Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

October 23, 2014, 1-2:30 p.m. (EDT)

"Psychological Health Issues Affecting Women Service Members and Veterans"

Thank you all for standing by. All lines have been placed on a listen-only mode throughout the duration of today's conference. Today's conference is being recorded. If you do have any objections you may disconnect at this time. I'd like to hand the call off to Major Demietrice Pittman. Thank you. You may begin.

All right. Good afternoon and thank you for joining us today for the DCOE Psychological Health October webinar. My name is Major Demietrice Pittman, and I'm a clinical psychologist with the Deployment Health Clinical Center, one of three centers for the Defense Center of Excellence for psychological health and traumatic brain injury. My experiences include psychological and neuropsychological assessment, operational psychology, forensic assessment, and a spectrum of psychological health concerns. I will be your moderator for today's event.

Before we begin, let's review some webinar details. Live closed captioning is available through the Federal Relay Conference Captioning. Please see the pod beneath the presentation slide. Defense Connect Online and Adobe Connect are the technical platforms hosting today's webinar. Should you experience technical difficulties, please visit dcoe.mil/webinars and click on the troubleshooting link under the monthly webinars heading.

At any time during the webinar, please submit technical or content-related questions via the question pod. The event planning team will address the technical questions as soon as possible. Our first presenter and I will answer content-related questions after her presentation, and the last 15 minutes of the webinar will be dedicated to answering content related questions for our second presenter. While we encourage the network and identify ourselves to other attendees via the chat pod, please refrain from marketing your organization or products. The chat pod will be left open for additional networking opportunities ten minutes after the webinar has concluded. Today's resource list, presentation slides, and handouts are available for download from the file pod below.

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Throughout the webinar you are welcome to submit technical or content-related questions through the Q&A pod located on the screen. All questions will be anonymous. Please do not submit technical or content-related questions via the chat pod.

I will now move on to today's webinar, "Psychological Health Issues Affecting Women Service Members and Veterans." Women represent more than 15% now serving in today's military. Education and awareness of women's health issues are key factors in maintaining current operational readiness. An increase in the presence and engagement of women in the military has resulted in an equally rapidly growing population of women veterans, projected to reach 50% of the total U.S. veteran population by 2013.

This presentation will describe relevant research findings and clinical guidance to inform best practices for meeting the unique needs of this population. Current research findings indicate many women in the deployed environment hesitate to seek medical care when they have health concerns related to their gyno, urinary, or reproductive health. Issues around pregnancy and breastfeeding lead to occupational health concerns. Other important gender differences that exist, compared to their male counterparts, women may develop mental health difficulties, such as post-traumatic stress disorder and depression related to combat and/or military sexual assault.

At the conclusion of this webinar, participants will be able to review the effects of combat on psychological health, explain the rigors of maintaining proper nutritional and gynecological health in deployed environments, communicate issues about sexuality and motherhood with service members, describe gender differences and the effects of military service on mental health and wellbeing, and identify the components of gender-sensitive clinical care.

I would now like to introduce our presenters. First, we have Dr. Ritchie. She's the chief clinical officer Department of Behavioral Health for the District of Columbia. She retired from the Army in 2010, after holding numerous leadership positions with Army Medicine to include the psychiatry consultant. She trained at Harvard University, George Washington University, Walter Reed, and the University Service University of the Health Sciences, and has completed fellowships in both forensic and preventative and disaster psychology. She was professor of psychiatry at the University Services University of Health Sciences at Georgetown University.

An internationally recognized expert, Dr. Ritchie brings a unique public health approach to the management of disaster and combat mental health issues. Her assignments and other missions have taken her to Korea, Somalia, Iraq, and Cuba. She has over 200 publications, mainly in the areas of forensic, disaster, suicide, ethics, military combat, and operational psychology and women's health issues.

Our second presenter is Dr. Strauss, who is the women's mental health program manager at the Office of Mental Health Services Department of Veteran Affairs, as well as assistant professor of psychiatry and behavioral sciences at Duke University. She contributes to VA policy recommendations and their implementation and oversight as related to women's veterans mental health. She has also written over 30 journal articles and book chapters and received independent research funding from the Department of Veterans Affairs, National Institutes of Mental Health, and the Department of Defense. She graduated from Emery University with a Bachelor of Arts Degree and received her Masters and PhD degrees from the University of Miami.

Her areas of interest and content expertise include women's mental health, post-traumatic stress disorder, military sexual trauma, the development of self-management interventions and strategies for increasing individual's collaborative involvement in the treatment process and the integration of complementary alternative techniques and evidence-based therapies.

Thank you so much for joining us, and welcome Dr. Ritchie and Dr. Strauss.

Thank you. It's a real pleasure to be here today. What I'd like to do this afternoon is give everybody a big overview about medical and psychological issues for female service members. And one of the important things for folks to remember is that there really isn't much of a clear distinction between medical and psychological in some cases, because if you have a medical issue, such as a urinary tract infection, you

have a psychological issue because you're miserable. And we tend to break things down a little bit in terms of separating one from the other, but they're all intertwined.

The usual disclosures, but I will be talking a little bit about off-label uses. One of the things in this field, especially in the field of post-traumatic stress disorder is there is a lot of new and innovative techniques, which are worth discussing. So we're going to talk a little bit about the effects of deployment and combat, about maintaining good nutrition and gynecological health, and talk about things that are often verboten and taboo, like women's sexual desires and motherhood and how do you deal with motherhood.

I don't really need to talk about my credentials since your Major Pittman did those already. What I do want to do is have you think about different environments, because for women especially, their reproductive status, whether they're pregnant, whether they're breastfeeding, intersects with where they can be sent and where they should be sent, and then medical issues, psychological issues, and we'll some perspectives on sexual assault that I will be a little different.

So, again, my experience, I was in the Army for a long period, deployed everywhere, have written a lot of literature in the field about issues for mental and peri women, about breastfeeding, about sexual abuse. Some of this conversation has reemerged under the leadership of people like Colonel Patty Deuster at the Uniformed Services University and the Women's Health Research Group, and there's more research that's coming up again. But one of the take-home points is there is a date of dearth of research in many areas in women's health issues. There was actually more before 9/11, but then everybody got so busy going to war that a lot of the efforts that were going on have faded. So I'm going to cover, quickly, the high-level topics; reproductive, musculoskeletal, deployment health, and combat health, psychological reactions, and then sexual assault.

So why are reproductive issues important? Well women in the military, by and large, are young and of reproductive age and are often interested, at some point, starting a family, but then they're trying to figure out how they can do that and still maintain their military career. This is not easy. As I went along in my career, most of my colleagues, who were female and had children, ended up getting out of the military because they couldn't do everything. And I hope that one of the -- again, another take-home point is we need to pay attention to this, because women are too important to just say, okay, once you have children you can leave. They've been 15% for in the force for long time. They're really of critical importance for us.

So pregnancy, if you're pregnant you may not deploy, and, therefore, I'm calling it a Garrison issue, and even in Garrison -- and by Garrison, I mean home-based for those who don't know, Fort Bragg, Fort Hood, Washington, D.C., the Pentagon. In Garrison, even if you are pregnant, you may be exposed to things like petroleum products and other toxins. You're not allowed to deploy, but sometimes people deploy and then find out they're pregnant. And then, of course, it's got a special physical training program.

