based on timing of evidence pick up, refrigerate the sealed kit. However, if you are in a deployed or natural disaster environment that does not have refrigeration, it will be unlikely to preserve specimen.

STEP 1: Fill out the information requested on the Victim Information Form (next page).

BLOOD SPECIMEN COLLECTION

Note: Blood specimen collection must be performed only by a physician, registered nurse or trained phlebotomist.

STEP 2: Cleanse the blood collection site with the alcohol-free prep pad provided. Following normal hospital/clinic procedure, collect blood using two 10 ml blood collection tubes with 100 mg of sodium fluoride and 20 mg of potassium oxalate. Allow blood tubes to fill to maximum volume.

Notes:
(A) Immediately after blood collection, assure proper mixing of anticoagulant powder by slowly and completely inverting the blood tube at least five times. **Do NOT shake!**
(B) Discard venipuncture needle(s) and prep pads as recommended by OSHA guidelines. **Do NOT** place the venipuncture needle(s) or prep pads in the specimen collection box.

STEP 3: Fill out all information requested on two of the three Specimen Security Seals provided. Then remove backing from the two Specimen Seals. Affix center of seals to the blood tube rubber stoppers, and press ends of seals down sides of the blood tubes, then place both filled and sealed blood tubes in specimen holder.

URINE SPECIMEN COLLECTION

STEP 4: Have subject void directly into the urine specimen bottle provided. A minimum of 60 ml is required.

STEP 5: After specimen is collected, replace cap and tighten down to prevent leakage.

STEP 6: Fill out the information requested on the remaining Specimen Security Seal. Affix center of seal to the bottle cap and press ends of seal down sides of bottle, then place urine bottle in specimen holder.

STEP 7: Place specimen holder inside the zip lock bag, then squeeze out excess air and close the bag. Place specimen holder in kit box.

Note: Do not remove liquid absorbing sheet from specimen bag.

STEP 8: Place DoD Toxicology Kit Victim Information form in Toxicology Kit. Retain a copy of the form with the SAFE Report.

STEP 9: Close kit box and affix kit box shipping seal where indicated.

STEP 10: Fill out all information requested on kit box top under "For Hospital Personnel".

STEP 11: Hand sealed kit to investigating agent.

Note: If the officer is not present at this time, place sealed kit in secure and refrigerated area, and hold for pickup by investigating officer. Work with law enforcement/investigating agent to ensure the **CHAIN OF CUSTODY IS MAINTAINED.**

MCIO or investigating agent should mail kit with Form 1323, Toxicological Request Form (found at: www.afip.org) to:

Armed Forces Medical Examiner Division of Forensic Toxicology Bldg 1102 1413 Research Boulevard Rockville, MD 20850	**EFFECTIVE 1 DEC 2011:** **Armed Forces Medical Examiner** Division of Forensic Toxicology Bldg 115 Purple Heart Drive Dover AFB, DE 19902

DoD TOXICOLOGY KIT VICTIM INFORMATION FORM FOR UNRESTRICTED REPORTS ONLY	Patient Identification
1. VICTIM'S NAME *(Last, First, Middle Initial)*	
2. VICTIM'S DATE OF BIRTH *(YYYY/MM/DD)*	
3a. DATE OF SPECIMEN COLLECTION *(YYYY/MM/DD)*	b. TIME
4. IS VICTIM A SMOKER? ☐ Yes ☐ No	
5. IS VICTIM TAKING ANY PRESCRIPTION DRUGS? ☐ Yes ☐ No	
a. IF YES, NAME OF DRUG(S)	
b. DATE DRUG(S) LAST TAKEN *(YYYY/MM/DD)*	c. TIME
6. IS VICTIM TAKING ANY OVER-THE-COUNTER DRUGS? ☐ Yes ☐ No	
a. IF YES, NAME OF DRUG(S)	
b. DATE DRUG(S) LAST TAKEN *(YYYY/MM/DD)*	c. TIME
7. WHY IS DRUG SCREEN BEING REQUESTED?	
8. PERSON COLLECTING SAMPLE	
a. NAME *(Last, First, Middle Initial)*	b. TITLE / c. DATE *(YYYY/MM/DD)*

DD FORM 2911, SEP 2011 COPY 1 - TO BE SENT WITH KIT TO AFIP Page 14 of 14 Pages

APPENDIX M

For UNRESTRICTED Reports

Dear XXXX

This letter tells you what we will do with your claim and what you can do to help us. Please read the enclosure to this letter entitled, "Veteran Claims Assistance Act (VCAA)." The enclosure explains how we obtain evidence related to your claim and the legal requirements for supporting your claim.

