No. 14-7115

IN THE UNITED STATES COURT OF APPEALS

FOR THE FEDERAL CIRCUIT

SERVICE WOMEN'S ACTION NETWORK and VIETNAM VETERANS OF AMERICA,

Petitioners,

v.

SECRETARY OF VETERANS AFFAIRS,

Respondent.

Appeal of Denial of Petition for Rulemaking by the Secretary of Veterans Affairs Pursuant to 38 U.S.C. § 502; Fed. Cir. R. 47.12

CORRECTED BRIEF OF PUBLIC HEALTH AND MENTAL HEALTH SPECIALISTS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS SERVICE WOMEN'S ACTION NETWORK AND VIETNAM VETERANS OF AMERICA

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UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Service Women's Action Network and Vietnam Veterans of America
v. Secretary of Veterans Affairs

No. 14-7115

CERTIFICATE OF INTEREST

Counsel certifies the following:

1. The full name of every party or amicus represented by me is: Dr. Madelon Baranoski, Dr. Traci Cipriano, Shelley Geballe, Gregg Gonsalves, Alice Miller, and Dr. Howard Zonana.

2. The name of the real party in interest (if the party named in the caption is not the real party in interest) represented by me is: The real interest parties are named.

3. All parent corporations and any publicly held companies that own 10 percent or more of the stock of the party or amicus curiae represented by me are: None.

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court are:

   Gibson, Dunn & Crutcher LLP: John C. Millian, Partner.

February 3, 2015 /s/ John C. Millian
John C. Millian

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BRIEF OF PUBLIC HEALTH AND MENTAL HEALTH SPECIALISTS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS SERVICE WOMEN'S ACTION NETWORK AND VIETNAM VETERANS OF AMERICA

I. INTEREST OF AMICI CURIAE

Amicus Curiae Dr. Howard Zonana is a Professor of Psychiatry at the Yale School of Medicine and an Adjunct Clinical Professor of Law at Yale Law School. His many professional positions include Chair of the Bioethics Committee at New Haven Hospital; Director, Medical Director and President of the Medical Staff of the Connecticut Mental Health Center; and President of the American Academy of Psychiatry and the Law. He also works with the American Psychiatric Association on the Council of Psychiatry and the Law and Judicial Action Committee.

Amicus Curiae Dr. Traci Cipriano is a licensed clinical psychologist in private practice, and a licensed non-practicing attorney. Dr. Cipriano is an Assistant Clinical Professor of Psychiatry at the Yale School of Medicine in the Division of Law and Psychiatry. She also consults to the Connecticut Psychological Association in the role of Director of Professional Affairs, and is a clinical supervisor in the Yale Psychology Department.

Amicus Curiae Dr. Madelon Baranoski is an Associate Professor of Psychiatry at the Yale School of Medicine in the Division of Law and Psychiatry. She works at the Connecticut Mental Health Center and serves as Vice Chair of the Yale University Human Investigation Committee. Dr. Baranoski received her

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Amicus Curiae Alice Miller is a co-director of the Global Health Justice Partnership, an Assistant Clinical Professor in the Yale School of Public Health, and an Associate Professor of Law at Yale Law School. She is an expert on women's rights, sexual and reproductive rights, and health as a human right.

Amicus Curiae Gregg Gonsalves is a co-director of the Global Health Justice Partnership, a Research Scholar in Law and Lecturer in Law at Yale Law School, and a leading HIV/AIDS activist.

Amicus Curiae Shelley Geballe is a Lecturer at the Yale School of Public Health and a Visiting Clinical Lecturer at the Yale Law School. She is also a Distinguished Senior Fellow at, and co-founder of, Connecticut Voices for Children. She has served on multiple state task forces to reform Connecticut's mental health system.