Breastfeeding also it can be problematic, and this is something that's not talked about enough. Some of the topics I'm going to talk about here may make men feel a little bit uncomfortable, because they haven't thought about, for example, how to maintain breastfeeding in the field if you've got to manually express your milk. But it's something that should be talked about and known by leaders, by soldiers, so that you can encourage somebody. As you know, women with children are encouraged to breastfeed for a year. Well you may go to the field during that time, can you do both?

And then motherhood, of course, many mothers deploy, so it can be an issue in Garrison, in the field. By "the field," again, I should say what I mean. That's usually training exercises, whether you're at Camp Edwards in Korea or Fort Bliss or JRTC, Joint Readiness Training Center. That's what I mean by field exercises, and those are designed to simulate deployment.

By deployment, you can have deployment to combat or you can have deployment, such as about to happen to Liberia or Humanitarian Assistance, and then combat itself, and so there's a spectrum here. But what happens is somebody's reproductive status does affect where they can go to.

So musculoskeletal issues, this is a concern for women. After 9/11 happened, we started putting people into heavy Kevlar, and, in many cases, they weren't used to it, and, therefore, we had a number of stress fractures. So the attrition rate at our basic training sites -- and you remember the coed training sites for the Army are Fort Jackson and Fort Sill, and the for-males-only, Fort Benning and others. But what was happens is that we began to put our people into heavy equipment and they developed stress fractures, and this is very hard to recover from a pelvic stress fracture and go back to duty. So we got smarter, and instead of putting them into heavy equipment all at once, we'd belt them up for it.

The conversation about women in combat often has to do with how much weight somebody can carry and whether they can hump that ruck. That's part of the issue. But I'm going to also make the argument that it's these other issues, the bathroom issues and others, that are really important.

Genital urinary issues what we've seen over and over is that bathrooms aren't well attended to, and by "bathrooms" I don't literally mean a bathroom, I mean a Porta-Potty or another place to relieve one's self. They tend to get pretty stinky and awful, and, again, this is just kind of basics of biology. I hope nobody gets offended by me saying this, but women normally have to sit down, where men don't, and if you have nothing but a toilet seat full of feces, as what happened in the Porta-Potties when I was stationed in Korea, and they weren't cleaned out very well, you didn't want to go to that Porta-Potty. Or if you were in Kosovo or Afghanistan or Iraq and you may have a bomb at the side of the road or maybe personally vulnerable, you don't want to get out of the convoy.

So what happens is women often restrict fluids, and then they're likely to develop urinary tract infections or get dehydrated, which can lead to falling out and all sorts of other issues. Now we have known this for a while. This has been a subject of conversation prior to 9/11. But what happened is a lot of the work that was being done there on female urinary diversion devices and others kind of got sidetracked by the war, and what you'll find, shortly, is that these are the same issues now that they were back when I was deployed Korea 20 years ago.

Another major issue is how you manage your menstrual cycles in the field. Well, actually this is fairly easy. Women can go onto what's called suppressing medication; that's usually over the counter -- excuse, me not over the counter. It's usually oral contraception, not over the counter, and that can suppress your menses for the time that you're deployed. And this is something that may not be right for everybody but may be very helpful, and it's something that the female service member, female soldier, marine, others, should discuss with their doctor prior to going.

And then the question of birth control; of course, women, men, don't have sex in the field; right? Never happened. Well, it does, and but if there's not birth control available -- I know, I'm surprising you guys. You think that that's not true, but it does. Women get pregnant in the field, and we need to have birth control easily available.

Okay, so what is the difference in deployment versus combat? Usually they're both austere dirty places. Combat, you've got somebody shooting at you. So I wrote a paper back, again, prior to 9/11, talking about issues for military women in deployment, and they covered all of the things I've just been talking about, as well as home front problems, because the women is often the center of the family, she may have kids at home or aging parents, and when she's away, it's hard for her to do everything.

Colonel Anne Nacleario, who is my coeditor on the forthcoming book called "Woman at War," did an assessment in Afghanistan, and she found it was the same issues, what, 12 years later, plus some other additional issues related to combat; body armor, wearing heavy body armor, and then more post-traumatic stress disorder and traumatic brain injury. Although, most females with PTSD, actually, it's related to prior areas rather than simply combat. So these are some of the issues that came out, and this is available on the Web. If you want to find the resource it's in your references and resources.

So this is looking at women in Afghanistan in 2010/2011, and this is what the women reported, same things I've been talking about back in Korea and Somalia; how to urinate in the field, maintaining hygiene, managing menstruation, managing lactation, and also improper fit of uniform. A lot of the body armors

and other uniforms simply were not made for female body types, which, of course, vary in size and shape. And then dealing with female health issues in an austere environment, feeling comfortable with the providers, what to have if you don't have your menses regularly, getting infections, again urinary tract infections or yeast infections, access to birth control, and unintended pregnancy.

So kind of take-home point here is we have been busy, and I still say, "we," referring to the military, we have been busy as a military, but we've got to address these issues so that you don't lose people unnecessarily, and basic preventive medicine.

Now some of this is kind of surprising, because the military medical culture has a lot of women in; nurses, doctors, physical therapists, techs, medics. However, what you often have is -- in the hospital setting deployed, you have a large amount of women, so you can have female-only sleeping tents, while in the far forward area, it's harder. Let me give you one example. When I deployed from Somalia our of Fort Bragg with a 528th, I was the only woman in the combat stress control team, and the general at the time said that women and men couldn't sleep in the same tent, so I had to relocate and find another tent that had women. The only other tent that had women were Somalian interpreters, and I was taken away from my unit, et cetera, et cetera.

By the way, this photo is courtesy of my co-editor, Ann Naclerio. This is a female bathroom, and this is often the type of thing that you get, even today. And some people say I make too much of an emphasis on clean bathrooms, and it shouldn't be that big of a deal and maybe this is the reason people shouldn't be -- women shouldn't be if the military. I will say, well we have clean mess halls and a clean bathroom benefits men as well as women, and the older men in the audience usually nod appreciatively when I talk about that, because, you know, a pipe is okay if you're a marine and out in the very austere environment, but we've been in Afghanistan for a long time, we need to be thinking about some of these issues. Okay, enough on bathrooms.

What about mental health? So, unfortunately, there's actually very little research on women and mental health in the service, and this is somewhat surprising. And people say, well what about the Mental Health Advisory Teams? Well, actually, nearly all of them focus on combat units, which, by definition, have been male, combat brigade team. There is a little bit of data out of MHAT-2, and a tiny bit out of MHAT-7. MHAT-2, mental Health Advisory Team, 2005, did study women, and, interestingly, we showed essentially equal rates of post-traumatic stress disorder in men and women, a tiny bit lower in women. Now why is that?

There are several schools of thought, and one school of thought is women have less exposure to traumatic events in combat, so their PTSD rate is lower; that they do have slightly lower exposure to combat. On the other hand women, again, are often in as nurses in medical settings high exposure to trauma, including not just trauma for our soldiers but third-party nationals and Iraqi and Afghani children and others, so quite a high exposure -- and detainees as well. So they are exposed. I, of course, being bias, being a female in the military -- and, Major Pittman, I know you're going to agree on this one -- think women who join the military are pretty resilient. Women who go to combat are pretty resilient and are self selected, and, therefore, they do quite well. I'm going to show you some data on PTSD also in a moment.

