Recognizing and Addressing Gender-Based Violence in the Veteran Community

INTRO

Welcome to the National Veterans' Training Institute podcast series, where we discuss pressing issues affecting today's veterans.

Host

Welcome to today's NVTI podcast, Recognizing and Addressing Gender-based Violence in the Veteran Community. I'm your host, Hannah. Just a note for our listeners before we begin. This podcast contains discussions on sensitive topics that may be difficult for some listeners. If you or someone you know is experiencing gender-based violence, please see the resource guide for helplines and other support services. Now let's jump into our podcast. We have a wonderful panel with us today and to begin, I'd like each of you to just take a moment to introduce yourselves. Tell us where you're from and a little about your role. LeAnn, if you jump in first, I'd appreciate it.

LeAnn

Hey, thank you so much for having us today. I'm Dr. LeAnn Bruce. I'm the National Program Manager for the VA's Intimate Partner Violence Assistance Program, or what we might refer to as IPVAP. Which falls under Care Management and Social Work Services at VA Central Office. This program was initiated about 10 years ago to implement a comprehensive programming across the VA healthcare system to promote safe, healthy relationships for veterans, their partners, and VA staff.

Jenny

Thanks for including me in this conversation. Hannah. My name is Jenny Knetig. I am a clinical psychologist by training, and I am the National Program Manager over two pilots at present. One is called the Megabus 5304, and that basically is a pilot that care management social work services conducted in the VA to look at, Is it feasible? Is it advisable to serve veterans who've experienced sexual assault, and in our work, we've focused on veterans in historically marginalized communities.

The other pilot I'm working on right now for VA is an anti-human trafficking pilot, and we're looking at kind of similar issues in in that pilot as well.

Kate

Hello. I'm Kate Iverson and very pleased to be here. I am a clinical psychologist and health services researcher at the National Center for PTSD at the VA Boston Healthcare System. And I started doing research and clinical work on gender-based violence, in particular, intimate partner violence just over 20 years ago now, so really important topic.

Tovah

Thank you for having me. My name is Tovah Kasdin. I'm an attorney by training, and currently, I'm a public health advisor at the Substance Abuse and Mental Health Services Administration, SAMHSA, where I focus on gender-based violence and human trafficking. Good to be with you.

Host

Well, thank you all so much for joining us today for this really critical discussion. And before we get started, I think it's important that we discuss and really set a baseline around what gender-based violence is. According to the 2023 U.S. National Plan to End Gender-Based Violence, gender-based violence, or GBV, encompasses various forms of interpersonal violence experienced throughout an individual's life. This includes sexual violence, violence from intimate partners, stalking, and other related forms of violence and coercive behaviors. Would you all like to add anything or potentially some more context to that definition?

Tovah

Thanks, Hannah. Sure, I'm happy to do so. I think it's important to recognize that there are many forms of gender-based violence and some forms of gender-based violence occur within a relationship, an intimate partner relationship.

And that can be consisting of co-occurring forms of abuse like you mentioned, physical abuse, sexual abuse, psychological abuse, technological abuse. There's many ways in which a perpetrator can put violence onto another person, but it's also important to recognize that gender-based violence can also be a one-time incident, so it could be a one-time sexual assault, physical assault.

So both the one-time, as well as the pattern abuse makes this quite a complex issue and what we know is that a person can experience gender-based violence throughout their lifetime. It doesn't just happen at one point in time. So there aren't certain groups of people that experience it and then they're safe and don't experience it later in life. So it's important when we want to be inclusive of survivors that we're talking about abuse across the life course.

In terms of national data, it is quite pervasive. What we know about intimate partner violence from the National Intimate Partner and Sexual Violence Survey (NISVS) is that about 41% of women and 26% of men reported having experienced at some point in their lifetimes, contact sexual violence, physical violence and or stalking by an intimate partner. So those numbers are incredibly high and important to note too, that not everyone experiences violence in the same way, and there's disproportionate impacts on those who are from marginalized communities, whether that is marginalization based on gender, race, or other factors like ethnicity, immigration status, religion, disability, or socioeconomic status. So we know that those who are often at the margins are not seen and heard in this conversation. So we want to do everything we can to amplify and include all survivors when we're talking about gender-based violence.

LeAnn

Those are great, points, Tovah. And it really it really speaks to the prevalence of this in our society of this kind of violence. We know that it is a widespread problem across, like you said, all populations with some populations certainly being potentially more at risk. And something that we definitely need to be addressing and

be aware of. To that just to mention, it's also really important to avoid biases and assumptions and stereotypes.