What Do We Still Need from You?

We need additional evidence from you. ***Please put your VA file number on the first page of every document you send us.***

We need specific details of the personal trauma incident(s) that resulted in post traumatic stress disorder (PTSD). It is important that you read the following information and respond to our request within 30 days from the date of this letter. If you do not respond, VA may deny your claim.

Complete and return the enclosed questionnaire. We realize that this may be a difficult subject for you to discuss, but the information will be safeguarded and used only in support of your claim. If you are not able to provide the exact date of the incident, please indicate the location and approximate time (a 2-month specific date range) of the stressful event(s) in question.

Give us reports of private physicians, if any, who have treated you for this condition since discharge. The reports should include clinical findings and diagnosis. If you have been treated for this condition at a VA medical facility, furnish the date(s) and place(s). We will obtain the report(s).

If you have been treated in the Vet Center, tell us the dates of treatment and the address of the Vet Center. We will request the records.

Identify any possible sources of information and evidence such as police reports or medical treatment records for assault or rape.

Send us supporting statements from any individuals with whom you may have discussed the incident. Furnish copies of correspondence you may have sent to close friends or relatives in which you related information about the incident.

We have requested the following records from the Department of Defense:

- DD Form 2910, Victim Report Preference Statement, or similar form, and/or
- sexual assault forensic examination (SAFE).

If you have these records in your possession, please provide us with copies. If you don't have the records, you may obtain copies of them by contacting the Sexual Assault Prevention and Response Office (SAPRO) at the military base where you filed your report.

We need this evidence within 30 days.

- if evidence is not submitted within 30 days, VA may decide the claim based on all the information and evidence in the file, and

- you have one year from the date of VA's request to submit any evidence or information to substantiate the claim.

Send us any treatment records related to your claimed condition(s). This includes reports or statements from doctors, hospitals, laboratories, medical facilities, mental health clinics, x-rays, physical therapy records, surgical reports, etc. These should include the dates of treatment, findings, and diagnoses. If you want us to try to obtain any doctor, hospital or medical reports on your behalf, please complete and return the attached *VA Form 21-4142, Authorization and Consent to Release Information.*

If you have received treatment at a Department of Veterans Affairs (VA) facility or treatment authorized by VA, please tell us the dates and places of treatment. We will then obtain the necessary records if you give us enough information to locate them.

You may also send us your own statement, or statements from people who have witnessed how your claimed disabilities affect you. All statements submitted on your behalf should conclude with the following certification: "I hereby certify that the information I have given is true to the best of my knowledge and belief."

We have enclosed a "VCAA Notice Response." We encourage you to return this document, as it may expedite a decision on your claim.

Where Should You Send What We Need?

Please send what we need to this address:

Department of Veterans Affairs

[redacted]

How Soon Should You Send What We Need?

We strongly encourage you to send any information or evidence as soon as you can. If we do not hear from you, we may make a decision on your claim after 30 days. However, you have up to one year from the date of this letter to submit the information and evidence necessary to support your claim. If we decide your claim before one year from the date of this letter, you will still have the remainder of the one-year period to submit additional information or evidence necessary to support your claim.

What Have We Received?

XXXXXXXXXXXXXX

What Have We Done?

- Requested entire service personnel file.

Important Information

You may be able to receive free counseling and medical care for problems associated with personal assault whether or not you are receiving compensation. If you want information about counseling and treatment or you want to discuss these services before deciding, please contact the nearest VA medical facility or community based outpatient clinic (CBOC) or Vet Center. Also, the counselors at these facilities will be helpful to you in documenting the details of the stressful event that can be used to support your claim.

If you have any questions concerning your claim or our request for information, you should call name, our Women Veterans Coordinator, at phone number.