The other source of research is a millennium cohort study. This is a long study out of Naval Health Research Center, and I think they're going to publish more about gender-specific issues. They may have already. I haven't been able to find too much. I'm sure I'll get some comments on it though, and there may be more. And I think the research is beginning to ramp up again. But overall, there's very little research from on women, including we have nothing on wounded women, women with traumatic brain injury, and there needs to be a lot more.

Now there is one bright spot here. The next slide I'm going to show you is courtesy of Dr. Mike Carrino, who is at the Office of the Surgeon General. And he's got some data on behavioral health evacuations. And this is kind of a busy slide but I'd like to walk you through it. The first column is who's been deployed to theater, and you see that women are at almost 10% of people who have begun deployed to theater. And is this is Army data specifically, so it's going to vary a little bit from other services.

And the next one is percent of soldiers medically transported out of theater, and you see that women are transported at slightly higher rates, so they're deployed just under 10% and it's 12.7% that they're transported out of theater. And then the next one is, are they transported for behavioral health issues not PTSD, and women do have a higher rate of being evacuated, and then you have soldiers transported out with a finding for PTSD, and they're you're right at about the same rate that they're deployed in, and then you have diagnosed PTSD not associated with deployment, much higher for women than for men, and then diagnosed PTSD associated with deployment history is just at their baseline. So what this slide is telling me, of people who get deployed out of theater, so that's a small amount overall, that it's non-PTSD or PTSD not associated with deployment. And then at the bottom you see the overall numbers for soldiers requiring air medical transport out of theater. Okay, again, busy slide, but one of the few episodes of good hard data.

Okay, so what is PTSD, and is this going to be a brief review for all of you who know this already, but I just want to talk about this. This is the old criteria, DSM-4, Diagnostic and Statistical Manual. You have a traumatic experience with so-called criterion A2; that's intense fear, helplessness, or horror at the time. Three main type of symptoms; experiencing numbing, physiological arousal, impairment and social or occupational functioning, and the persistence of symptoms.

What has changed under the new DSM-5? It removes criterion A2. Remember, that's intense fear, helplessness, or horror. This is good. This is very important, because a lot of our soldiers who are well trained when the bomb went off knew that they had to return fire, drag their buddies. They didn't have time for intense fear, helplessness, and horror. They did their job, but they may well go on later to develop symptoms of PTSD.

And then additional criteria were added; bodily or somatic reactions, you smelled something, you get physically sick. Sleep is an enormous issue for people with PTSD. Just about everybody has a sleep issues. Depressive issues and symptoms and anger and irritability. Now when this first came out, I was very pleased with it, because I thought it would widen the aperture, and some people who were getting, say, anxiety disorder not otherwise specified would get post-traumatic stress disorder.

Unfortunately, my colleague, Charles Hoge, did a study -- not unfortunate that he did the study, but, unfortunately, it showed that a lot of people who would have met the old definition don't meet the new definition. So I'm urging everybody, you know, if it smells like PTSD, acts like PTSD, it probably is PTSD. Fortunately, the army and the military have a similar position that they would -- and I'm not speaking for the Army or DOD here, but this is what I've learned from colleagues, and they are going to keep as many people within that aperture as possible.

Okay, so treatment of PTSD, we get into a little bit of a box here, because we have evidence-base approaches for PTSD, psychotherapy and pharmacotherapy, and I'll go into a little bit more detail on those. But the problem is, even though they work, if you get somebody all the way through them, or at least they work in about two-thirds of the time, soldiers and service members don't particularly like these methods of treatment, so only about a third of patients who start with them finish them. And a lot of times, providers don't like the psycho manualize-based psychotherapy either.

So the psychotherapies have been called "manualized" because they can be done according to a manual, and the two most common are cognitive behavioral therapy and Prolonged Exposure. Again, another problem, they're usually 12 to 20 sessions, and although they are delivered in the military, in the VA, many times people who start them don't complete them. I just finished being on the IOM, Institute of Medicine, committee, looking at the way DOD and VA delivered care for PTSD, and we heard over and over again, from therapists and from soldiers, marines, service members, that they didn't like these treatment,. They didn't complete them or the therapists who were trained on how to do them said, "I can't get my service members in," either because they couldn't get them in the clinic or they were being deployed to the field. There's all kinds of logistical problems.

Now there's a new variation, not so new anymore actually, it's called "virtual reality." And this is essentially prolonged exposure over a computer, and in various iterations it's performed either by a therapist or by the patient themselves, and there's usually virtual Iraq simulated on the computer screen, and the person can titrate their level of exposure. Skip Rizzo has been in the lead in that particular area.

Psychopharmacology, and just briefly to review, there's two therapies that are FDA approved, Sertraline and Paroxetine; however, they cause, in many cases, sexual side effects, young men, young women don't like sexual side effects. And so what I want to do is talk a little bit about a couple of different strategies, and again, this gets into the areas that are not yet FDA approved but clinicians find useful.

Another very controversial area is the use of what's called "second generation" or "atypical antipsychotics," which are used a lot for depression in PTSD. Now one large VA trial did not find them to be more effective, but a lot of clinicians find them very helpful, especially in low doses. So, for example, Quetiapine is used to treat psychosis at high doses, 600 to 800 milligrams, but clinicians are using it at 25 to 50 milligrams for trauma-induced nightmares. Everything in here is a balancing act though, because it helps with the nightmares, but these medications can cause metabolic syndrome, so you have to be very careful.

Another medication that's being used a lot, and there's some good research by Murray Raskin and others, is Prazosin, which is blood pressure medication, but that helps a lot with nightmares. Bupropion -- Wellbutrin -- Is a antidepressant that's not yet FDA approved but is often well tolerated and doesn't have the same weight gain or sedating qualities that some of the others can have.

Now sedation can be helpful. I mentioned before that insomnia is extremely common and you have to address it, because, unfortunately if you don't address it, you often the confounding bottle of Jack Daniels to get to sleep, et cetera. Most of the time, people will use standard sleep medications. They may use Trazodone, which, of course, is an antidepressant, but you use it in a low dose. If you're using it in male patients you warn about priapism. Ambien and others, you've got to warn about interactions, avoid Benzodiazepine. So, bottom line is you need to treat sleep, and, of course, I should say that good sleep hygiene is important here, irrespective of medication.

So now I want to talk a little bit about the new and innovative approaches. I've already mentioned the second generation antipsychotics. What gets a lot of people excited is some of the integrative or complementary and alternative medicines. In some cases, these can be a treatment on their own, and in some cases, they act as a bridge. The person won't come and talk to me, they'll come and talk to my dog. So the one's that have probably the best evidence around them are acupuncture, and, actually, the DCoEs themselves have been the lead in looking at acupuncture for PTSD. And like many things, it started out being used for pain and then helped with post-traumatic stress disorder.

Another one that's exciting, and there's a couple recent studies that have just come out. Dr. [indiscernible] and others in military medicine, October, in anesthetic journals is stellate ganglion block, which is an anesthetic block inserted into the cervical ganglion with Lidocaine or others. It's been found to really help some people with refractory PTSD. We don't yet know which patient population is the best. Some people it works like a charm, other people it doesn't.

So here's one more plug. Actually, I'm going to direct this one to the VA. VA, this would be a great opportunity for you to do systematic research. We need good clinical trials. Okay, everything else has been used, yoga, martial arts, meditation, mindfulness, one of my favorites and this is a whole talk in itself, is the use of canines or horses, partly because if you're working with a dog or a horse, you need to slow yourself down, regulate your affect. It's sort of like biofeedback for yourself, and this can be very helpful. I don't advocate just doing dogs. It should be a combined approach with some of the other areas.