With several of us here that work in the Veterans Administration working predominantly with male population, although in our case we have to remember, you know, we have a lot of veterans and military who are females as well. But it is so important to be inclusive and to not bring our biases and stereotypes to the table when thinking about gender-based violence, because it is important to note that that males or those who identify as male also experienced intimate partner violence, and this is sometimes thought of as a female issue, although we also know that the risks can look very different. But it's just really important, I think, to to mention when we're talking about the subject that it's important to check your biases and to be very inclusive in how we're thinking about these issues.

Host

Those are really, really important points. Thank you all so much for taking the time to provide a little bit more context to this discussion. And now that we have a more clear definition of what gender-based violence is and understand that it is rather pervasive, unfortunately, and really, it has no biases, as well, let's talk about some ways that people are impacted by gender-based violence, and in particular, how does gender-based violence uniquely impact veterans?

LeAnn

One thing I think that is important to think about is veterans do make up the general population as well, so we know that interpersonal violence, as we already mentioned, is very prevalent in society. But the thing about interpersonal violence, I think that makes it different in some ways to random violence that someone might experience, and things, is that when it is interpersonal, you feel a deeply personal connection. It is, it is prone to damage the person at the very core of the individual's sense of self, their security, and safety in this world. So, they're taking it very personally because they're being targeted very personally. Then when you add the layer of potentially

that they're being targeted for this violence based on their gender, something that they would, you know, how they were born into this world, or they feel like they can't change or because of something inherent to who they are, that just adds insult to injury. That's another layer of harm that can be done to the person magnifying this potential for long-term harm to their self-worth, their core of their being.

So interpersonal violence that has the gender component to that is certainly regarded as a public health problem and of course leading to the Plan to End Gender-Based Violence and when applying it to the veteran population, you just add more layers, basically, you've got the interpersonal violence, you've got that there's a gender component that's attacking the person at the core of who they are. Many veterans actually come into the VA having had, like you said, there are, are sometimes, Tovah, you mentioned that can go across a lifetime of violence and traumatic experiences from childhood. Maybe high levels of ACES scores, witnessing violence, experiencing violence. Sometimes they go into the military to escape that and maybe have layers of more violence that they've witnessed or taken part in in combat and trauma, maybe experienced military sexual violence as a part in their service, other forms of interpersonal violence during that time, so it can be layers upon layers for veterans and in some cases they can be exposed to violence and trauma that the general population might not be exposed to, so they have some higher risks.

And I know that some of my counterparts here will talk about some of the pockets of underserved populations that you know, even within our constituency, that even have higher risk than that. But again, it's just really important that in in the work we do in the VA and the military, it is highly identified as male and it's just really important to keep that, keep it in mind and again to be inclusive, to know that some populations, such as the LGBTQ population, gay men, those who are identifying as men and those identifying as women. It goes across the board that they can be stigmatized and they can be a victim. And they can be a victim just for reaching out for to help for help, which can be significant barriers. I think in some cases, military and and

maybe not as much, but still relevant in the veteran services it's not something people want to reach out and say, "Hey, this is happening to me," which is a major barrier to getting care.

Jenny

I appreciate those comments, LeAnn. You've touched on a lot of important points, and I think for me, when I go back to your question, Hannah, "How are people impacted by gender-based violence?" There's not one response to that question as I think most on the call would understand and appreciate, we're all different, our experiences are different. Those factors that Dr. Bruce just mentioned, some of them elements of our identity, our gender, our sexual orientation, our ethnicity, our racial background, our where we live in the world, are we in a rural area? Are we in an urban area? Are we veterans, are we not? All of these things can really impact, can kind of add to the experience and make it very unique. So, when I think about how we serve veterans impacted by gender-based violence, we're striving to be person centered. We're striving to really understand their experiences as best we can. Never perfectly, always striving and really striving to understand, you know, what is the impact for them. It can be global. Not only can it have a psychological impact, disrupting their psychological health and sense of well-being, it can have a physical impact.

