Elizabeth Yano: It's a privilege to be able to present the cyber seminar to you today. This follows on the Secretary of Defense's ordering of a 90-day review of sexual assault in the military. He, within days of his official appointment and confirmation, established an Independent Review Commission on Sexual Assault in the military, and that commission was directed to make recommendations related to accountability, prevention, climate and culture, and victim care and support.

We were asked to organize a briefing through the Women's Health Research Network in VA on the state of what's known on VA military sexual trauma or MST research, and that was organized for an April 2021 briefing.

We convened calls with nationally-recognized VA MST researchers to address four areas we'll review today: the prevalence of MST; the adverse consequences of MST on mental health, physical health, and other outcomes; evidence-based care for MST survivors in VA; and barriers to MST-related care. And then Dr. Street will be providing a brief overview of commission recommendations, and we're really excited to have Dr. Bell who also briefed the Independent Review Commission speaking with us today about some of her perspectives as well.

Thank you so much and let me hand the baton to Dr. Galovski.

Tara Galovski: Thank you very much Dr. Yano and truly thank you to all the members of the audience for joining us today in this very important topic. And I want to echo Dr. Yano's thoughts and sentiments and really express appreciation to the IRC for their truly enormous efforts and really, their excellent product, and the report that Dr. Street will share down the road.

So, in getting started, military sexual trauma, or MST, so we're on the same page, refers to experiences of sexual assault and/or sexual harassment while a member of the armed forces is serving. Within this definition, sexual harassment is defined as verbal or physical contact of a sexual nature which is threatening in character; and MST certainly includes experiences of this nature that occur really at any time while on duty or certainly off-duty while the individual is a member of the Armed Forces. And the perpetrator can be anyone: a fellow service member, coworker, civilian that perpetrates this crime while the service member is a member of the armed services.

It is difficult to quantify military sexual trauma in the veteran population for a number of different reasons, but recent meta-analytic study suggests that approximately 16 percent of veterans report MST. We know the rates are higher for women as compared with men, such that 38 percent of women report MST compared to about 4 percent of men, and

when we separate the elements of MST out and consider them separately, about 14 of veterans report a sexual assault, and the gender differences in sexual assault remain significant such that about one in four women report being sexually assaulted as compared to about 2 percent of men.

And then when considering experiences of sexual harassment, this is quite prevalent as well, particularly among women veterans with about half of women veterans experiencing sexual harassment and about 1 in 10 of male veterans.

I mentioned that the prevalence rates certainly vary across studies and, indeed, we see a higher prevalence rate in studies that include self-reports and interviews as compared to data pulled from VA medical records. Perhaps, this is due to the anonymity of self-report and the ability of the interviewer to ask follow-up questions in studies that include interviews. We do not see differences in MST prevalence rates when studies are conducted with VA-engaged participants excuse me versus non-engaged VA participants.

And it really should be noted that MST experiences in males are particularly understudied in comparison to those studies that include women survivors of MST.

There is an elevated risk in a number of groups within the larger veteran population, specifically those groups with low societal and institutional power. Certainly, the women that we just discussed fall into this category and also those with lower rank and racial and ethnic minorities. Sexual minority and transgender service members are also at elevated risk for MST; and a recent study suggests that MST experienced by LGBT service members is twice that experienced by non-LGBT service members.

With respect to prevalence rates across age cohorts, women veterans aged 45 to 54, those whom we consider to be midlife, report the highest prevalence rates of MST, which is interesting; women veterans in midlife also represent the largest group of women veteran VA users.

We'll move on to talk about the adverse consequences of MST across a number of different domains, and we can start with kind of an overview. You'll see that the impact of MST is quite far-reaching and certainly can last for years and even decades. As we'll discuss further, the impact of MST is complex and it can manifest in an array of negative mental and physical health outcomes; it can also result in impairments in functioning across really any number of life domains. There's really no singular clinical presentation associated with the sequelae of MST and indeed, the outcomes and combinations of these outcomes can really vary quite

widely across survivors. These outcomes can be influenced by a host of social determinants of health and contextual factors, including one's age, race, ethnicity, sexual orientation, where you live, whether it's a city or a rural area, and certainly your economic instability or stability. Clearly, the breadth, and the range, and the scope of all of the different kinds of outcomes of MST are complex and they vary across survivors. As a result, there really is no single solution for treating the consequences of MST.