So a couple clinical pearls -- again, these aren't FDA approved -- I mentioned some sexual dysfunction from SSRIs, some clinicians add a little bit of Bupropion, and that really helps with the difficulties with retrograde ejaculation. If it's anxiety, Propranolol, which has been used for social phobias, for problems with public speaking, can be helpful. We've already talked about Quetiapine and Prazosin, and then the

most important thing is sometimes it helps to do several. So one young marine I talked to said, "You know, before the yoga I just couldn't focus, now I can calm myself down." It calms a hot brain, and so using some of these others.

One thing I haven't mentioned that I'm really impressed is art therapy at the NICoE, the National Intrepid Center of Excellence. They've got a gorgeous wall, which is the art therapy map. Many, again, I'm going to say young men and young women, don't like to talk. They don't like to share their experiences with words, but they are wonderful artists, and it gets to that other side of the brain.

Okay, so comorbidities, we all know that some, confused, depression, physical injuries are very common. We know that after Vietnam veterans slid into unemployment and homelessness. Many states, including Washington D.C., where I am now, are developing state plans, which focuses not just on health care but employment, housing, education, and the criminal justice system to try to keep people from going down into that slide.

I'm just going to mention TBI for a moment. You all know what TBI is, traumatic brain injury. What we don't know, coming back, for female service members, is the difference in the way TBI is expressed in males and females. We believe there's some differences, based on hormones, based on treatment, but this is an area my colleague, Victoria Teppie [ph] has a nice chapter that goes through this in detail. But the bottom line is we don't know enough about the difference between men and women. We do know that you want to take the person away from the frequent insults, whether it's a bomb blast or football, and allow the brain time to heal.

Okay, so, again, I'm giving you big picture areas. The last area I'm going to talk about is sexual assault, and I have listed some of my credentials here in the beginning. I have worked a lot in the area of sexual assault, mainly as an expert witness. So this is kind of my perspective, and there's many different perspectives on the subject. There's obviously the medical, the leader, the one I am most often, subject matter expert victim advocate and the defense in the prosecution, and there's different solutions and different ways to view the problem. It is intended to be the emphasis on individual vulnerability. I see a lot with the people getting together for a night of fun, and things happen; sexual predator leadership failure, occupational hazard and environmental contribution. And I'm going to focus on the latter part, because I don't think we talk about that one nearly enough.

Okay, so individual vulnerabilities, and this is an example of mine. I'm standing by the banks of the Tigress River. This is back in 2004, and shortly after that, my colleague spotted red spots on my back, pushed me out of the way. They were a sniper, who was training their lights on me, and here I am a minute before kind of being individually foolish.

In the area of sexual assault, we often see that the victim had prior risk factors of impulsiveness, prior history of sexual or physical abuse, maybe poor socioeconomic upbringing, poor boundaries in the home, alcohol, drug use, perhaps a marginal soldier -- and this goes into the next part, which is the sexual predators who may pick their victims because they've got some vulnerabilities. Often these happen in remote locations where there's nobody to confide in. And then afterwards the person often is too worried to tell or worries that they'll get into trouble.

Again, in one of the common scenarios -- and by the way, this is, I think, an area that's very important to look at different scenarios. We tend to lump all sexual assault in together, and it should not all be together. There's clearly different patterns. The most common that I've seen is friends getting together, they go to Hamburger Hill in Taejon. In Seoul and Korea, they drink from the Soju tea kettle, which has a powerful alcohol mixed in with the fruit juice, something happens back in the barracks room, and then you get into the issue of what's often he said, she said. He says it's voluntary, she says either, no, it wasn't, or that she's too drunk to remember. Now I'm saying "he said, she said," but, of course, men can also be victims of men or women. Women can be perpetrators. What I see have seen most often is the male alleged perpetrator.

Having said that, I think they both end up as victims, because a guy who's charged with rape or sexual assault, most of the time, he's going to leave as well, even if he's found not guilty at a court-martial, but it's going to be out. And if convicted, of course, he's going to go to jail for felony, and he's going to have a hard problem with a career anywhere.

A different pattern with the sexual predator -- so the one I just said before, they're usually of equal rank and age, may well be buddies -- this one is much more what we've seen at the Air Force training site, at other training sites, when you have a recruiter or drill sergeant who is often picking on different victims, and picking on them by selecting them, and, again, may choose a vulnerable one. What we saw at Aberdeen with the scandal back in the late '90s is that the victims who were picked were having problems with the PT techs with their push up. So it was kind of like, well, if you do what I want you to do, you can stay here, otherwise you're going to be out. So, again, the same caveat here.

Seldom weapons are used but force may be. But it's usually coercion. And the important piece about recognizing that is if you give people education about this particular way, then they're more empowered that if the drill sergeant puts his hand on your knee to know what to do about it or who to tell.

Often they are leadership failures. A central theme of what I've seen is often that there can be a culture, and we've had this at Aberdeen in the late 80s -- excuse me, late '90s. I'm not saying it's there now, but often you have a place that's relatively removed. In basic training the trainees are in and out of there. They just want to graduate. And in some cases, and we've certainly seen this, the leaders will ignore the warning signs or may collude. So the final theme of this part is that it's an environmental problem and that you have what's called "behavioral drift," and a "Lord of the Flies" situation, and that often happens in remote areas such -- and this is civilian world too, in jail cells, with nobody there to tell. I asked leadership, look at your environment, look at where you have sexual assaults. Is it under the park bench? Do you need to put a light over the park bench.

So just to conclude -- and, again, this has been a high-level discussion of women and service members, and some of the issues they grapple with in the intersection between physical issues, such as urinary tract infection and then the TBI and PTSD gender-specific issues. I think I neglected that we don't know anything about gender-specific differences in treatment for PTSD in female service members. We know something about the civilians, but we need more research in that area. So more attention needs to be paid. We need to talk about this with the leadership, because if you don't talk about why it's important to have a clean bathroom, that won't be part of your priority. Health planners need to anticipate that women are deploying. Again, we're 15 -- we were, we are 15% of the force, and we need to develop an organized approach to solving these problems.

Thank you very much for your attention. And I believe I'll take some questions and discussions now. This photo that I will close on is Lieutenant Harrison, a commanding officer of the U.S. Coastguard Cutter. Part of reason I've put it here is to remind ourselves that the Coasties are also part of our military mission, and we need to acknowledge their contributions as well. Thank you.

Thank you so much, Dr. Ritchie, for your presentation. If you have questions for Dr. Ritchie, please submit them now via the question pod located on the screen. All right, so we'll go ahead and answer one question. There was a question about if you are a service member, do you have some suggestions of things they can say to their commander to discuss breastfeeding and their health concern.

Okay, so if you with a junior service member, it can be really hard to say, boss or lieutenant or captain, I am planning to try to continue breastfeeding when we're being deployed to JRTC or NTC, can we talk about how I could do that. So I think it would probably be easier for a junior service member to approach a female non-commissioned officer. But a much better way to think about it strategically is for the senior non-commissioned officers, male and female, to bring it up with their junior soldiers, to know that if somebody is of childbearing age, that may be thinking about getting pregnant, they may planning to just get pregnant, and let's not have it as taboo conversation that you've got to have the E4 bring it up themselves. This is to be something that you captains, your lieutenant colonels, your brigade

commanders are thinking about. And if you look at retention of women, childbearing issues are critically important.