Each individual supporting this *amicus curiae* brief is dedicated to ensuring that our nation's veterans who suffer from the effects of Post-Traumatic Stress Disorder related to military sexual assault have a fair opportunity to obtain treatment and medical benefits. For reasons stated in Petitioners' brief, *amici* agree that the VA's denial of this rulemaking petition violates the Administrative Procedure Act and the Fifth Amendment. *Amici* submit this brief pursuant to Rule

29 of the Federal Rules of Appellate Procedure, upon consent of all parties. Fed. R. App. P. 29. Counsel for *amici* authored this brief in whole. Furthermore, no party, party's counsel, or other person contributed money intended to fund preparing or submitting this brief.

II. PRELIMINARY STATEMENT

Post-traumatic stress disorder (PTSD) is a debilitating condition affecting our nation's veterans, and can be caused by a variety of traumas experienced during the course of service. One of the most common stressors for PTSD, especially among our country's servicewomen, is sexual assault during military service (also known as "military sexual trauma" or "MST"). The Department of Veterans Affairs (VA) has recognized the importance of treating PTSD symptoms in service members; however, it has created an arbitrary distinction between combat-related PTSD and MST-related PTSD. When applying for VA medical and psychiatric benefits, a veteran must establish that her injury was connected to her military service. While the VA presumes service connection for PTSD related to combat, fear, or experience as a prisoner of war (and, indeed, for over 150 other health conditions as well), it has refused to grant such a presumption for PTSD related to military sexual assault. The VA has imposed additional hurdles on MST survivors seeking PTSD benefits. In adopting 38 C.F.R. § 3.304(f)(5), the VA required personal assault survivors with PTSD, including MST survivors, not only

to demonstrate corroborating evidence of in-service trauma, but also to submit that evidence for review by a third party to verify the existence of the claimed stressor. Veterans with combat-related or other forms of PTSD, by contrast, are not required to meet this high evidentiary burden.

Amici submit this brief to aid in the Court's understanding of mental health and public health studies addressing this important issue, which support Petitioners' case. First, *amici* assert that MST-related PTSD merits a presumption of service connection, in part because the stressors particularly associated with MST exacerbate the already-debilitating symptoms of PTSD. These stressors include institutional betrayal (or betrayal trauma theory); the nature of the perpetrator-victim relationship in the military; and social stigma and bias against sexual assault survivors.

Second, *amici* note that the VA's current evidentiary requirements for MST-related PTSD claims impose unfair and harmful burdens on MST survivors. In particular, because service members under-report sexual assault (due, in part, to the aforementioned military stigma and other cultural barriers), it is unlikely that they will have corroborating marker evidence of their assaults. Furthermore, the arduous and lengthy claims proceedings in which the VA questions the validity—and even existence—of the veteran's sexual assault, expose PTSD claimants to re-

traumatization, a phenomenon known as "secondary victimization." This experience can adversely affect the claimant's PTSD symptoms.

Third, *amici* contend that the science behind PTSD diagnosis supports establishing a presumption of service-connection for MST-related PTSD claimants. Namely, current clinical processes properly diagnose PTSD; and, there is a strong proven correlation between MST and PTSD. Additionally, it is unlikely that individuals suffering from MST-related PTSD are diagnosed in numbers greater than their actual occurrence, removing the need for the VA's stringent requirements of corroborating evidence and third-party review.

Finally, *amici* end in demonstrating the utter importance, from a public health and mental health perspective, of ensuring that veterans with PTSD attain access to proper treatment. In particular, denying treatment to veterans with MST-related PTSD can have disastrous consequences on their mental health, employment, income level, and housing status—and thus, on society as a whole. For the foregoing reasons, *amici* urge this Court to hold the VA's denial of Petitioners' formal request for rulemaking unlawful and reverse the agency's decision. Alternatively, *amici* request that the Court vacate and remand the decision to the VA to provide a reasoned explanation or to institute a new rulemaking.

III. ARGUMENT AND AUTHORITIES

A. Stressors Associated with MST Exacerbate the Debilitating Symptoms of PTSD.

Certain factors specific to the military context exacerbate the PTSD symptoms of sexual assault survivors. In particular, the military-specific dynamics of institutional betrayal, perpetrator-victim familiarity, and social stigma and bias against assault victims can intensify the survivor's manifestations of PTSD.