Adding to this complexity, the context of MST is quite unique from a socio-political perspective. As is the case with all sexual traumas, the interpersonal betrayal is clearly an egregious element of this type of crime; and in the case of MST, this betrayal really can be compounded by institutional betrayal. Reporting MST can have significant implications for one career, including demotions or early attrition.

If the perpetrator is also a member of the armed services, the survivor of MST may continue to have to work and even live side by side with the perpetrator; and in some cases, for example, when someone's deployed, the survivor of the assault is also far from home and all of the supports that home and your home community offer and can provide; and in some cases, the perpetrator is also the very person for whom the survivor safety depends.

Taken together, this is a significant chronic environmental strain that this crime occurs within. This interacts with the traumatic stress that's associated with the experience of MST and really can result in the amplification of potential negative mental and physical health outcomes.

With respect to mental health outcomes and consequences of MST, post-traumatic stress disorder, or PTSD, is clearly the most common psychiatric condition to develop. We know that women veterans with MST are estimated to be nine times more likely to develop PTSD when they're compared to women veterans who have not suffered through this experience. Women veterans with MST have a higher risk for a PTSD diagnosis relative to men; and certainly, MST may be associated with increased risk for developing PTSD even compared to sexual trauma within civilian contexts. So, there really is something distinct about MST as a form of trauma, and some of those are the unique aspects of military careers and exposure that I just reviewed, but can also include things like stigma and reporting barriers, being less able to access care. All of these factors certainly can amplify the distress that is consistent with the MST experience, and increase the likelihood of a host of negative mental health outcomes.

PTSD is truly a difficult disorder to treat because it rarely occurs in isolation; the comorbidity really complicates the recovery. This is true

for PTSD secondary to MST; similarly to PTSD, that can result from any number of different traumas--and we know that women who suffer from MST-related PTSD also are likely to receive a comorbid diagnosis including depression, any anxiety disorder, eating disorder, substance use disorders, to name a few. MST has also been identified as an independent risk factor for suicide; and in a recent study of MST survivors, three-quarters of the participants reported suicidal ideation after MST and 41 percent reported a suicide attempt. In other words, the experiences of MST, particularly sexual assault in this study, were associated with the presence of suicidal ideation for our women veterans.

Although PTSD is the most commonly occurring mental health diagnosis after MST, it is certainly not the only possible outcome by any means. Indeed, survivors of MST are at increased risk for any mental health disorder and for more severe courses of those disorders; additional disorders can certainly include depression, anxiety, eating disorders, insomnia and higher rates of alcohol and drug use disorders. The physical health consequences of MST are also significant and include a host of potentially negative outcomes, including increased risk of diabetes, a host of cardiovascular complications, negative reproductive health outcomes including implications for fertility, pregnancy termination, and perinatal depression; MST in women also increases risk for sexual dysfunction disorders, including sexual pain, low satisfaction in sexual activities; and then recent studies suggest that sexual and functioning impairment in women who have experienced MST may be greater than man and women who have experienced childhood sexual abuse.

Further, in a study of women veterans who served in the Gulf War, the range of physical health consequences was quite profound and extended to gastrointestinal, genital, urinary, musculoskeletal, neurological symptoms. We see that there's an increased risk for homelessness particularly in male veterans who have suffered through MST; and taken together the medical care for the range of physical health consequences can be more complicated when the veteran is suffering from the added burden of mental health consequences as well.

Given the nature and extent of these mental and physical health consequences of MST, it's not surprising that impairment and psychosocial functioning is also elevated for MST survivors. For example, post-9/11 women veterans who experience MST often report negative impact on family, and work, and school functioning when they're reintegrating into civilian life after service; and women veterans, as long ago as the Vietnam era continue to report negative impacts of life functioning and continued disability even after accounting for mental health diagnoses.