We know the mind, body connection and the body shows trauma in sometimes unpredictable ways. We also know that it can impact other social drivers of health, like housing insecurity. If one has experienced gender-based violence that can have an impact on their finances. People are less likely to make it to work on time. They're more likely to lose their jobs if they've experienced gender-based violence. So, there's an economic impact for many people, so it can be quite disruptive. And I would say when I think about a big take home message for me as a clinician, in my experience with working with veterans, is the social impact. We know that connecting with people who are safe and who love you and are trying to help you can be like the most powerful thing in recovery and gender-based violence can often undermine

that, as Dr. Bruce mentioned, really disrupting one's sense of trust and safety in the world. So, I could go on, but I will just add briefly on your second question, which is "How does it impact veterans?" Again, quite uniquely depending on the person and their identities, their experiences. But I think I would just add that for those veterans who Dr. Bruce mentioned, who may have experienced trauma while serving in the military or prior to their military service, that experience may make it harder for them to engage with us at VA or at other in other systems who are specializing in serving veterans. So, I think that clinicians really being mindful of that can help us in in engaging people in care that that they need or and want. Thanks.

Tovah

I really appreciate all of the panelists bringing up the important intersectional impacts of gender-based violence and how it can affect your mind and body. What we focus on at SAMHSA is the intersection of gender-based violence in behavioral health and at SAMHSA when we talk about behavioral health, we're talking both about mental health and substance use, and there's many ways in which those all intersect for someone who is experiencing or recovering from gender-based violence. So, for example, a survivor of gender-based violence may turn to substances in order to numb the pain and trauma that they're experiencing because they've had to endure violence from either an intimate partner or another form of gender-based violence or human trafficking. What we know, too, is that oftentimes, perpetrators will force survivors to use substances as a way to control them, as a way to impact their ability to leave the relationship, and so that form of power and control is very harmful to survivors of gender-based violence.

So at SAMHSA, we're very focused and have been building capacity in advancing the National Plan on Gender-Based Violence to strengthen our assets to address this intersectional area of gender-based violence, human trafficking, and how we can focus on vulnerable populations, especially those who are marginalized, which other panelists have described: survivors who are part of the LGBTQ+ community, racial and ethnic minorities, religious minorities. It becomes that much more

difficult often times to reach out for trauma-informed and culturally competent and humble services, so we always want to make sure that there's no wrong door, and especially for the behavioral health that we're asking and screening appropriately because someone may be using substances or experiencing a decline in mental health because they are in fact survivors of gender-based violence, either now or in their past.

Host

Thank you all so much for your attention to detail and in answering those questions. That was all so important. Now, based on the conversation that we're having and everything you've shared, I think we can all see that it's likely that a veteran service provider will at some point work with a veteran who has experienced gender-based violence. What are some signs that they might be aware of that could help them recognize that a client has been impacted by gender-based violence?

Jenny

I appreciate that question, Hannah. I think certainly there are a number of signs. Some of the things I as I'm pondering that I'd really like to highlight would be some of the behavioral signs. So, when clinicians are working with clients, we always, I think, strive to approach any interaction from a trauma-informed stance.

And thinking about, so just making the assumption on the front end, this person may have experienced some trauma. What might that look like behaviorally? I think clients who may struggle to attend appointments. They chronically miss. They may struggle to be there on time. They may struggle with following through on, you know, your recommendations, your homework assignment. They may be difficult to engage with for any number of reasons. They may be unlikely to be open in discussing their history, shut down. They may appear, I think some people would even like label folks as disruptive or overly aggressive, and when I think about those things, when I think about somebody who comes in and doesn't want to talk and is appearing angry and mistrustful of me and my services or the system, I go ahead and think

about what are the things that led to this place. I think about what are these other what what's going on underneath, and we definitely should consider trauma as an option. It's not always the case, for sure, but when I think about just your question of what, what might be some indicators, so these people, again, this is a generalization, this is does not apply to everyone, may really struggle to engage with mental health.

And as mentioned before, some people who've been historically underserved are going to have potentially additional struggles with that. So as clinicians, we're thinking about, for me anyway, I strive to think about, “What does safety look like for this person? What do I need to do to try to help create some safety here?” and then once that's established, at least at some like minimal level, then I can get into assessment and look at what are, you know, how has this impacted their physical self, their psychological self, their social self? And I'm going to turn it over to my other colleagues because I know they have a lot of wisdom to share as well. Thanks.