1. Institutional Betrayal

Institutional betrayal occurs when an institution causes harm to an individual who trusts or depends upon that institution. Carly Parnitzke Smith & Jennifer J. Freyd, *Institutional Betrayal*, 69(6) AM. PSYCHOLOGIST 575, 575–587 (2014). Often, as with trusted interpersonal relationships, the individual expects the institutional environment to be safe and may even depend upon the institution for survival, as in the military context. Carly Parnitzke Smith & Jennifer J. Freyd, *Dangerous Safe Havens: Institutional Betrayal Exacerbates Sexual Trauma*, 26 J. TRAUMATIC STRESS 119, 120 (2013). Betrayal trauma theory predicts that an individual who experiences sexual assault within a context where his/her safety depends upon an institution, such as the military, would have increased difficulty functioning within that environment after the assault. *Id.*

Consistent with betrayal theory, studies have shown that sexually assaulted women who also experienced institutional betrayal suffer from higher levels of

several posttraumatic symptoms than those who experienced sexual assault outside of an institutional context. *Id.* at 122. One such study compared the experiences of female veterans who had experienced civilian sexual assault to those of female veterans who had experienced military sexual assault. Alina Suris 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, 197 (2007). Military sexual assault is likely to involve more institutional betrayal than civilian assault, given that service members are dependent upon the military for safety and employment. Even controlling for the number of lifetime sexual assaults, the women who had experienced military sexual trauma reported more health difficulties than the women who had experienced civilian sexual assault. *Id.*

In particular, women experiencing institutional betrayal demonstrate more severe posttraumatic symptoms in the following four areas: anxiety, sexual dysfunction, dissociation, and the Sexual Abuse Trauma Index (SATI). Carly Parnitzke Smith & Jennifer J. Freyd, *Dangerous Safe Havens: Institutional Betrayal Exacerbates Sexual Trauma*, 26 J. TRAUMATIC STRESS 119, 122 (2013). Betrayal trauma theory helps explain the differences in physical and psychological difficulties that survivors of military sexual assault experience from those experienced by survivors of civilian sexual assault.

2. Nature of the Perpetrator-Victim Relationship

Another military-specific factor that exacerbates PTSD symptoms in survivors of military sexual assault involves the nature of the perpetrator-victim relationship. The nature of the perpetrator-victim relationship has been found to impact the severity of subsequent traumatic symptoms; and in the military context, the perpetrator may be a coworker, supervisor, or personnel with higher rank. Alina Suris & Lisa Lind, *Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans*, 9 TRAUMA, VIOLENCE, & ABUSE 250, 264 (2008). The service member may be required to continue working with his or her perpetrator—a situation less likely to occur in the civilian world. Military personnel often operate within confined areas, such as bases in foreign countries. They are unable to leave their duty stations without permission and are subject to disciplinary action, including court-martial, if they attempt to leave. *Id.* Consequently, military personnel who are sexually assaulted are unable to easily transfer to another duty station or quit their jobs. Because of this trapped environment, assault victims are often forced to endure repeated contact with their perpetrators. *Id.* The unit cohesion that generally provides a protective barrier in the military environment may not be available to a service member who has been assaulted by another member of the unit. Ann Norwood et al, *Health Effects of the*

Stressors of Extreme Environments on Military Women, 162 MILITARY MEDICINE 643, 648 (1997).

This unique aspect of the military system might intensify the severity of symptoms experienced after sexual assault, especially given that military personnel may be under conditions of chronic stress and have less time to seek treatment or social support. Alina Suris & Lisa Lind, *Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans*, 9 TRAUMA, VIOLENCE, & ABUSE 250, 269 (2008).