Experiences of harassment specifically were associated with impaired functioning and work, romantic relationships, and parenting for women veterans; and likewise, romantic relationships and parenting for males. The physical consequences that we just discussed persisted in the Vietnam era cohort and poor health and physical functioning was indeed an indicator of lower quality of life as our veterans aged. This is another example of the long-reaching consequences of MST; and as our post-9/11 veterans age, it will be interesting to see if we can turn this course.

So, let's turn our attention to how we're going to resolve some of these long-term consequences of MST and start to turn our attention to recovery. The VA regularly and intentionally screens veterans for MST experiences in the VA Universal MST Screening Program, and we know that investigators have evaluated the effectiveness of the screening program. Research has shown it to be feasible and useful; it yields important information; it begins the process of matching veterans who are suffering from the sequelae of MST with appropriate venues, and avenues, and options for care. This screening process has resulted in a higher likelihood of veterans getting the care that they need.

These types of questions can be difficult, but additional investigation has found that veterans' experiences with the screening process are generally satisfactory.

And as we discussed, PTSD is the most common psychiatric condition to develop secondary to MST. We'll review the current status of the research, particularly with respect to this disorder, recognize that it really is beyond the scope of this hour to review the entirety of the interventions for all of the different outcomes that we know can occur after exposure to military sexual trauma.

The VA really has been a leader in developing evidence-based interventions for PTSD nationally, but certainly, globally as well; we have several empirically-supported psychotherapy treatments that we offer within the VA, and these truly are the gold standards of care, which means that our veterans are getting indeed the best therapies available. These include prolonged exposure therapy and cognitive processing therapy today. The VA has conducted national rollouts of these evidence-based treatments and this healthcare system really allows for this robust infrastructure, which includes structured training workshops and ongoing supervision and consultation until the provider meets the standard of care.

Once the formal training process is complete, we also continue to provide ongoing consultation on an as-needed basis to really ensure that our providers are well-trained and doing the best job possible in delivering these evidence-based practices. In training, these treatments

really support the implementation and certainly the delivery of these services.

The bulk of the treatment studies target PTSD and comorbidity with respect to the treatment outcome literature for the centrality of trauma such as MST; and systematic reviews and meta-analytics study really show that psychotherapy for PTSD yields larger effects in treating PTSD as compared to pharmacotherapy; and we know that trauma-focused treatments are generally more effective than non-trauma-focused treatments.

Clinical practice guidelines across a number of different national workgroups have been developed independently; the VA DoD guidelines are an example of those types of guidelines, and they tend to recommend best practices for all of the different disorders including PTSD. Across all of the clinical practice guidelines, we found that the quality of evidence for the effectiveness of prolonged exposure and cognitive processing therapy was given the highest ratings.

With respect to PE and CPT, it's interesting that they were both originally developed and tested with civilian survivors of sexual assault and rape, and so it was not a significant leap for these to be applied within other types of traumas, including MST within the VA system. There's been several VA randomized controlled clinical trials that have included MST-related trauma are focused entirely on MST-related PTSD; and overall, we see significant reductions in the primary outcomes of PTSD and depression over the course of these therapies. We also have a host of published effectiveness studies that have looked at the effectiveness of these interventions in our clinics nationwide, and we've seen strong results as well.

In a recent study, we saw that veterans with MST benefit from PE and CPT treatment similarly to those who have PTSD from a different type of trauma.

And studies in veterans in residential care who reported MST were compared to those who did not report MST and also had PTSD; we saw that male patients with MST had more severe PTSD than female patients and these diagnoses were derived from clinician-assessed instruments which are our gold standard for diagnosing PTSD, and we saw that patients significantly improved on PTSD over the course of CPT; and potentially, there's a greater rate of improvement for women than for men in this residential study.

And with that, I will pass the mic to Dr. Kelly.

Ursula Kelly: Thank you so much. I'm so happy to be here. I'm just going to jump right in. So, what we all know is that the VA is a leader in PTSD treatment and we have several established modalities as you have just learned. But the reality is that some veterans do not improve with these current gold standard treatments like PE and CPT, even if they complete the treatment. And then some simply do not complete therapy or are not able to begin it because of fear of how they will do.

The good news is that there are other non-trauma-focused therapies for PTSD that are recommended both within and without the VA, including present-centered therapy and interpersonal therapy. Additionally, STAIR, as you see here, Skills, Training, and Interpersonal Regulation developed by Dr. Cloitre is as a very successful modality.