Kate

Dr. Knetig did a beautiful job sharing some very relevant and clinically rich examples of both clinical signs that someone may have experienced gender-based violence as well as the array of sequela we may see amongst people who've had these experiences. Which again, remember those numbers Tovah shared with us at the beginning of this podcast, 41% of women, for example, had experienced violent sexual assault or stalking by an intimate partner. We know that these rates tend to be higher in veterans, both for experiences with sexual violence and intimate partner violence, and our research very clearly shows the incredible strengths and resiliency that veterans demonstrate, including in the face of various types of physical, sexual, and psychological trauma.

So, our approaches when working with veteran clients should really highlight these strengths while also validating, assessing, and treating the significant effects of these forms of violence on people's health and well-being, certainly

something that's always something we're striving to do in the VA. Now much of my work has focused specifically on women veterans, and we have a number of studies that very clearly show the large impacts of gender-based violence and that the effects can be cumulative over time and that interpersonal violence before, during, and after military service can all impact current mental health needs. For example, women who've experienced past year intimate partner violence are two to three times more likely to have a diagnosis of depression and/or PTSD than those who have not experienced intimate partner violence in the last year, and that's even after controlling for accounting for other experiences of trauma, such as military sexual trauma.

That said, we also know that gender-based violence, including intimate partner violence, sexual trauma, and other experiences, are not a mental health diagnosis. Yet they often impact mental health, and so to be able to help folks make these connections, and when appropriate, treat the mental health symptoms, is very powerful and cannot actually increase people's safety and interpersonal relationships over time.

Tovah

It's important to know that there are many impacts on behavioral health, ranging from stress to serious mental illness and substance use disorders that can co-occur when someone experienced gender-based violence. And it's not just that someone needs a diagnosis. There are so many survivors of gender-based violence and human trafficking who live with the daily stress, anxiety, depression, any number of negative mental health and substance use outcomes because of the violence and trauma they experienced, and even if it doesn't rise to the level of a serious mental illness that is diagnosable as bipolar or schizophrenia, something like that, it's still impactful on the individual.

And so, we have to remind ourselves that anyone who's experienced gender-based violence may have a different response than the next person and a different mental health or behavioral health journey because of it. And so,

when we're serving and supporting survivors of violence, we want to ensure that we're mindful that no two people experience the same type of impact and that we want to individually tailor services and responses to meet the goals of that survivor.

LeAnn

Those are really great points, and I would love to, just for a moment, take us back to the original question about veteran service providers, those who are serving veterans, you know, being aware of some of these issues. I'd just like to make another point that we never know, you may not have to be a veteran service provider specifically serving veterans in particular system. It's really important to note that veterans are everywhere. Their family members are everywhere, wherever you may be in serving families of any kind, it's really important to identify if you are serving a veteran so you can think about some of the things that might be specific risk factors or just even treatment factors for veterans themselves because they are everywhere in our communities and could present themselves in, you know, in any capacity or certainly their family members could as well. So, I think all of these are very relevant to any service provider population. And it's so important, as we've all already mentioned, that you can't really tell when somebody's walking through the door that "Oh, that person might be experiencing gender-based violence or intimate partner violence." It happens to, you know, every spectrum of society.

So, we believe that both combination of screening and universal education is what is really vital to be able to open up the conversation. And so, we do promote that universal education, meaning that everyone who comes through the door is offered information about these issues. Whether that's a brochure or wallet card or screening or a poster or something on the on the TV, scrolling, whatever it might be, a variety of resources to ensure that we get information in everyone's hands that this is an issue. Let them assess does this affect you? Here's what you can do about it. And that hey, we understand, and you can talk to us about it. So that's the universal education piece that doesn't rely on screening. It doesn't rely on a disclosure. It's

there for everybody and we know that even with screening so that we might ask people over and over again if this applies to them and they're going to tell us no because of the guilt and the shame and the barriers and all the things that sometimes inherently come with this. We know that maybe they don't want to tell us about it, but they will take that brochure and call a hotline number or get some local care that they need. So that is just paramount.

But screening is also important to open the conversation from a very early intervention prevention standpoint and a risk mitigation standpoint to initiate screening in a regular, routine way to identify if some of these traumatic interpersonal violence situations, if someone has experienced those, and in our case in the VA we also are listening for if someone is potentially using some of these behaviors in their relationships because we do have some services for that as well to try to mitigate that risk and help people learn more effective and more safe behaviors and relationships.

Host

Thank you so much. LeAnn, I'd love to hear a little more about VA screening protocol. Would you just tell us a little bit more about that.