3. Social Stigma and Bias against Survivors

A third military-specific factor that can exacerbate PTSD symptoms for sexual assault survivors is the social stigma they face in the military context, after their assault. Studies support that individuals reporting lower levels of perceived social support after a traumatic event reported higher levels of PTSD symptoms or rates of current PTSD. Emily Ozer et al, *Predictors of Posttraumatic Stress Disorder and Symptoms in Adults: A Meta-Analysis*, 129(1) PSYCHOLOGICAL BULLETIN 52, 52–73 (2008). In most studies, the emphasis was on emotional support. One study even found that the social support factor was the strongest predictor of whether someone would develop PTSD. C. R. Brewin et al, *Meta-Analysis of Risk Factors for Posttraumatic Stress Disorder in Trauma-Exposed Adults*, 68 J. CONSULTING AND CLINICAL PSYCHOLOGY 748, 766 (2000).

Frequently, survivors of sexual assault in the military not only experience a lack of a social support network after their assaults, but even experience intense stigmatization from their peers. This stigmatization can include taunts and threats to dissuade the individual from reporting, refusal to believe the survivor's story, and labeling the survivor as a promiscuous person. These social stigma-related barriers constitute some of the most salient concerns among veterans with PTSD, and prevent many service members from reporting their assaults. Jessica Turchik et al, *Perceived Barriers to Care Among Veterans Health Administration Patients with Posttraumatic Stress Disorder*, 8 PSYCHOLOGICAL SERVICES 212, 223 (2011). Studies of female sexual assault survivors have found that stigma-related barriers, such as feelings of shame and fears of negative consequences or reactions, were common reasons why women did not report an assault. *See e.g.* Courtney E. Ahrens, *Being Silenced: The Impact of Negative Social Reactions on the Disclosure of Rape*, 38 AM. J. CMTY. PSYCHOLOGY 263, 269 (2006). These stigma-related barriers are just as, if not more, powerful when the MST-survivor is male. Due to the hyper-masculine heterosexual environment of the military, male survivors of sexual assault report feeling embarrassment and shame in seeking mental health support after their assaults. Jessica Turchik et al, *Perceived Barriers to Care and Provider Gender Preferences Among Veteran Men Who Have Experienced Military Sexual Trauma: A Qualitative Analysis*, 10 PSYCHOLOGICAL

SERVICES 213, 213–222 (2013). Other stigma-related barriers include a belief in self-sufficiency (not wanting to talk about one's emotional problems), concerns about the privacy and confidentiality of the reporting process, self-blame, fears they will not be believed, and the concerns about the sensitivity and reactions of the provider. *Id*.

Because these stressors associated with MST (institutional betrayal, perpetrator-victim relationship and social stigma) exacerbate the already-debilitating symptoms of PTSD, they support the conclusion that MST-related PTSD merits a presumption of service-connection.

B. The VA's Evidentiary Requirements for MST-Related PTSD Claims Impose Unfair and Harmful Burdens on MST Survivors.

1. Corroborating Marker Evidence, Like Direct Evidence in Service Records, is Unlikely to Exist Because MST is Under-Reported.

Under the VA's current rule, a veteran's lay testimony, coupled with a diagnosis of PTSD, is insufficient to establish the occurrence of a claimed stressor. 38 C.F.R. § 3.304(f)(5) (2014). Instead, a veteran with MST-related PTSD must present corroborating evidence of his or her sexual trauma, known as "secondary markers." However, corroborating marker evidence is unlikely to exist because MST is largely underreported. The DoD estimates that in 2012, 89% percent of service members who experienced sexual assault did not report it to a DOD official. Petition for Rulemaking, at 23.

Stigma-related concerns prevent many MST survivors from reporting their assaults. If a service member attempts to report an assault, she is likely to face serious professional and social resistance and retaliation. Index of Record 13, Government Accountability Office, GAO-14-447, (2014), at 1-2 ("[MST] claims can be difficult to substantiate, given that servicemembers may be unwilling to file formal complaints at the time of the precipitating incident or incidents and, hence, lack official documentation to support their claim."); Battle for Benefits: VA Discrimination Against Survivors of Military Sexual Trauma 3 (ACLU & SWAN, 2013) ("Because systemic under-reporting of in-service sexual trauma often limits the amount of documentation surrounding that trauma, producing corroborating evidence can often be difficult.").