In addition, the VA is really a leader in innovative approaches to treatment, including complementary therapies. There have been several systematic reviews, one as recently as 2018, but really dating back almost a decade, that show that mind-body interventions like mindfulness and yoga show promise in reducing PTSD symptoms, but those studies have been sufficiently small that it's hard to establish that they're fully effective. However, recently, we had a sufficiently powered study on trauma-sensitive yoga compared to cognitive processing therapy, one of the gold standard treatments, which showed comparable effectiveness at follow-up, but with the benefit of earlier symptom improvement and 25 percent greater retention than CPT for women veterans with MST-related PTSD specifically. So, that's one very promising treatment.

In addition, other innovative models of care include peer support, in which veterans who have experienced trauma and gone through treatment become VA employees and provide peer support; and then there have been the development of mental health apps. Beyond MST was developed by Dr. Street, who will speak after me, and others; as well as the DESTRESS app; and then there are others that are available to the public in general, like Headspace, et cetera, that many, many folks are using.

So, despite all of these advances and evidence-based treatment that we have available, there are still multiple barriers to MST-related care and MST research within the VA. The first thing to remember--and this isn't a barrier, per se--but the first thing to remember--and I often honestly have to remind myself of this--is that not every MST survivor has long-term mental health consequences or needs care; that's an area where we could all benefit from learning more about what that resilience pattern is. But, in fact, not everyone who experiences trauma and MST specifically goes on to develop either physical or mental health consequences.

In terms of barriers, expected and commonly-cited barriers to PTSD treatment really include avoidance of trauma cues; for example, for women veterans in particular, but men as well, who experienced MST coming to the VA which is a pseudo-military environment and male-dominated, can be very traumatizing in and of itself, and so survivors may avoid care for that reason; as well as stigma about mental health; not recognizing that they have PTSD; stigma related to being sexually assaulted.

Additionally, though, institutional betrayal at the time of the assault. So, institutional betrayal by the DoD really in terms of how people responded or did not to the trauma at the time really can have a long-term impact at the barrier to veterans seeking care in the VA, even though it technically is a different institution. They may also have had negative experiences with the VA earlier or with helping systems in the community where they are not finding people with experience and knowledge about MST and PTSD.

What can help, however, is seeing friends and colleagues, other veterans improve as they have engaged in care.

So, in terms of VA MST-related research, the VA has funded MST research for over 25 years; and on this call and headed up by Dr. Yano and others, there's really been a robust body of research conducted related to MST, and really pushing researchers within the VA to include women in sufficient numbers or to focus on women in their research.

We have a better understanding of needs and system outcomes related to MST, including service needs and outcomes, Dr. Ann Sadler has been a leader in that area; impact on health behaviors, gynecologic care, and fertility, as well as reproductive care and other issues specific to women. And Rachel Kimerling has really done tremendous work in evaluating VA screening and treatment for MST.

As a result of this research, we've seen increased options for evidence-based care and have had these studies funded by VA to establish the evidence for PE and CPT, as well as alternative therapies such as trauma-sensitive yoga; and then Dr. Cloitre, who develops STAIR to home-based psychotherapy in rural areas; and really the VA paying more attention to increasing trauma-sensitive environments in our research.

And with that, I will turn this over to Dr. Street. Thank you so much.

Amy Street: Thank you, Dr. Kelly. And hello to everyone on the call; it is great to have you all join us today. So, what you've just heard Dr. Galovski and Dr. Kelly so eloquently present, are the sort of key highlights of the briefing that our full team put together to share with the Independent

Review Commission on sexual assault in the military; and our focus was really on one particular line of effort, that line of effort focused around victim care and support, which was the line of effort most relevant to much of the research that's going on within VA. So, these were the key takeaways from this very tremendous and extensive body of research that you've just heard an overview for. I'm sure everyone's heads are spinning. We do a lot of research in VA.

Essentially, though, it's essential to continue to improve our responses by asking the right questions specific to the screening processes and knowing that we're both asking the right questions of our veterans to understand their experiences of MST, but also that we're asking the right questions from a research perspective.