LeAnn

Absolutely. I would love to. We're very proud of our screening protocol. We do are very committed to it and that it does open the door to building trust, opening that conversation, providing that education and identifying risk and offering intervention. And there's multiple screenings in the VA system. There's the military sexual trauma, our veterans, as they come through the door, they will be screened for a variety of things, but I'll talk specifically about our screening, which is the Intimate Partner Violence Program. We call it the Relationship, Health and Screening Safety Screen. At this time, it is mandatory for all women of childbearing age, which we've defined as under 48 years old, and that's consistent with the United States Preventative Services Task Force recommendations. We highly recommend that all veterans be

screened. As we mentioned, you can't really tell that somebody coming through the door isn't having these issues. And we also recognize that there again there is a number of other groups that are highly vulnerable for these issues and for these risks, but we have a very ingrained program that is trauma-informed. We make sure that we are really careful about the language we use. We train staff to be able to do the screening. Any staff can actually do the screening that's in the in the in the medical chain of the veteran. So, it's just a little training.

We use our primary screen. It really uses Dr. Kevin Sherrin's HITS screen, which is validated and so we start there and that gives us some really rich information to be able to look at potentially the kind of violence that's being experienced and to what extent with severity. So, it's on a Likert scale and if that is positive, then a secondary screen comes up that asks some questions that help the clinician or the screener determine if that person is at higher risk, you know or not. So, we really get some very rich information from the screen and what is what that can lead to is the ability to either provide education, provide resources, provide consults for further assessment, or provide consults for actual interventions that we have available. We have an Intimate Partner Violence Coordinator at every VA Medical Center, so they're there for consultation for complex cases or to help find resources potentially in the community.

Let's say we're working with a veteran's partner who's disclosing having some issues, to work with them to get them established with resources, and so the screening is just the tip of the iceberg.

Host

Wow, it really is. Thank you for taking the time to explain that to us a little bit more. I think that's really valuable. Now it's essential and we're hearing that as we discussed today, that veteran service providers come prepared with the right intentions and a deep understanding of their own emotions and biases. NVTI, the National Veterans' Training Institute does have a course 9650: Unconscious Bias,

Diversity, Equity, Inclusion and Accessibility in Veteran Services. It could be a great resource to our listeners if you would like to take that, but with this in mind, how can veteran service providers start conversations with veterans about gender-based violence in ways that are both respectful and effective? And how can we ensure that these critical discussions are held in safe and supportive environments?

Kate

I think that the training Dr. Bruce touched on is really critical to help people feel prepared and increase their confidence in opening up a conversation about experiences with gender-based violence. Whether this is through a routine screening protocol like they have in the VA versus another approach, such as various open-ended questions or clinical interviews. There are some important things to keep in mind to help veterans feel safe while you are asking about gender-based violence and while you are responding. We know from focus groups and interviews with veterans that they really want options in terms of disclosure and potential services. So, this includes deciding when to disclose, to whom to disclose, and how much to disclose, and also of what of that information they want documented in their medical records with respect to their personal safety and privacy. So, in terms of these options, some veterans, like others in the community, take a while to feel comfortable opening up about this sometimes very difficult experience.

So, this really speaks to the importance of, you know, not thinking about screening or inquiry in a “one and done” manner, but really it's something that's done again over time. And through doing things like Dr. Bruce was talking about, providing universal education about gender-based violence and normalizing discussions around this can help destigmatize these experiences and the health effects that so often come with them. And also, we want to be respectful of people's autonomy in terms of their readiness or their safety to disclose. Their readiness to learn about or follow up on service options that might include things like community services or specific mental health treatments. And we also know that veterans want

options to learn about gender-based violence experiences, the effects and resources on their own, without necessarily needing to disclose to a provider. So having things like websites and promotional materials that will allow veterans to go learn more in the safety and comfort of somewhere that's safe for them to learn more about gender-based violence can be very empowering.

Jenny

Dr. Iverson, I really love what you're saying. I mean, so many of your comments just now really highlight principles of trauma-informed care. So, we think about clinicians, what are we trying to do when we're working with veterans or anybody who's experienced gender-based violence. We're striving to build safety, as we've talked already today, emotional safety, psychological safety, physical safety. We're striving to be trustworthy and transparent. What might that look like?