Yes, speaking just for myself as the mother of two children, a lot of my colleagues are getting out right now, and childbearing is one of the main reasons they're getting out.

And you're a psychologist, an Army psychologist, and we need every Army psychologist we can get.

Right.

I won't ask you this question, Major Pittman, for you to answer, but I'll throw it out there as a hypothetical, how many times did a senior officer say, "You know, I'd really like to help you figure out these issues about child care and breastfeeding and pregnancy so that you can do all that and be a successful mother and a successful officer?"

Well, you know the answer to that ma'am. Well we'll go ahead and move on to our next question. There was a question about how do you specifically prepare a woman for a trial, so in the instance of, like, military sexual assault?

How do you prepare a woman for a trial, a court-martial? Very good question. Because being in a court-martial, where you are essentially put on trial as well, is incredibly humiliating. One experience, I'm sitting there as an expert witness, and the defense attorney is basically putting the victim on trial by talking about her sexual behavior, about what she wore, how provocative, and her family is sitting there in the courtroom, because, of course, these court-martials are open to the public. And it was just so humiliating. So I think as much as possible, you're going to talk about what the trial is going to be like, and you're going to emphasize to the person that, you know, the importance of going forward.

I would like to say, if it gets to a court-martial, everybody loses, and that's why I come back again to the preventative occupational medicine approach of how can we prevent this. And classical there's been some good strategies, have a battle buddy. But, also, I would urge, again, the leadership out there who might be listening to this to look at their fast few rape scenarios, sexual assault scenarios, look where they happened. They were probably in isolated remote places -- again, the analogy is no light above the park bench where they're going to party -- and see how you can prevent them in the first place by having it just be harder to happen. And it's tough because your soldiers are adults so you can't say no behavior, but I think you really can minimize the problematic behavior.

All right, great. Great answer. Another question was, "Can you please comment on single moms and PTSD, being separated from their children?

From single moms and what being separated.

About post-traumatic stress and being separated from their children.

Okay, that's sort of a couple questions in there. So let me take the single mothers being separated from their kids, and, again, these are difficult issues. So if you're a single mother in the military and you deploy, you'll be separated from your children. That's hard. But if you say, single mothers should not deploy, then you've got the burden heavier on everybody else. So whether you're single or married if you're a mother it's difficult. And so most of the time, people do it by having god childcare packages. Very often it's a grandmother who takes care of them.

Now if you have post-traumatic stress disorder, it's that much harder and more challenging. And, again, I would say let's talk about it in advance and see if we can come up with a good plan for deployment. I would not want to say single mothers should not be the military. Single mothers do a great job, but let's see if we can accommodate their needs.

Thank you. . We have a question about kind of innovative approaches and new research. So have you heard of using community clowning experiences, AKA, kind of the "Patch Adams" approach the treat PTSD, depression, and inner grief?

I have heard about the Community Clowning Experience. I don't know a lot about it. The things I talked about here were all in a series in psychiatric annals last year that I edited. I would say anything that improves mood is going to help. We do have a long history of recreational therapy. I mentioned art therapy, recreational therapy, occupational therapy. One thing that's very important for folks, in general, is to feel motivated. A good job is a great motivator, and then to feel happy is obviously a great motivator. But I don't think the research is out there yet on clowning.

Okay. Thank you. We have time for one more question. We wanted to talk a little bit more about research and kind of therapies. What about acupuncture? The question asks about acupuncture being available when you're active duty, but it's not being available if you go outside the network.

Yes, the military -- and this is something I'd really like to stress -- the military has done a great job with these new and innovative approaches. Some leaders are at Walter Reed at the National Intrepid Center of Excellence, out at San Diego at Balboa, Fort Bliss, at Fort Hood, Fort Bragg. There's a lot of places where acupuncture is offered, and we don't have to worry about third-party payment. It is much harder to get it or to get it covered, either in the civilian world. I won't speak for the VA. My anecdotal impression, and perhaps our next presenter can speak more specifically to the VA. The VA is doing some acupuncture. I really hope that we get some large clinical trials of acupuncture of stellate ganglion block. The NICoE is doing some research there, again, that's the National Intrepid Center of Excellence. They were also doing research on dogs, which we need more of as well, but more needs to be done. Thank you everybody very much for your attention and your patience.

Thank you so much. We will now move onto our second presenter, Dr. Strauss.

Dr. Strauss, are you on mute, so you can begin your presentation.

Thank you. Sound coming through okay? All right, I'm going to take that as a yes. So thank you for having me. My name is Jennifer Strauss. I know Dr. Ritchie spoke about some of the austere environments that one deals with in the military. I'm calling you from a different type of austere environment. I'm calling from my VA office. So I'm going to be talking about a slightly different perspective. I'm talking about women veterans, and specific to mental health, and with a focus on how they may or may not differ from men in the mental expression, and their needs, what the research shows us about that, and how to structure care and think about sexualized care in a way that's sensitive to their unique needs. Let's see, there we go.

So that's the overview I just went through, so I won't go back through it. And in terms of conflict of interest, I don't have much to report. I do want to stress, of course, that the views I'm expressing are mine and don't necessarily reflect those of my employers.

All right, so what I'm going to do here is I'm going to -- 30 minutes is a short amount of time to kind of get a lot of information across, and so the way I'm approaching this is I'm going to hope to sample some of what we know or some of the ways we think from different lenses, and then maybe tie it off with a magical bow at the end. So, first, just talking about the numbers, what do we see in terms of just, you know, some of the epidemiologic approach of what our women veterans look like?

So Dr. Ritchie mentioned that women in the military are now 15% of active duty, and we know both in terms of their involvement, women's involvement in the military, men, of course, the presence in the veteran population, there's been tremendous growth over recent years. Currently, women comprise about 10% of our overall veteran population. The projection is over the next 30 years or so that we'll see about 60% increase, and we'll have women at 16% of our veteran population. So point there is women are a clear gender minority but a growing, one and changing in some ways, that we'll talk about.

Yeah, I've been looking sort of a little bit about the chat box here, and so I can kind of see people reading and chiming in and saying where they're from. I know we have military, we have VA, we have community providers, so kind of a wide audience here. My numbers that I'm going to show you are specific to the Veterans Health Administration, because I have those numbers. These are regularly reported off of our administrative data. So, again, the point here is just to show you trends, and there's not a quiz on these numbers at the end.

So we've seen within the VA system, just this huge growth in the number of women who are accessing VA care. That said, within the VA, of course, as in the military, women are very much the gender minority. About 7% of our current patient population are women. But when I talk about the growth over time of women using VA, this is a nice little visual. It looks from 2005 through, I guess the last fiscal year, so it's an obvious trend, so this overall, in terms of the number of women we're seeing in VA, within that eight-year timeframe, we've seen a 68% increase, which is pretty significant. But you can also, without even looking at the numbers, visually what you see is this can kind of -- kind of a clear linear increase over time, and the expectation would be that we're going to continue to see this.