We really wanted to convey that the consequences of MST are very complex and complicate all aspects of care. So, certainly, PTSD is a key concern among MST survivors, but it is not the only concern; there are many additional mental health disorders associated with experiences of MST and certainly, as you've heard, physical health disorders and many of those mental and physical health conditions are often comorbid with each other leading to more complicated clinical presentations.

We have a really strong basis in understanding evidence-based practices that have been assessed within the MST population, specifically when we have gaps in that knowledge, there is a large evidence base of information that we can borrow from and other related populations; and you also heard about some kind of emerging areas of evidence that I think can help to meet the sort of broadest number of needs as we can among our MST survivors.

Certainly, VA implementation of evidence-based practices is incredibly strong and comprehensive, it's really currently the gold standard in terms of a major huge rollout of these evidence-based practices for the treatment of PTSD within a healthcare setting. And I think, perhaps, the biggest take-home point that we hoped both to convey to the members of the Independent Review Commission--and also to all of you here today--is just that the portfolio within VA on research on MST-specific, providing care to MST survivors, understanding how to most effectively treat MST survivors, particularly around PTSD is expansive, and continues to be a strong commitment among policymakers and researchers when deciding where to focus efforts within the research portfolio.

So, those are some of the most important points that we hope to convey, as we were very honored to brief the IRC.

So, none of us who are involved in this briefing were actually members of the Independent Review Commission; we were just called in because of our specific expertise and experience around research specific to survivors of MST within VA. But the Independent Review Commission did, a few months after our briefing to them, release a very detailed and extensive report summarizing the findings. As a reminder--and Dr. Yano mentioned this early on--but as a reminder, our focus on victim care and support was just one arm of effort within the Independent Review Commission's larger review; the other three arms of effort were the issue of accountability, the issue of prevention, and the issue of climate and culture.

So, this review was incredibly comprehensive; briefings from many, many organizations beyond just VA and many, many individuals beyond the ones who are included here. The review also included a lot of discussion and conversation with service members and veterans, particularly those who are survivors, both men and women who are survivors of experiences of military sexual trauma.

So, it was in July of 2021 that the IRC released a detailed report: here's the name of it: Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military. It's extremely comprehensive and includes 82 recommendations and sub-recommendations, and is much more comprehensive than I could ever review here, but the document is a beautifully-written one and actually, I'll admit I'm biased, because I feel passionately about this issue, but it was, actually, I thought, a pleasure to read. I have the full link for you here if you'd like to learn more.

I'm going to focus on just highlighting a few themes and a few specific recommendations from the Independent Review Commission that I felt, in my review of their work, were most relevant to those of us in VA and most relevant to the briefing that we had provided.

One aspect of the commission's report included just a set of relevant overarching themes that they heard repeatedly across their efforts and their research, and summarized as sort of a starting place for their recommendations. And again, there were many of them, but a few that I felt were particularly relevant, was the theme that sexual harassment and sexual assault exist on a continuum of harm. I felt like that was particularly relevant because that is the way that we conceptualize these different types of traumatic experiences within the VA, that sexual harassment and sexual assault are can be considered sort of a related construct consistent to thinking about them under the umbrella of the term "military sexual trauma".

The IRC noted that they had observed that outdated gender and social norms persist across the force, and to my eyes, this felt very relevant to the conversation that we had raised around the larger context of MST and why sexual assault within the military may be particularly challenging for survivors because of some unique aspects of that experience, including gender and social norms present within the military services.

And then I think broadly, but importantly, that victims bear a heavy burden. We've outlined for you here, the mental and physical health care costs as well as other quality of life and problems, and living issues; and it was very nice to see the IRC recognize the potential costs for many survivors of these experiences.

The IRC also included a few high-level recommendations beyond their 83 specific recommendations; and one, again, that I thought was particularly relevant to the issue of victim care and support was a general recommendation in all efforts to center the survivor by maximizing survivors' preferences in cases of expedited transfer, restricted reporting, and time off for recovery from sexual assault.