I think being open about, like, to Dr. Bruce's comments earlier about screening, about why we screen, about what the screening might look like. Principles of collaboration and mutuality. I am not here as someone who is going to do a screen. We're going to work together, if you've given me permission to do so, to talk about your relationship health and safety. As Dr. Iverson mentioned, we're asking permission to talk about these things. We're asking permission to write a note. And we're really, as she mentioned, we're focusing on strengths. We're thinking about how the veteran's cultural experiences, historical, religious framework, gender identity, how that all impacts where they are in the moment, how their trauma or traumas have affected them, and how they may or may not want to engage with me. And we're always thinking about, again, the person there that we're with in the room, virtual room or otherwise.
What does recovery look like to them? And I think your original question was, you know, how can we start conversations that are respectful and effective? And you mentioned about intentions, bringing the right intentions.

And for me, the right intention in this work, when I'm serving veterans who've experienced gender-based violence, is my intention is to try to be a safe person you want to be with and you want to talk to. My intention is not I'm trying to change your situation, I'm trying to get the violence to stop, I'm trying to get you out of there. I will be your co-collaborator in getting your life in a place where you want it to be or building health and safety for yourself, but my intention is not to change your situation. And I think when we remember that, it can help to promote a sense of respect. And as Dr. Iverson referenced, it just works better. Thanks.

Tovah

And I appreciate all of the resources that the VA provides. They're so exceptional and so important that veterans feel supported in that way. When working with survivors of gender-based violence in terms of veterans as well as non-veterans, every person has a different timetable and a different way in which they feel safe to access services that are best tailored to their needs.

And for some people, that may be services within the VA, and for others, they may feel more comfortable accessing community-based resources. Let's say, for example, from a domestic violence shelter in the community or a program in the community or a sexual assault community program. There's also many national resources that will be provided at the end of this podcast, like the National Domestic Violence Hotline, which provides wraparound referral services 24-7, both in terms of phone calls, chat services, that are able to help survivors linkage to resources anywhere in the United States.
SAMHSA also has behavioral health support 24-7 with the 988 Suicide Helpline. And so really important to know that every person will feel safe accessing resources at a different time and a different place and in a different way, and that's okay. As long as they know that the resources are there when they're ready, that's most important.

LeAnn

These are all such great points, and I feel like I would just be repeating, but just quickly, thinking about that there is often a stigma already discussed and sometimes attached, and it can be a barrier. All of these suggestions that you all have made really help to break down that barrier, to build that relationship of trust, and just how imperative it is to, again, check your biases. I know we all work on that so much, and probably all of our agencies have trainings and discussions about this.

It is something I think the greatest achievement is that it's out in the open. We're talking about it. We can help each other. I learn something every single day, I think, in just conversations with our team about, “Oh, wow, that's an old stereotype that's still in my head,” and just the way we approach things so that in building that sense of trust, that environment of safety, because obviously we know that someone who's had layers upon layers of trauma is going to be very skittish about coming in and opening up to this level with anyone. So just being aware of those things.

I think it's wonderful that you mentioned the NVTI course on unconscious bias. That is just so enlightening. And if you're in the VA system, we have some internal VA products as well for our staff. More to come as we get more and more into supporting initiatives to end gender-based violence.
So, I just think it's a good thing that we're continuing to have this discussion.

Host
Completely agree. I was just going to say what a fantastic discussion this is already. And I do want to make a point just to let all of our listeners know, you've already heard a plethora of fantastic resources.

And there is a resource guide that goes along with this podcast. So in the same location you've accessed the podcast, you should also be able to access a PDF resource guide with all of these resources in it. So you don't need to panic and write them down or anything like that. You've got it all right there for you.

So once a client, and we've gotten into this a little bit, but I want to delve in some more. Once a client shares that they have experienced gender-based violence, what are some best practices for the next steps for that veteran service provider who they've disclosed to?

Kate

I'm looking forward to hearing from all of the members on this question, because it's so important that we're all aware of best clinical practices for asking about and responding to and addressing gender-based violence. And I'd like to specifically focus on disclosure in response to screening or direct inquiry, in which there needs to be a notable and compassionate clinical response. Sometimes, unfortunately, veterans may have had a bad experience with disclosure in the military, including have their experiences minimized, ignoring them, questioning their validity, or they may have even been punished in some way, maybe moved to another unit because they've disclosed sexual assault during military service.

Or perhaps they've disclosed to a healthcare provider or other person in their life and experienced minimization or even messages of blame, such as, “Oh, it's not that bad.” We don't have a clear and compassionate clinical response. Those are the types of messages and impacts we can have on intentional consequences there.