Now, looking just at our more recent veterans, these who -- sorry, I'm getting a little note about my sound. Apparently I'm easier to hear now. So if we just look at the women who participated in our most recent conflicts in Iraq and Afghanistan, those in Operation Enduring Freedom, Iraqi Freedom, OIS, OND, there are some -- if you look at those numbers, there's some interesting trends that I just want to highlight. So, first of all, in terms of veterans accessing VA services, we have 62% of women, 60% of men. So one thing to point out is that in this case, it's not very much of a gender difference. We're seeing pretty similar use of VA services across genders. It's incredibly high rates, I mean, I think, unprecedented rates, you know, almost two-thirds of those eligible using service. Again, that's within this most recent generation of veterans. So that's, I just -- I don't know, that makes me raise my eyebrows.

Two, in terms of women and men seen in the VA, over half are receiving a diagnosis, a mental health diagnosis, so in terms of need, I just find that, again, sorted of an impressive number. I don't think it reflects the presence of mental illness necessarily in the community population, but thinking about strictly those entering VA services, that's huge.

The third thing is, in terms of the type of mental disorders we're seeing and that we're diagnosing in VA, again, a lot of similarities between men and women. We're seeing essentially a lot of adjustment reactions, PTSD, and depressive disorders. So that's my -- oh, my slides just disappeared, so. Oh, I'm back.

Okay, so the point of this slide -- or a point of this slide is just to remind all of us that, in many ways, men and women veterans are more alike than not. So I'm not trying to say that women are so unique that they are just, you know, completely -- that in every way they're different than men. That is certainly not true and not the perspective that I want to convey. So having said that, let's talk more about the ways that they may be different.

So I'm going to talk -- I'm just going to share some of what we know in the literature about gender differences, and then throw out some ideas about what those differences might be. The idea here is, again, to kind of guide clinical sexualization, treatment planning, just how we -- not just how we identify differences but how we maybe think about them, particularly, that would influence clinical care.

All right, so here are some things that we know. And this is -- I'm talking now across all veterans, not necessarily our more recent veterans. So in all veterans we know that women are more likely to have a mental health diagnosis. They have higher rates of depression and anxiety, and they have higher rates of both medical and mental health comorbidities; meaning multiple health issues and/or mental health and medical problems. So what those first three bullets kind of hint at, and it's a trend -- it's kind of a theme that comes up from time to time, is just there's some evidence that maybe women, in some cases at least, are clinically more complex than men, and that may have implications, of course, of the appropriate intensity of treatment, staging of treatment, collaboration of care across providers, et cetera. That's one trend that's kind of rising to the surface.

Okay, second point, we also see this in the general population, so, you know, these types of gender differences are evidenced in the community as well, which kind of begs the question, so do we really need to talk about gender differences between veterans or can we really just glean what we know from the literature, which is a larger literature in the general population and apply that to our veteran community? And the answer is, yes and no. So absolutely there's a lot that we know about men and women in general that we can use to inform care for veterans. But there are some distinctions, and so it would be, I think, misguided to just assume that men and women veterans are similar or, you know, are the same as their community counterparts.

Here is an example. When you look at PTSD rates in our veterans coming back from Iraq and Afghanistan, we see pretty similar rates between men and women. That is different, very different, than what we see in the general community, where we see two to three times more PTSD among women versus men. So just an example of how you can't always apply what we know about the general population to the veteran population.

You know, so hypothetically or just, you know, why do we think there may be differences? And, again, this is -- you know, if we think about why there are differences, this has implications about how we approach these issues clinically. So the one issue would be just -- oh, you know, I have a feeling -- I do, have an extra slide in here. So in terms of the way in which men and women veterans are expected to differ, in terms of the prevalence and expression of some mental health concerns or how they respond to treatment or engage in treatment, you can kind of chunk it up into two different flavors; potential biological, sex differences, and then social and cultural differences. And, of course, we can go down to a finer grain, but just for the purposes of this discussion, I'm going to just categorize it relatively broadly and give some examples of those.

So in terms of buy logical considerations, these are relatively obviously, and Dr. Ritchie touched upon some of these as well. There are known effects of sex-specific hormones, and transitions in hormones that occur over the lifespan of women that have mental health implications. Pregnancy, perimenopause, menopause, these are all times in a woman's life where we would anticipate hormonal changes and that we know that those hormonal changes can have an impact on mental health and wellbeing. So that's one kind of view on that. And then the even more obvious aspect is that, you know, women get pregnant, men don't, and not only are there, you know, hormonal changes around that, around a pregnancy to consider, what it means more specifically, from a clinical standpoint, is, to the extent that a clinician is working with a woman who is pregnant or is planning to get pregnant in a family planning kind of mode, there are some really -- in some cases, there are some really important decisions to be made about how to approach that women's treatment, particularly around psychiatric medication. So this is an opportunity for, I would call, you know, patient-centered, shared decision-making between a provider and a patient.

You know, on the one hand, we know that there are some potential adverse effects of medications on a woman and her baby. On the other hand, we also know that there are [indiscernible] consequences if a woman with a mental health disorder is not treated. So there is a delicate -- there's some nuances here, and certainly any prescriber working with a woman would need to be informed about these sorts of issues but also be well versed and comfortable helping a woman to kind of go through the pros and cons herself and make an informed decision. So, you know, reproductive mental health is pretty specific, obviously, to our women. All right. So, again, that's not the whole universe of biological differences but some key examples to think about.

Another direction, another way to think about things is social cultural differences, and what we know about those is or think we know about those, that may have an effect. So what we know in the general population, we know that social differences, there are difference, in general, in terms of social resources, socioeconomic status. And we know, again, in the general population that those differences do influence mental health and wellbeing and functioning.

Now, if we look at some of these sort of -- these issues in men and women, do we see some differences? We do. We know, for example, that women are more likely to be unmarried. Women veterans are more

likely to divorce and remain divorced, as compared to male veterans but also as to age-matched civilian women. So in terms of the availability of sort of social and socioeconomic resources, you know, this is kind of in broad strokes. In general, we see more areas in women's kind of socioeconomics, sociodemographics profiles that would suggest that they have fewer resources, and, again, there potentially are implications there, both in terms of manifestation of mental health but also in sort of avenues to take to -- maybe in treatment in and case management.

This kind of, you know, an indication of that, we looked -- there's been a study, at least one study, looking at men and women that veterans receiving care for PTSD in the VA. So same treatment environment, same diagnosis PTSD, but they report different some different experiences. Women veterans, on average, report viewer interpersonal and economic resources than their male counterparts. So, again, that's sort of some evidence to suggest that there really are some differences that, again, so maybe PTSD in one may not -- you know, it's not necessarily the same in terms of, particularly, the individual resources an individual brings to the treatment settings across gender.

So having said that -- and I'm kind of throwing out some ideas and some of what we know in the general population, we do not yet know the specific impact of these factors on the mental health of women veterans, so this, in some ways, conjecture, and I'm just using from what we can use and from what we know in the general population. But you would expect there to be some differences there.

Okay, another kind of take on this is women veterans, you know, they differ from their civilian counterparts, and also for male veterans in probably their experience of military service and being a veteran. So there's evidence -- particularly, you know, most of the research has been done in men, but there's evidence that unit support is protective against mental health issues. What we hear anecdotally is that women, as a general minority, may not experience the same level of kind of connection and support from they are unit. We don't have the research yet to really show what the impact of that is, but it's a consideration, and it may suggest, again, that in term of important protective factors that would be helpful, particularly in a military setting, women may have less than that, on average, than men.