Multiple mental health studies within the context of the military discuss underreporting due to stigma concerns. For example, in one of her studies, Rachel Kimerling of the National Center for PTSD noted, "Operation Enduring Freedom and Operation Iraqi Freedom Veterans report stigma associated with help-seeking." Rachel Kimerling et al, *Military-Related Sexual Trauma among Veterans Health Administration Patients Returning from Afghanistan and Iraq*, 100 AM. J. PUB. HEALTH 1409, 1411 (2010). Some of the noted barriers include "embarrassment and reluctance to disclose symptoms, the fear of being perceived as weak, not knowing where to go for help or poor access to services, the eagerness

to return to life as it was before deploying, fear of stigmatization, and possible impact on military career or military discharge." Patricia Conard et al, *Deployment and PTSD in the Female Combat Veteran: A Systematic Review*, 48 NURSING FORUM 1, 8 (2014).

2. Current Procedures Unduly Expose MST-Related PTSD Claimants to Re-Traumatization Because of the Nature of the Evidence Demanded by the VA.

Not only do stigma-related barriers render it difficult for MST survivors to meet their evidentiary burden for service-connection, these barriers can also expose survivors to a risk of re-traumatization. This phenomenon, termed "secondary victimization," occurs when service members seek physical, emotional, or legal help from military institutions following a sexual assault and, instead of receiving help, encounter difficulties ranging from victim-blaming to disciplinary charges for underage drinking, fraternization, or adultery. Carly Parnitzke Smith & Jennifer J. Freyd, *Institutional Betrayal*, 69(6) AM. PSYCHOLOGIST 575, 583 (2014). "When victims reach out for help, they place a great deal of trust in the legal, medical, and mental health systems as they risk disbelief, blame, and refusals of help." Rachel Campbell, *Rape Survivors' Experiences with the Legal and Medical Systems: Do Rape Victim Advocates Make a Difference?* 12 VIOLENCE AGAINST WOMEN 30–45 (2006). When institutions such as the VA question the nature or even existence of these veterans' traumatic experiences, this deep lack of validation may result in

additional trauma. Christine A. Courtois & Julian D. Ford, *Treating Complex Traumatic Stress Disorders (Adults): An Evidence-Based Guide* (2009) (a deep lack of validation of an interpersonal trauma by an institution mirrors a mechanism thought to predict the development of complex posttraumatic responses).

Furthermore, the VA requirement of secondary marker evidence further exposes MST survivors to re-traumatization by forcing them to repeatedly relive their assaults, as they collect evidence and proceed through the interminable claims process. Because the VA's current evidentiary requirements for MST-related PTSD claims impose these unfair and harmful burdens on MST survivors, a presumption of service connection is warranted.

C. Evidentiary Presumption Is Anchored in Established Medical Diagnosis of PTSD.

1. Current Clinical Processes and Procedures Properly Identify and Diagnose PTSD.

The current clinical standards for diagnosing PTSD are thorough and reliable. To receive a PTSD diagnosis, an individual must meet the criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA).[1] Just last year, the APA updated the PTSD diagnostic criteria, publishing its fifth edition of the DSM (DSM-5). Under the DSM-5, diagnostic criteria for PTSD include "a history of exposure to a

[1] *See* PTSD: National Center for PTSD, "DSM-5 Criteria for PTSD," *available at* http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp.

traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity." *Id.* Additional criteria concern the duration of symptoms; assess functioning; and, clarify symptoms as not attributable to a substance or co-occurring medical condition. Screening instruments for applying these PTSD criteria, such as the PTSD Checklist (PCL) and the Primary Care-PTSD (PC-PTSD) are reliable scientific tests.

