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Testimony to the United States Senate Committee On Veterans' Affairs

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Submitted by
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Good Afternoon Senators. It is indeed an honor to address this Committee. I have been asked by this Committee's Chairman, the Honorable Senator Akaka, to discuss with the Committee the ability of the Department of Veterans Affairs to meet the needs of veterans who have experienced military sexual trauma, with particular attention to the National Guard and Reserve.

I am Dr. Connie Lee Best, a Clinical Psychologist and Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina. Today I am speaking to you from several perspectives. First, as a psychologist who has spent more than 25 years treating victims of sexual assault. Second, as someone who spent twenty years in the United States Navy Reserve, retiring in 2004 at the rank of Captain (06). Third, as the Director of an office at the Medical University responsible for responding to complaints of sexual harassment within the University. Finally, as a civilian psychologist who has served in a variety of consulting and advisory positions, both paid and unpaid, for the Department of Defense.

According to the VA, military sexual trauma (MST) refers to both sexual harassment and sexual assault that occurs in military settings. It can be experienced by both men and women. Sexual harassment is defined as repetitive, unwanted sexual attention or sexual coercion. Sexual assault is sexual activity against one's will.

Numerous research studies have documented rates of rape ranging from lows of 6% for active duty women and 1% for active duty men to rates that are significantly higher. One study found that 23% of female users of VA healthcare reported experiencing at least one sexual assault while in the military.

There are aspects of sexual trauma that are unique to the military. MST most frequently occurs where the victims live and work so that often the victims remain in close proximity to the perpetrators. The perpetrators are just as frequently their supervisors or higher ranking peers who will be responsible for making decisions concerning the victim's promotion or duty assignments. The risk of re- victimization by the same perpetrator is real. These factors, combined with the value placed on unit cohesion, especially in the combat theaters, add to the reluctance for victims to come forward. Even given the relatively new system in the military that allows victims to seek medical and psychological care without required reporting to law enforcement, the unique aspects of MST have the effect of reducing the likelihood that victims will seek psychological services.

The devastating affects of MST are clear. As any veteran or their family members will tell you, victims may suffer the effects for years. Those who have experienced MST often develop post

traumatic stress disorder (PTSD), major depression, substance abuse problems, and functional impairment in social, interpersonal, and employment settings. The effects of MST do not stop once the service member leaves the military.

As of April, 2007, there are approximately 76,000 Reservists deployed worldwide to support the war on terrorism. In 2005, that number was 120,000 higher. Members of the Guard and Reserve face their own unique sets of challenges when they experience MST. Compared to their regular active duty counterparts, many members of the Guard and Reserve may not be as familiar with the resources available.

Once released from active duty recall, they do not remain on a military base; they return to their hometowns. There is an understandable urge to return as quickly as possible to their spouses, children, jobs, and their "normal" lives. Once returning home, they are often far away from needed resources, away from other unit members, and away from their military social support systems. Although during their Post-Deployment Health Assessment conducted immediately after returning from deployment, they are given the opportunity to indicate if they had experienced a MST or are experiencing mental health effects associated with that trauma, Reservists are acutely aware that if they do endorse serious mental health concerns such as PTSD, they will likely be retained on active status and not be allowed to return to their civilian lives. Furthermore, the victims of sexual trauma may feel that if they could just return home to their families and jobs, they will be able to overcome this experience on their own.

For Guard and Reserve members who have also experienced combat-related trauma, the suffering can increase exponentially. A 2006 study by mental health professionals at Walter Reed Army Institute of Research, found that the prevalence rates of reporting a mental health problem among service members returning from Iraq and Afghanistan were 19% and 11% respectively, with combat experiences as the most frequently cited reason for their problems. If a service member was unfortunate enough to have experienced combat-related traumas and was also a victim of sexual trauma, the risk would be expected to be great for the development of significant mental health problems.

Another group of military researchers found that service members are twice as likely to report mental health concerns 3 or 4 months after returning from deployment rather than immediately afterwards. This time of greater reporting of PTSD and other mental health concerns is a time well beyond when the Post Deployment Health Assessment screening typically would occur. Members of the Guard and Reserve would already likely be demobilized and at home.

I believe that the VA is staffed by some of the best mental health providers and by some with exceptional expertise in MST. However, I believe that one of the problems facing the VA in their responsibility to meet the needs of today's veterans who have experienced MST is one of sheer numbers. The significant number of veterans who may well be experiencing MST, in addition to those who may also be experiencing both sexual and combat-related trauma, combined with the long-lasting nature of PTSD, means that the VA must be prepared to meet what is expected to be a growing number of veterans in need of mental health services in the years to come. To quote a line from a well known movie, Jaws, when one of the characters saw the shark for the very first time he uttered the understated and prophetic words---"we're gonna need a bigger boat." That is what I would say to the VA-we are going to need a bigger boat.

That means more qualified and appropriately trained providers must be available. Those providers must be able to provide specialized sexual assault services and understand the interaction of sexual trauma with combat-related trauma. They must also be sensitive to the special issues of the Guard and Reverse communities. Perhaps now is the time to consider some of the following: adding specialized training programs for providers in the treatment of MST; adding additional training internship sites for psychologists and psychiatrists which are both cost-effective and will ensure that there will be a sufficient number of providers in the pipeline to meet the ever-increasing numbers and needs of veterans; collaborations with academic medical centers with expertise in sexual trauma; and the creation of specific out reach programs to address the needs of returning Guard and Reservists who face significant barriers to treatment.

Thank you