How Can You Contact Us?

If you are looking for general information about benefits and eligibility, you should visit our web site at http://www.va.gov. Otherwise, you can contact us in several ways. Please give us your VA file number, [redacted], when you do contact us.

Call us at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal number is 711 (international number is 1-800-829-4833).
Send us an inquiry using the Internet at https://iris.va.gov.
Write to us at the address at the top of this letter.

What is eBenefits?

eBenefits provides electronic resources in a self-service environment to service members, Veterans, and their families. Through the eBenefits website you can:

Track the status of your claim or appeal
View your payment history
Obtain verification of military service, civil service preference, or VA benefits
Receive a copy of your military discharge documents, and
Manage your VA life insurance policy

Enrolling in eBenefits is easy. Just visit www.eBenefits.va.gov for more information.

We look forward to resolving your claim in a fair and timely manner.

Sincerely yours,

Veterans Service Center Manager

Enclosures: VA Form 21-0781a
VA Form 21-4138
VA Form 21-4142
Veterans Claims Assistance Act (VCAA)
What the Evidence Must Show - Service connected comp
VCAA Notice Response
What the Evidence Must Show - Claim For Increase
What the Evidence Must Show - Secondary S/C

[redacted]

Veterans Claims Assistance Act (VCAA)

What the Evidence Must Show for Service Connection

To support your claim for service-connection, the evidence must show:

You had an injury in military service, or a disease that began in or was made permanently worse during military service, or there was an event in service that caused an injury or disease;
AND

You have a current physical or mental disability. This may be shown by medical evidence or by lay evidence of persistent and recurrent symptoms of disability that are visible or observable;
AND

A relationship exists between your current disability and an injury, disease, or event in military service. Medical records or medical opinions are generally required to establish this relationship. However, under certain circumstances, VA may presume that certain current disabilities were caused by service, even if there is no specific evidence proving this in your particular claim. The cause of a disability is presumed for the following veterans who have certain diseases:

Former prisoners of war;

Veterans who have certain chronic or tropical diseases that become evident within a specific period of time after discharge from service;

Veterans who were exposed to ionizing radiation, mustard gas, or Lewisite while in service;

Veterans who were exposed to certain herbicides, such as by serving in Vietnam; or

Veterans who served in the Southwest Asia theater of operations during the Gulf War.

What the Evidence Must Show for an Increased Evaluation

To support your claim for an increased evaluation of your service-connected disability, medical or lay evidence must show a worsening or increase in severity and the effect that worsening or increase has on your employment and daily life.

What the Evidence Must Show for Secondary Service Connection

In order to support your claim for compensation based upon an additional disability that was caused or aggravated by a service-connected disability, the evidence must show:

You currently have a physical or mental disability shown by medical evidence, in addition to your service-connected disability
AND

Your service-connected disability either caused or aggravated your additional disability. Medical records or medical opinions are required to establish this relationship. However, VA may presume service-connection for cardiovascular disease developing in a claimant with a certain service-connected amputation(s) of one or both lower extremities.

VA is Responsible for Getting the Following Evidence:

Relevant records that you adequately identify and authorize VA to obtain from any Federal agency. These may include records from the military, VA medical centers (including private facilities where VA authorized treatment), or the Social Security Administration.

VA will provide a medical examination for you, or get a medical opinion, if we determine it is necessary to decide your compensation claim.

On Your Behalf, VA Will Make Reasonable Efforts to Get the Following Evidence: Relevant records not held by a Federal agency that you adequately identify and authorize VA to obtain. These may include records from State or local governments, private doctors and hospitals, or current or former employers.

How Can You Help: If you have any information or evidence that you have not previously told us about or given to us, please tell us or give us that evidence now. If the evidence is not in your possession, you must give us enough information about the evidence so that we can request it from the person or agency that has it. If the holder of the evidence declines to give it to us, asks for a fee to provide it, or VA otherwise cannot get the evidence, we will notify you. *It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.*

How VA Determines the Disability Rating: When we find disabilities to be service connected, we assign a disability rating. That rating can be changed if there are changes in your condition. Depending on the disability involved, we will assign a rating from 0 percent to as much as 100 percent. VA uses a schedule for evaluating disabilities that is published as title 38, Code of Federal Regulations, Part 4. In rare cases, we can assign a disability level other than the levels found in the schedule for a specific condition if your impairment is not adequately covered by the schedule.