2. There is a Strong Correlation between MST and PTSD.

Studies have demonstrated that survivors of sexual assault in the military frequently develop PTSD as a result of their traumatic assault experiences. Women veterans with MST histories are nine times more likely to develop PTSD compared to women with no sexual assault histories. Alina Suris & Lisa Lind, *Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans*, 9 TRAUMA, VIOLENCE, & ABUSE 250, 259 (2008). In one study of PTSD disability-seeking female veterans, 71% reported MST experiences. Maureen Murdoch et al, *Prevalence of In-Service and Postservice Sexual Assault among Combat and Noncombat Veterans Applying for Department of Veterans Affairs Posttraumatic Stress Disorder Disability Benefits*, 169 MILITARY MEDICINE 392, 395 (2004). In fact, research specific to military personnel demonstrates that sexual trauma poses a risk for developing PTSD as

high as, or higher than, combat exposure. For example, in a study of 327 women veterans treated in a VA clinical program for stress disorders, researchers found that sexual stress (stress related to sexual harassment and abuse) was almost four times more influential than duty-related stress in the development of PTSD. Alan Fontana & Robert Rosenheck, *Duty-Related and Sexual Stress in the Etiology of PTSD among Women Veterans Who Seek Treatment*, 49 PSYCHIATRIC SERVICES 658, 662 (1998). Likewise, studies have found MST to be significantly related to PTSD in male veterans, as well as female veterans.

As the medical science behind PTSD diagnosis is reliable, and PTSD is strongly correlated with MST, a presumption of service connection for MST-related PTSD is warranted. In particular, as sexual trauma has been found to be equally, if not more highly associated with PTSD than combat-related trauma, it defies logic that the VA would presume service connection for combat-related PTSD, but not MST-related PTSD.

3. Requiring Corroborating Evidence May Encourage the Adjudicator to Consider the Wrong Factors.

As MST is so frequently under-reported and under-documented, VA adjudicators sometimes consider evidence of behavioral changes following the claimed assault. *See* 38 C.F.R. § 3.304 (f)(5) (2014) (VA instructions to adjudicators: "[e]xamples of such [corroborating] evidence include, but are 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. Evidence of behavior changes following the claimed assault is one type of relevant evidence that may be found in these sources. Examples of behavior changes that may constitute credible evidence of the stressor include, but are not limited to: a request for a transfer to another military duty assignment; deterioration in work performance; substance abuse; episodes of depression, panic attacks, or anxiety without an identifiable cause; or unexplained economic or social behavior changes.") However, in considering these kinds of factors, adjudicators may prefer obvious, blatant, and concrete evidence, over the subtle, nuanced evidence that is more likely to be in the claims file. Jennifer C. Schingle, *A Disparate Impact on Female Veterans: The Unintended Consequences of Veterans Affairs Regulations Governing the Burdens of Proof for Post-Traumatic Stress Disorder Due to Combat and Military Sexual Trauma*, 16 WILLIAM & MARY J. WOMEN AND THE LAW 155, 171 (2009). Service members manifest their post-assault physical and emotional challenges in a variety of subtle ways, which may not present themselves in the form of concrete evidence. By focusing on concrete evidentiary factors, VA adjudicators may miss important signals that the veteran is, in fact, suffering from MST-related PTSD. *Id.*

4. It Is Unlikely that Individuals Suffering from MST-Related PTSD Are Diagnosed in Numbers Greater than Their Actual Occurrence.

Given the strong correlation between MST and PTSD, as well as the fact that survivors of MST largely under-report their assaults due to social stigma, it is unlikely that individuals suffering from MST-related PTSD would be diagnosed in numbers greater than their actual occurrence.