While the VA specifically didn't receive a lot of attention within the IRC's report, many of the recommendations were more specific to DoD, which is appropriate given the IRC's mandate. I did think this idea of centering the survivor resonated quite a bit with much of the work that we do in VA where a lot of the research relevant to military sexual trauma has really been about, "Let's center the survivor; let's understand the survivors perspectives on their recovery; let's engage their perspectives and their research that we're doing; and let's make sure survivor perspectives are at the center of the care that we're providing." So, I found that one quite compelling.

I want to highlight a very small number of the specific recommendations--again, the IRC recommendations are much broader than what's here. But one place that VA was specifically mentioned, was under the recommendation to expand victim service options to meet the needs of all survivors of sexual assault and harassment. And Recommendation 4.2 b suggested authorizing service members to access the full spectrum of VA services for conditions related to military sexual assault and sexual harassment confidentially, and without a referral--which is actually a policy that exists in practice but is implemented only in vet centers at the time, and so, there was some discussion that I imagine we will be hearing about for some time to come as our policymakers struggle with this issue around expanding that implementation more broadly.

The report did also acknowledge that there are some implementation challenges specifically related to privacy and confidentiality for survivors, so I think this is a complicated issue. And the report, I think, did acknowledge some of the complications involved in this change.

Another specific recommendation under this larger bullet, Recommendation for 4.2 d, was about creating survivor-led peer support programs that allow for in-person, virtual, and telephone interaction, and the report offered this specific rationale for the change, saying too many survivors feel isolated and alone after sexual assault, and that peer support programs can help with that sense of isolation and loneliness as part of a larger path towards recovery.

And I was happy to see this one here as peer support was something specifically we had talked about in terms of one potential extension of services for survivors that can be really valuable; and, in fact, the report specifically referenced the Women Veterans Network, which is a peer support network for women veterans specifically out of Boston University School of Medicine, that Tara Galovski and I developed, and that is actually currently being piloted in VA by peer support specialists. So, that was exciting for us to see as well.

And then I wanted to just give you a few quotes to end, that were the final thoughts of the IRC report. And, for me, this was valuable because it may help give you sort of a tone of the report and also because, for me, I felt like the report ended on quite a hopeful note with a real emphasis on the potential for change.

So, one of the final thoughts in the report was in the battle against sexual harassment, and sexual assault in the military, there can be no middle ground; leaders can either be all in for a culture free from sexual harassment and sexual assault or they can allow for a culture of impunity to persist. They also said that service members closely observe when commanders enforce what they teach, so no breach can go uncorrected. I found those to be powerful--appropriately powerful--words on the part of the IRC.

And then the IRC also said they believe that the hard truths uncovered here are not intractable problems; and that realizing a more inclusive and safer military is achievable.

So, I, for one, felt a lot of hope both by the thoroughness and the comprehensiveness of the review, and also sort of regardless of specific ways in which recommendations are implemented, that this has generated a lot of important conversations for all of us who care so much about protecting our service members and providing care for our veterans.

And with that, I am thrilled to turn the conversation over to our discussant, Dr. Bell. I know you heard her bio at the top of the hour, so I won't repeat it now; other than just to say I think we're lucky to have her today because she is probably the one person who I know, who knows the most about working with survivors of military sexual trauma both from a clinical and provision of care perspective, but also extremely knowledgeable from a policy perspective about the work that's going on within VA.

So, with that, Margaret Bell, I will pass the mic to you.

Margaret Bell: Thank you, Amy. Thank you for that segue. It's a little disconcerting to have my face staring back at me like this, but I'm so glad to be here.

And I really, really love the quotes you just ended on; in some ways, I'd rather we were looking at a slide with those quotes and having those hanging in the air much more than looking at my face. Because I agree with you, I think the report is really such a tremendous and important document, and so beautifully written, and eloquent, and powerful; it really is quite moving to spend time with it.

It is a fixed document, but well worth the read--and an emotional read, honestly, which can be unusual for kind of policy-focused documents. I think the IRC did tremendous work, pulled together a tremendous document that is exceptionally important regardless of where the recommendations specifically go. So, as others have said, I echo what's been said about being grateful to them for their work. I think it's a real service; it's a real service.