And then it all kinds of carry forward to, then, after military separation in a post-deployment setting as the -- because women are the gender of minority, they may have more difficulty than men just connecting with other veterans in their community, having that sort of sense of a connection of, you know, an identity as a veteran in the community, because a lot of those communities are historically male. So, you know, again, you're just sort of looking at the sources of support that you assume would be protective and resources a woman could draw upon.

The public, unfortunately, doesn't always yet remember or recognize that women can be veterans, and so just in terms of also support recognition, you know, from the public, from our community, and the pride associated with that, women may receive less of that than men, and that's something we hear anecdotally, again.

And then finally -- Dr. Ritchie also touched upon this -- this is an area of ongoing research, but there's a question about because women's traditional gender role is to be the family caregiver and the nurturer, when they return home from a deployment or, you know, just kind of reintegrating into civilian setting, do they have the same experience in their own families that men do, or are they expected to step right back into that nurturing caregiving role? And perhaps they could use some nurturing and caregiving themselves. So we have anecdotal reasons to believe that women, because of their gender roles, maybe have a different experience within their own families, within their communities, within their community network of veterans that may influence the amount of support they have, and, again, there are some mental health potential implications there and a lot of research still being done in that area.

All right, so different lens, so can't do a -- you know, makes no sense to try to give you an encyclopedic review that all that we know from the research on gender differences, but I can give you some examples. So, first, I just -- you know, one interesting example is just the growth of the amount of research being done and published in women veterans and on mental health over time. So this is a chart, and I know I'm

supposed to try to give you the page number for those who may not be watching the slides, so I'm at slide number 70 at this point.

So if you just look, this is a chart looking, I think, from 1978 until 2011, and it's just exponential growth in the amount of research being conducted in this area, so huge interest, some tremendous panelists looking at this. And so it's heartening to know that we know so much more now than we did 20 years from now, and at this rate of growth, each coming year, it each year is just the knowledge-based changes and deepens.

And so with that in mind, I actually was lucky enough to be part of a recent systematic review. It was led by Dr. Jennifer Reynolds, who is a clinical psychologist and investigator with the VISN 6 [indiscernible]. So what we did there, there has been a series of systematic reviews done where [indiscernible] state of research, and there had actually been three previous. I mean, again, the literature is changing so quickly it made sense to kind of update this, and changing so quickly that our team decided to pick up where the other investigators had left off, and so we're doing just, you know, within the past several years, what's new, and how is that consistent with what we already know, how does it add, contribute new knowledge to the field, where do we think there may be gaps. So that was kind of the overriding purpose of the review.

And, you know, it was a review, so we went through a whole lot of findings, but I just want to point out some of them, because, you know, again, I think they're relevant to some of the issues that we're talking about, and these are empirical findings, things we know, or are beginning to know.

Functional impairment, so that's one area. So what we do know, and this is kind of the consistent finding and this is kind of evidence of some of the ideas we've been talking about around reintegration and how military service can affect family relationships for both genders the extent of an individual has post-deployment trauma system that is associated with relationship disruption. So just when you probably need all the resources you can get, you know, and it makes perfect clinical sense, it's not a surprise, but that is something that disrupts relationships, social, professional, you know, spousal, familial, et cetera.

What we -- for the most part, though, that research based in men, so what we don't yet know -- we don't have enough out there yet to look to see if there are gender differences in the way the relationships are disrupted, the extent to which they're disrupted. And so, you know, we hypothesize that some aspects, for example gender roles and women kind of roles as a caregiver, might actually make that transition more difficult. There's some great research going on, just a really well designed large-scale studies that are actually in progress that will be able to look at this issue, so you know, stay tuned. So this is a growing area.

And then also, this is something we talked about, but there is new evidence that if you look at veterans with PTSD, women veterans with PTSD look different than male veterans with PTSD in some ways. Specifically, women tend to report more health impairment and more interpersonal impairment, so, again, this idea that there may be some clinical nuances, and even some complexities that distinguish women in some cases from their male counterparts, you know, more health concerns and potentially fewer interpersonal resources, all of which have treatment implications and would suggest that women, they may have treatment needs, even with similar diagnosis of their male counterparts.

The second piece to think about are utilization of services and barriers, and this is something, you know, again, in the VA is something we think about quite a bit. So one thing, if we just look at the -- these are our most recent veterans, those are from a citing study, actually, that were conducted only on OIS/OAS veterans, given the timeframe, we had not gotten to Operation New Dawn at that point. But in characterizing those veterans and looking at women versus men, what you see -- and, again, it's just kind of schematics -- women are higher users of primary care and mental health, so, again this idea that there is a need there. It's lovely that they're accessing VA services, but potentially some indicators of complexity.

The other thing that's kind of interesting is that that group of veteran women are, on average, younger that than are men. So in addition to gender issues in that case, you also have age differences and potential generational differences to consider, so, you know, more complexity to sort of throw into the clinical picture.

And, you know, ongoing barriers, unfortunately, women tend to be less aware than their male counterparts about service eligibility, so they're eligibility for VA care or, you know, for care in general as a veteran. And there's these misconceptions that within the community, often, that women -- that VA only treats men. Absolutely not true; that VA only has expertise -- or not only just VA, but I think organizations that are kind of focusing on veteran populations that the expertise bears on men and that there's not expertise in women. Again, I think, you know, not true. But a barrier, there's, you know, a tremendous amount of public access, you know, on other kind of efforts to kind of get the word out, but, unfortunately, that's still perceptionally out there, but getting -- I think, improving, I should say.

All right,, so, I think I've got five minutes left. I'm on slide 73. How does that all of that influence our approach to clinical treatments? You know, how do you kind of pull that together in a way that's organized and makes sense? So let me start about sort of, you know, avoiding confusion. I hear -- there are several terms that I hear quite a bit that are related but different. So I just want to do some kind of clarification of terms so we can avoid confusion and make sure that we're all using the same lingo. And these are all perspectives and treatment approaches that have gender implications, but they're different.

So trauma sensitive care, trauma sensitive care is, by definition, care that addresses the effects of one's trauma history on current care. Gender sometimes shows up, so, for example, to the extent that a woman or a man has a history of sexual trauma, there's also a preference and sometimes a clinical, you know, clinically indicated that a single gender group would be more therapeutic than a mixed gender environment, though not always the case, and I think it's important to stress that; that there is, I think, on an individual patient level -- in different situations, it makes clinical sense to do women's only, but also mixed gender, there's some real value to that as well, and that's you know, kind of an opportunity, I think for patient-centered care and providers of patients kind of being clear with each other. So the point is, that has to do -- trauma sensitive is not only about women. It's kind of gender neutral, but gender can be a piece of it, to the extent is to develop a treatment approach that's sensitive to that history.

Gender specific, pretty simple; that is care that is specific to a gender. For example, only women experience postpartum depression, so when you're talking about services for women, there are no gender differences there. These are services that women may have that their male counterparts don't, and that goes both ways.

Okay, and then there's this idea of gender sensitive, and this has been a guiding principle that, you know, at least in the terms of the group I work with in women's mental health and mental health services in VA, gender sensitive is a broader term that I think encompasses but is kind of broader than these other ideas. So gender sensitive is informed by this understanding that there are gender differences with regard to mental health treatment needs and response, and it kind of assumes all of these ideas that we've been talk about so far; social, cultural, family realities, and how those influence the individual's presentation, needs, access, et cetera.