We consider evidence of the following in determining the disability rating:
Nature and symptoms of the condition;
Severity and duration of the symptoms; and
Impact of the condition and symptoms on employment.

Examples of evidence that you should tell us about or give to us that may affect how we assign a disability evaluation include the following:
Information about on-going treatment records, including VA or other Federal treatment records, you have not previously told us about;
Recent Social Security determinations;
Statements from employers as to job performance, lost time, or other information regarding how your condition(s) affect your ability to work; or
Statements discussing your disability symptoms from people who have witnessed how they affect you.

How VA Determines the Effective Date: If we grant your claim, the beginning date of your entitlement or increased entitlement to benefits will generally be based on the following factors:
When we received your claim; or
When the evidence shows a level of disability that supports a certain rating under the rating schedule or other applicable standards.

If VA received your claim within one year of your separation from the military, entitlement will

be from the day following the date of your separation.

Examples of evidence that are relevant to determining the effective date of any benefits we award include the following:
Information about continuous treatment or when treatment began;
Service treatment records in your possession that you may not have sent us; or
Reports of treatment for your condition while attending training in the Guard or Reserve.

VCAA NOTICE RESPONSE

Date of Claim:

We provided a notice to you about the evidence and information VA needs to support your claim for benefits. At this time, you may choose to indicate whether you intend to submit additional information or evidence that would help support your claim.

Your signed response will let us know whether to decide your claim without waiting 30 days, or whether we should give you the full 30 days from the date of the letter sent with this notice response before deciding your claim.

Your signature on this response will not affect:

Whether or not you are entitled to VA benefits;
The amount of benefits to which you may be entitled;
The assistance VA will provide you in obtaining evidence to support your claim; or
The date any benefits will begin if your claim is granted.

RESPONSE

I elect *one* of the following: (Whichever box you check, you have one year from the date of the notice to give VA any other information or evidence you think will support your claim.)

☐ I have enclosed all the remaining information or evidence that will support my claim, or I have no other information or evidence to give VA to support my claim. Please decide my claim as soon as possible.

☐ I will send more information or evidence to VA to support my claim. VA will wait the full 30 days from the date of the letter sent with this notice response before deciding my claim.

_____ _____

Claimant/Representative Signature Date

APPENDIX N

CODING SHEET FOR MST/PERSONAL ASSAULT ARTICLE (SEE ALSO, CODING KEY)

I. Initial Claims Processing Information:

1. Docket #:_____ 2. Citation #:_____ 3. Spreadsheet #:_____
4. RO Location:_____ 5. Type of Claim:_____ 6. Representation:_____
7. Service Dates:_____ 8. Service Branch:_____ 9. IN RD:_____
10. IN Disp:_____ 11. AP RD:_____ 12. AP Disp:_____
13. (A) CAVC?: Y / N / U (B) Disp. and Date:_____ 14. Elapsed Time Between Assault(s) and IN RD:_____

II. Claimant Information and MST/Personal Assault Experiences:

1. Gender (M, F, Unknown):____
2. Date of Initial Trauma:_____ 3. Duty Status at Time of MST / Personal Assault:_____
4. (A) More than one MST / Personal Assault Raised in the Claim? Y / N / U; (B) Date(s):_____
5. (A) Separate Claim for Acquired Psychiatric Disorder, inc. PTSD Included? Y / N / U (B) Basis:_____
6. (A) Law Enforcement Report? Y / N / U; (B) Retaliation Indicated? Y / N / U; (C) Hostile Deployment? Y / N / U; (D) Transferred? Y / N / U
7. Physical MST, Non-Physical MST, or Both Alleged?:_____ 8. Personal Assault (Non-MST)?: Y/ N / U
9. Pattern of Trauma (Indicate all that Apply):_____
10. Single or Multiple Assailants:_____ 11. Status of Assailant(s) (Indicate all that Apply):_____
12. (A) Pre-Service or Post-Service Sexual Assault in Addition to MST/Personal Assault Claim? Y / N / U (B) Type:_____