And I know we were I'm not quite sure how much time we were going to have for me, so let me let me quickly look at my notes and see if I can triage what where to spend my time. I do want to make a few comments that kind of offer some integrative thoughts about the work that's been presented and the impact that has had on practice and on VA services; but I do want to let the research reviewed here remain the star of the show, so we'll just offer some thoughts to, hopefully, augment the presentation, but encourage us all to focus on the important body of knowledge and literature that's been reviewed here that I think is one of the most important takeaways from today's call.

So, another thank you out to the other presenters today. I think this is an exciting example of research being used to inform policy and institutional decision-making; I'm grateful to you all for the time that you put into pulling together this tremendous summary; it is quite a body of literature; and to have it distilled down into this digestible version is tremendous and is also a service.

As Dr. Yano mentioned, I was also glad to have a chance to brief the IRC on VA services and I'm glad that they were able to get the information both from the research side, and then also information about current VA practices and information that might be used to inform DoD's response.

And I think, it's telling and quite a compliment that the IRC looked to VA for this sort of information; certainly, in my backchannel conversations with some of the folks organizing these briefings, that the message conveyed was that we know VA has a lot going on in this area, has a depth of knowledge, has a depth of services and it's really important for us to learn from that as we're trying to inform DoD's efforts moving forward.

And I think the reality is that the bulk of the research that has been done in this area has been done by VA, and it is a tremendous body of knowledge but obviously, much more for us to dig in on in many areas.

I really appreciate the way this talk and the summary gave both, again, as I said, a graspable, digestible summary, but also didn't lose the richness and complexity of this; and in some ways, I think this encapsulates the area of MST. There's a lot that, in terms of recovery, and impact, and assisting survivors that overlap with the work and the best practices of other areas and fits with what we generally know about those topics, especially in relation to survivors of other forms of trauma; but there's also clearly here something that's different, and that needs dedicated work and needs kind of rich understanding.

So, some of the data that was presented on how experiencing MST is a significant risk factor for suicide, even after you control for comorbid health conditions. So, the message here being that even when we parse out kind of the health and the emotional well-being impact of this experience, there is something about it that still contributes to suicide risk; there is something unique and exceptionally powerful about the experience of MST that impacts people in pretty profound ways. And similar, the literature on--not necessarily reviewed today, but that is out there--how MST compares to the experience of other traumas. Again, there's just something in and the added health burden and the increased risk for mental health conditions afterwards, in particular, there is something unique and toxic here and some signs that there is special work that we need to do in this area to make sure that we are meeting survivors' needs.

This heightens the need for more research we can't just rely on the literature on civilian sexual trauma, there's something about the military context that affects how these experience the impact of it and the way forward from it.

I'm looking at the clock so let me just hit some highlights on a few other things I just wanted to comment on. I think one other thing that jumps out of the summary for me is how the impact of the experience of MST can really vary, which follows from that, of course, that survivors have different needs afterwards. I think there's a wealth of work that we need to continue to do both research-wise and operations-wise, system response-wise on how individual differences, and identity variables, and cultural backgrounds, and all those sorts of things affect the experience of MST and recovery afterwards. I know this has been a key area for us on VHA's national military sexual trauma support team, and we've been working on putting out some educational resources for our providers on this topic.

In particular, we've done some interviews with racial and ethnic minority, MST survivors, kind of collecting their words on how the experience of MST intersected with being a racial or ethnic minority veteran, how that affected their experience of MST, how it affects their recovery, and what they think is important for mental health providers to know to assist them in moving forward.

But I think kind of the takeaway from that is that it's really important for us, as systems, to have a range of services available to meet different veterans where they're at with what they need coming from their particular experience; and then also make sure that we have a variety of entry points available. And we don't have enough time for me to kind of talk through the ways in which VA prioritizes this, but I think some of the things we have in place, like having facility MST coordinators as key frontline points of contact, the range of educational efforts we have in place to make sure that all of our providers have basic information about MST, and in particular, our mental health and primary care providers complete a mandatory training on MST so that they have the clinical knowledge they need, all this is important in making sure that there's really no wrong door for people reaching out and accessing help, and that there are really a variety of services and models available in the system in order to meet the variety of needs, and preferences, and choices that survivors would like to make.