And so I bring that up because it is something that we had thought about a tremendous amount, and I thought really hard about, and so, briefly, this came up specifically for us, because in 2011 the women's section of Mental Health Services conducted a survey, and it was of every health-care system in the VA and there were a number of things we were looking at, including the availability of gender-sensitive health care. We contracted with investigators at the greater L.A. VA associated with the Women's Health Research Network, specifically Dr. Sabina Oishi and Becky Yano, to develop the survey. And what we all realized really quickly is that we needed to operationalize this idea in terms of something that's measurable and tangible, and that process involved a literature search, interviews with, I think, 15 different subject matter experts, a tremendous amount of collaborative thinking. And so it was no small task to think about how to apply this concept in a health-care setting.

So with that in mind, I offer you our -- kind of our conceptualization of what gender-sensitive care means and hope this can be sort of some guiding principles to the extent that one is thinking about how to develop -- how to tailor treatments in a way that would be sensitive to women's needs, and I would argue that probably for any minority population, these types of categories apply. So comprehensiveness, do you offer the full spectrum of care for each gender, or are there limited options for one? Choice; do you only have one -- you know, is there only one women's only, or are you offering choice, so that the patient and the provider have different options and they can tailor this to the individual woman's needs and treatment preferences?

Clearly, clinical competence, you need to make sure providers are well versed in women's unique treatment needs, and then I because this is a minority group, particularly in smaller settings and when we're talking about subgroups of women, there's some need for innovation and creativity, that on a local level there are different populations, different resources, and so just an understanding that you're going to maybe sometimes have to get a little creative in figuring out how to do this within a given setting.

So just, I think, I'm kind of at my time limit, but just to summarize key points, we have, you know, obviously this large rapid growing population of women's veterans, and an equally kind of and parallel growing area of evidence-based research about this. There are some known and some hypothesized differences and some kind of nuance differences between men and women veterans and how that manifests in their mental health, biological, sexual, -- excuse me, well, sex differences, social cultural differences, and, again, this kind of concept and categorizations with sort of structuring how we think about how to optimize care in a way that's sensitive to women's unique needs.

My final shout out, so particularly, I guess, for those who have access to the VA system, we have an e-mail distribution list that we use principally to get out the word about educational opportunities. If you're interested, please send me an e-mail and I'll get you in tough. We also sponsor a women's mental health monthly teleconference, and, at least for VA providers, the CEU credits are provided. And then finally, finally, we just launched an internal website, so it's a kind of one-stop shop, we hope resource when all things mental health related, so please visit if you can. And I think that that concludes. So I think probably I'm ready for questions.

All right, thank you so much for your presentation, Dr. Strauss. If you have questions for Dr. Strauss, please submit them now via the question pod located on the screen. We do have one question that has already come in. This question says, "I heard there is a call center specifically for women. Can you give more information on that," a VA call center?

And, in fact, if that individual e-mails me offline, Jennifer.Strauss@va.gov, I can provide a specific link to that. But there is a women's call center that's actually been stood up by women's health services, and it is this outreach actually, so there's outreach calls to women to make sure they understand their eligibility, but there's also an in-taking, of taking calls specifically from women, and then kind of helping them to connect with appropriate services. So it's a huge enterprise. And my guess is that if you just Google "VA Women's Health Hotline" it will come up, and I'm really happy to pass that information along directly.

Thank you so much. All right, so the next question is, "Where are the current military sexual trauma programs for women, and how does a person get access to those?"

So, first of all, just to clarify, the women's sexual -- actually, excuse me, the mental -- what am I saying. The MST, the Military Sexual Trauma program within VA are organized -- they're gender neutral, so each VA facility has a coordinator, an MST coordinator, and that individual works with both men and women who have experienced military sexual trauma. I hope individuals know that the VA offers free MST-related care to all veterans regardless of there otherwise eligibility for services, and so a way to get connected would be, you know, each home facility, you know, basically call the operator and ask to speak to the MST coordinator, and that individual's role is to kind of help the individual get connected with services.

Great. Thank you so much. All right, so the next question just wants you to, if you could please comment on the increase in homelessness among female vets and their families, especially given the VA effort to

end homelessness among veterans. I know you mentioned some of this in your presentation, but I don't know if you want to expound on it a little bit more.

I mentioned homelessness in my presentation. That we've actually, because it's a priority, it's actually a priority, ending homelessness is a priority set forward by the President, of all people, meaning, you know, high priority. My understanding is that we're actually seeing a decrease, so I, in fact, would need more information about -- kind of compare sources, but my understanding is that we're seeing a decrease, and, in fact, you know, that's another area, though, where women have some unique needs; for example, they are more likely than men to be homeless and have children, and that is a different housing situation. And there is, then, a tremendous effort with the community of making sure that women are housed who are homeless in facilities where they feel safe but also children can be present. So I'd need a little more information about the specific context. But, again, offline, happy to e-mail and to compare.

All right, no, thank you, that was a great job. The next one asks, "Do you have suggestions for topics that may be addressed in a female veteran anger management group, or can you speak to any experience with anger and female veterans?"

I have witnessed anger in female veterans, as I have witnessed it in male veterans. So that's an interesting question. So at least at my home facility, which is Durham, we have offered anger management, particularly in the [indiscernible] clinics, and there are, you know, kind of mixed-group gender -- mixed gender groups, of course, predominantly male. One, there are other approaches that are more skills based that have a greater evidence base in women and that often are sort of -- that are other alternatives.

Examples would be intervention called STAIR, Skills Training in Affective Interpersonal Management, which is an intervention that was actually developed for women who have experienced sexual trauma, and sort of a part of this is anger emotion and regulation issues around that, dialectical behavior therapy skills group, that's another -- these are not necessarily nationally available, but we happen to know that, you know, locally, particularly in facilities that have, you know, a women's health clinic, that we've sometimes seen that approach.

So, but in terms of topics, I don't know how the topics necessarily differ, but I think some sometimes some of the -- but I would broaden -- I would consider broadening the focus not just on anger management but on emotion regulation and expression in general.

Thank you so much. The next question asks, "How many referrals are made between the vets center in the VA for female service veterans, and how effective is that overlap a at this point?"

I don't know. I don't have that data.

All right, well we'll go ahead and end the question-and-answer session. Thank you again so much for your presentation. I want to again thank Dr. Ritchie as well for your presentation. After the webinar, please visit continuingeducation.dcri.duke.edu to complete the online CE post-test and evaluation, and then download your CE certificate of attendance.

We will archive today's presentation in the monthly webinar section of the DCoE website. To help improve future webinars, we encourage you to complete the CE vet tool that is opened on a separate browser on your computer. To assess the presentation and resource list for the webinar, visit the DCoE at dcoe.mil/webinars. We will post a downloadable audio podcast and edited transcript of the closed caption text to that link a week after the event. The chat function will remain open for an additional ten minutes at the conclusion of the webinar for attendees to network and chat.

Also, please be sure to save the date for the next DCoE TBI webinar on November 13th, from 1:00 to 2:30 Eastern Time, entitled "Technology Interventions for TBI." And then also, save the date for the next DCoE psychological health webinar on November 20th from 1:00 to 2:30 Eastern Time, entitled "Technology Intervention for Psychological Health."

Thank you again for attending. Have a great day.

That concludes today's conference. Thank you for participating. Please disconnect your lines at this time. Thank you.