III. Information About the Evidence:

1. (A) Law Enforcement Complaint Filed? Y / N / U; (B) Type:_____; (C) Result:_____
2. (A) Delayed Law Enforcement Complaint? Y / N / U; (B) By How Long?_____
3. Date of First Mention of MST / Personal Assault in Decision/Opinion:_____
4. Level of Official Military Action Taken:_____
5. Claimant Subjected to Punitive Action? Y / N / U
6. (A) Character of Service Determination Involved: Y / N / U; (B) Characterization:_____
7. (A) Involuntary Separation from Military? Y / N / U; (B) Reason?:_____
8. Nature of Evidence Claimant Presented to Support IN MST / Personal Assault Claim:_____

IV. Information About the RO's Evaluation of the Evidence:

1. (A) Basis for Grant:_____ (B) Basis for Denial: _____
2. (A) Did RO Obtain VA Exam, VHA Opinion, or Independent Medical Evaluation? Y / N / U; (B) Type:_____
3. (A) Did RO Request Information Not Provided by Claimant? Y / N U; (B) Type:_____

V. Information About the BVA's Evaluation of the Evidence:

1. Date of BVA Decision:_____ 2. VLJ / AVLJ and Gender:_____
3. (A) Basis for BVA Grant:_____ (B) Basis for Denial: _____
4. (A) "Choice of Authority" Issue? Y / N / U; (B) Type:_____
5. BVA Supplemented Analysis With Add. Matters Not Considered During Initial Review? Y / N / U; (B) Type:_____
6. Basis for BVA Remand (Indicate all that Apply):_____

INDICATE NOTABLE CONCLUSIONS OR RELEVANT QUOTES FROM DECISIONS/OPINIONS AT BOTTOM OR ON REVERSE SIDE

CODING KEY FOR MST/PERSONAL ASSAULT ARTICLE

I. Initial Claims Processing Information:

4. RO Location: Regional Office Location
5. Type of Claim: Service Connection (SC); New and Material Evidence (NME); Clear and Unmistakable Error (CUE); or Other (O)
6. Representation: Veterans Service Organization (VSO); Attorney (A); Non-Attorney Agent (NAA); Pro Se (PS); or Other (O)
8. Army (A); Navy (N); Air Force (AF); Marine Corps (MC); Coast Guard (CG); Unknown/Not Identified (U)
9. IN RD: Date of Initial Rating Decision By RO
10. IN Disp: Initial Disposition by RO (Grant, Deny, or Remand)
11. AP RD: Date of Rating Decision by RO on Appeal (if different from # 9)
12. AP Disp: Disposition by RO on Appeal (Grant, Deny, or Remand, if different from #10)
13. Did Court of Appeals for Veterans Claims (CAVC) Address Claim? CAVC Disposition (Affirmed, Vacated, or Vacated/Remanded)

II. Claimant Information and MST/Personal Assault Experiences:

3. Duty Status at Time of MST: Select one from (A); one from (B)
   (A) Regular (RG), Reserve (RS), National Guard (NG); or Other (O)
   (B) Active Duty (AD); Active Duty Training (ADT); Inactive Duty Training (IDT); Active Duty Special Work (ADSW); or Other (O)

5. (B) Basis: Combat Related or Non-Combat Related

9. Pattern of Trauma (Indicate all that Apply):
   (A) Penetration or Attempted Penetration of any Orifice
   (B) No Penetration But With Fondling, Touching, or Kissing
   (C) Vicarious Trauma: I.e., watching others sexually assaulted or harassed
   (D) Verbal Sexual Comments/Come-Ons Only, including frequency, if known
   (E) Quid Pro Quo Promises or Threats in Exchange for Sexual Favors
   (F) Unconscious/Drugged
   (G) Physical Assault or Threats (non-MST)
   (H) Other (Specify)
   (I) Unknown/Not Identified

11. Status of Assailant(s) (Indicate all that Apply):
   (A) Military Same or Lower Rank
   (B) Military Higher Rank
   (C) Military Special Duty to Victim (Health Care Professional, Company Commander, etc.)
   (D) Contractor, Accompanying the Force
   (E) Foreign National, Accompanying the Force
   (F) Civilian, No Military Affiliation
   (G) Unknown/Not Identified