Furthermore, childhood or civilian sexual assault does not account for the observed relations between MST and persistent traumatic stress among veterans. Rachel Kimerling et al, *The Veterans Health Administration and Military Sexual Trauma*, 97 AM. J. PUB. HEALTH 2160, 2164 (2007). One study found that PTSD diagnoses were more common among women veterans with MST than among those who reported other traumatic events or non-military sexual assaults. *Id.* Thus, the effects of previous trauma or civilian sexual assault do not explain the strong relationship between MST and PTSD.

Because requiring corroborating evidence may encourage the VA adjudicator to consider the wrong factors, and because it is unlikely that individuals suffering from MST-related PTSD are diagnosed in numbers greater than their actual occurrence, a presumption of service connection for MST-related PTSD is warranted.

D. Denying Treatment to Veterans with MST-Related PTSD Can Have Disastrous Consequences on Their Mental Health, Physical Health, Employment, Income Level, and Housing Status.

Denying PTSD treatment to veterans not only affects their mental health, but can also wreak havoc on their physical health, employment, income level, and housing. In these ways, denying PTSD treatment poses a problem not only for these veterans, but also for society. A study of the long-term outcomes of disability benefits in U.S. veterans with PTSD compared claimants who were denied benefits to those who were awarded, and found that 44.8% of the denied claimants reported poverty, compared with only 15.2% of the awarded claimants. Maureen Murdoch et al., *Long-Term Outcomes of Disability Benefits in US Veterans with Posttraumatic Stress Disorder*, 68 ARCHIVES GEN. PSYCHIATRY 1072 (2011). Furthermore, the awarded claimants were almost half as likely as denied claimants to have experienced homelessness. *Id.* at 1076. Awarded claimants were also on average more likely than denied claimants to report clinically meaningful reductions in PTSD symptoms. *Id.*

MST has been associated with a number of physical and psychological symptoms, which may worsen when left untreated. For example, MST is associated with increased screening rates of alcohol abuse and depression. One study found that women with MST were twice as likely as women without MST to develop alcohol abuse problems. Alina Suris & Lisa Lind, *Military Sexual*

Trauma: A Review of Prevalence and Associated Health Consequences in Veterans, 9 TRAUMA, VIOLENCE, & ABUSE 250, 259 (2008). Furthermore, female MST survivors report significantly more physical symptoms compared with women veterans without MST, including pelvic pain, menstrual problems, back pain, headaches, gastrointestinal symptoms, and chronic fatigue. *Id.* at 262. In fact, in a study examining the health status of a sample of women veterans, women who reported MST scored lower on every scale of the SF-36 study as compared with women who reported no MST, indicating poorer overall health functioning in every area. *Id.* In men, MST has been significantly associated with an increased risk of AIDS. Rachel Kimerling et al, *The Veterans Health Administration and Military Sexual Trauma*, 97 AM. J. PUB. HEALTH 2160, 2163 (2007).

Furthermore, studies indicate that PTSD may have pervasive negative effects on employment status and income, work absenteeism, as well as functional impairment. Keren Lehavot et al, *Barriers to Care for Women Veterans With Posttraumatic Stress Disorder and Depressive Symptoms*, 10 PSYCHOLOGICAL SERVICES 203, 208 (2013).

The debilitating, and in some cases life-altering, effects of denying PTSD benefits to MST survivors on their mental health, physical health, employment, income, and housing status support the conclusion that the VA should presume service connection for MST-related PTSD.

IV. CONCLUSION

For the foregoing reasons, this Court should hold the VA's denial of Petitioners' formal request for rulemaking unlawful and reverse the agency's decision. Alternatively, this Court should vacate and remand the decision to the VA to provide reasoned explanation or to institute a new rulemaking.

Dated: February 3, 2015

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) or Federal Rule of Appellate Procedure 28.1(e).

   □ The brief contains 4,396 words, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) or Federal Rule of Appellate Procedure 28.1(e) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6).

   □ The brief has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman.

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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury, that on this 3rd day of February, 2015, a copy of the foregoing Corrected Brief of Amici Curiae was filed electronically. This filing was served electronically to all parties by operation of the Court's electronic filing system.

/s/John C. Millian