And on that final note, I will just emphasize that point choice. Amy referenced it in talking about the IRC report, it came up at other points during the presentation. We know that the experience of trauma is fundamentally one of no choice, of choice being overridden; and offering the opposite of that, an antidote to that, or a restorative experience from that is really pivotal in the recovery process. And that is something that we try and build into our VA services in a variety of ways, most fundamentally being kind of offering a range of models and services so that survivors can be connected with the type of approach that's going to

go going to work for them, and allow them to have choices about what they think is going to work for them.

Part of that is not just focusing on formal treatment, but also making a range of recovery options available to assist survivors. So, I really appreciate the review's focus on some of those things, so the mobile health options, the Beyond MST app that we have put out; things like VA's Make the Connection website which focuses on videos of veterans telling their stories of recovery; peer support work.

All those things don't fall under kind of the traditional formal treatment model, but I think are really important in expanding the range of options available to veterans, making sure they have choices available--and acknowledging that there are just a range of paths to recovery; and part of our job is to help connect veterans with the path that is going to work with them as opposed to slot them into a particular approach, a particular way of moving forward which, I guess, brings us full circle because that's kind of where Tara started in terms of talking about how there's not one particular response to this problem, there's not one particular treatment. And I think that's maybe the most important thing we can walk away from this, is appreciating the digestible summary here, but holding on to the complexity and the richness, and sitting in that grayness and that complexity.

So, I'll pause there. I don't know who's going to take the mic to manage questions, but thank you to all of you on the call who are attending; and thank you to our other presenters, I'm really grateful for the strong research summary you've pulled together and look forward to hearing questions folks have about that summary, so we can all continue to grow in our understanding of the research and inform our practice from it.

Elizabeth Yano: Thank you so much. This is Becky Yano. I don't actually see Q&A on my screen, so I don't know if there are any questions that are coming up, Heidi, that you see?

Heidi: Oh, we do have several pending questions here--actually, we have about 20 pending questions. We've got four minutes left here, so there's no way that we're going to get to all of them. For the people that have submitted questions, I will get these put together and sent over to the presenters for them to take a look at.

Elizabeth Yano: And we will definitely respond to folks on those. Any other comments from our panelists, or from Dr. Lehavot or Dr. Creech who are part of this effort? Keren Lehavot: Well, what I do want to say is just a tremendous thank you to the folks that organized this material, and also to those of you who are conducting work in this space. We hope, on the Women's Health Research Network side, to continue to integrate

findings across research in order to present these kinds of syntheses in addition to being able to hallmark your individual work as we move forward.

This work could not have happened without the commitment and dedication of the National Center for PTSD, Women's Sciences Division, as well as the individual work from other medical centers represented here, and among several of you that we were not able to include in the group at the time. This kind of work continues to be absolutely essential in informing VA practice and policy changes that are evidence-based; and as you can see, inform high-level recommendations, if not also legislation as the work has penetrating effects on how we understand and act on experiences and quality of the veterans we serve.

So, I just want to thank, again, all of the speakers and also HSR&D service for funding the Women's Health Research Network and the work that many of these folks are conducting, and many of you in the field are conducting as well.

Elizabeth Yano: Tara, any last words.

Tara Galovski: Yes, thank you, Becky. I was glancing through the chat and my heart is full. I can say that, to my knowledge, none of the presenters are veterans, and so we do not understand the experience of military sexual trauma. And you are right; you are right to be angry about this experience. My heart goes out to you and I welcome anybody to contact me, and I'll speak for my colleagues, let us know what we can do better. I can honestly say that when I craft a study -- which sounds so academic--a survey, a question--I craft that with the person whom I know has experienced military sexual trauma with them in my mind, sitting across from me as I've walked through that story. I hold you in my heart, you're important, and I appreciate your bravery and courage, and I welcome any more conversations that people might want to have offline. We really appreciate you being here in this talk today.

Heidi: Thank you so much. And we are at the top of the hour, so we are going to close today's session out. We have received a few more questions and comments and I'll give everyone a few more moments to type if you are still typing there.

But when I close the meeting out, you will be prompted with a feedback form; we really would appreciate everyone's feedback in there also, which allows us to provide great cyber seminars moving forward.

Thank you everyone for joining us today and we look forward to seeing you at a future HSR&D cyber seminar. Thank you all.