III. Information About the Evidence:

1. (B) Complaint Type: Civilian (C); Military (M); Joint (J); Both (B); or Unknown/Not Identified (U)
   (C) Result: Substantiated (S); Unsubstantiated (US); Proven False (PF); Insufficient Evidence (IE); or Unknown/Not Identified (U)

4. Level of Official Military Action Taken:
   (A) Court-Martial: (i) Summary, (ii) Special; (iii) General; (iv) Unknown/Not Identified
   (B) Result: (i) Conviction on Sexual Assault Charge; (ii) Conviction on Other Charges; (iii) Full Acquittal; (iv) Unknown/Not Identified
   (C) Non-Judicial Punishment (Article 15)
   (D) Administrative Separation
   (E) No Action
   (F) Unknown/Not Identified

6. (B) Character of Service Determination: Honorable (H); Other Than Honorable (OH); General (G); Dishonorable (D); Unknown/Not Identified (U)

8. Nature of Evidence Claimant Presented to Support IN/AP MST/Personal Assault Claim:
   (A) Law Enforcement Records
   (B) Medical Records: (i) In-Service; (ii) Veterans Affairs; (iii) Private; (iv) Other
   (C) Psychological/Psychiatric Records: (i) In-Service; (ii) Veterans Affairs; (iii) Private; (iv) Other; (a) Inpatient; (b) Outpatient; (c) Attempted Suicide
   (D) Court-Martial Records
   (E) Witness Statements, Including timing, if known: (i) Professionals (Chaplains, Social Workers, etc.); (ii) Claimant; (iii) Others (Family, Fellow Service Members, etc.)
   (F) Hearing Testimony Before Any VA Body
   (G) Diary or Journal Records
   (H) Evidence of a Decline in Work Performance

CODING KEY FOR MST/PERSONAL ASSAULT ARTICLE

(I) Request for Duty Station Change/Unit Transfer
(J) Other (Specify)

IV. Information About the RO's Evaluation of the Evidence:

1. Basis for Grant:
   (A) Positive Medical Evidence
   (B) Equipoise
   (C) Other (specify)

   Basis for Denial:
   (D) No Veteran Status/Lack of Active Duty Time to Qualify
   (E) Absence of PTSD or a Qualifying Psychiatric Diagnosis
   (F) Failure to Meet the Definition of MST
   (G) Insufficient Proof the Assault Happened
   (H) Insufficient Proof MST Caused the PTSD or Mental Condition (nexus)
   (I) Cumulative Trauma
   (J) Other (specify)

2. VA Exam (sometimes called Compensation and Pension Exam); Veterans Health Administration (VHA) Opinion; or Independent Medical Evaluation (non-VA)

V. Information About the BVA's Evaluation of the Evidence:

2. Veterans Law Judge (VLJ) or Acting Veterans Law Judge (AVLJ) and Gender (M, F, Unknown)

3. Basis for Grant:
   (A) Positive Medical Evidence
   (B) Equipoise
   (C) Other (specify)

   Basis for Denial:
   (D) No Veteran Status/Lack of Active Duty Time to Qualify
   (E) Absence of PTSD or a Qualifying Psychiatric Diagnosis
   (F) Failure to Meet the Definition of MST
   (G) Insufficient Proof the Assault Happened
   (H) Insufficient Proof MST Caused the PTSD or Mental Condition (nexus)
   (I) Cumulative Trauma
   (J) Other (specify)

4. (B) "Choice of Authority" Type: Legal (L); Administrative (A); or Both (B)

6. Basis for BVA Remand (Indicate all that Apply):
   (A) No or Inadequate VCAA Notice
   (B) Clarification from Claimant
   (C) Outstanding Private Records
   (D) Outstanding Veterans Affairs Records
   (E) Outstanding Social Security Records
   (F) No Exam Provided
   (G) Inadequate Exam Provided
   (H) VHA/IME Needed
   (I) Hearing Requested Before Any VA Body
   (J) Issuance of Statement of the Case
   (K) Other Due Process Deficiency (Specify)