So, we hope you'll feel more comfortable asking about gender-based violence and responding. We just want to make sure, especially if you're using some kind of questionnaires or screeners that folks may fill out online or before they see you, that it's just really critical you're tracking those responses and following up on any endorsement. I've heard from my clients and been affected by others in my own life who've experienced inadequate or harmful responses, and I'll never forget what a woman veteran shared in our research.

She said, quote, “You can't make a person answer, but if they tell you and you don't follow up, then in the back of their mind they're saying, well, I told them, and they don't seem to care. I guess it's just like he says, I deserve it.”
In other words, when there isn't a notable and compassionate response, it can lead to harm and self-blame in this case, reinforcing beliefs that maybe she deserved it, the abuse. And although this quote I shared comes from a woman, I want to be clear. Having experiences minimized is not specific to those who identify as women.
This often happens to people of other gender identities and can be just as harmful. And we know from studies and anecdotal evidence and certainly what I've seen in my own practice is that clients don't really expect providers to have the perfect silver bullet response, but what matters most is empathy, validation, showing genuine concern, and offering information, education, and options. So in other words, coming back to this topic and theme of inquiring and responding from a trauma-informed care perspective.

Jenny
That's just such rich guidance, Dr. Iverson, and there's not a lot that I have to add. You've covered it. I think the one thing that comes to my mind when I think about, okay, so a patient, a client, a veteran has disclosed to you they've experienced gender-based violence.

Okay, what's next? So do everything Dr. Iverson just described and don't panic, which can be challenging. I think some clinicians, especially those who might be new to the work, may notice understandably their own anxiety. As Dr. Iverson mentioned, many people in health care have their own lived experiences or have family or friends with lived experiences, and that may be what brings us to this work. It can be a real strength for clinicians, and it can also be challenging if you have strong reactions to disclosure, and it would be understandable to have strong reactions to disclosure when you're working with someone who's been assaulted, who's been trafficked, and just pay attention to it. Pay attention to your own responses. Strive to not panic. Most of the disclosures are not emergencies. They are all important and

need following up, as Dr. Iverson mentioned. But striving to stay mindful and balanced and present, I think, is what I would recommend.

Tovah

And that's such a good point. I think when we think about the best outcomes for survivors and providing the best resources, it really begins with the relationships that are built in communities and across systems. So, for example, between the VA and community-based programs.

And that is the way that we ensure that providers don't have to be expert in everything, but that they know where to refer the survivor upon disclosure. So, for example, safety planning. Not everyone knows how to do that, and that's okay, but if a survivor discloses and needs assistance to stay safe, at least that provider should know where in the community and have a relationship to refer that person to.
So having those relationships ahead of time really take some of the stress out of ensuring that survivors in a timely way are referred to services that they need. So, in terms of what we do at SAMHSA, we know that there is a strong intersection between gender-based violence and behavioral health services. And so mental health providers, substance use disorder providers, domestic violence and sexual violence service providers, they all need to know from one another how to refer and to not exist in silos.

And when that is achieved, that's when you have the best results. So, I suggest cross-collaborations, cross-training. Maybe have, you know, brown bag lunches either virtually or in person where you get to know program staff.

And that will definitely be just an important relationship to be able to help in a holistic way survivors who want to have, you know, different needs met. And they're not expecting that one provider knows everything or has every service, but at least the knowledge to know where to refer.

LeAnn

These are, again, all such great points as far as responding to disclosures. The variety of stories that can be behind that disclosure, it's so important to have kind of all of these different things in your mind. Certainly, as you just mentioned, Tovah, you know, assessing for safety and having staff that feel that they are skilled and trained to engage in safety planning discussions is so important.

It's really, you know, first case scenario is making sure that that person is safe to leave your office. And in some cases, as I mentioned earlier, we have many paraprofessional staff who are screening. But there's a plan in place that if there's a positive disclosure, they do know what to do.

That's what the training is all about, to make sure they're confident in knowing if there's a positive disclosure, this is how I react to it. And this is how I can hand off to maybe a more advanced trained provider to do the safety planning and so forth. So always, you know, creating a system that everybody feels confident and competent in the role that they are playing.

And then that breeds confidence, hopefully, in the person that is disclosing. And so that is really important. And there's a variety of ways, even on our public-facing website, there's some safety planning material.

We often refer people to the myPlan app as well, which is a great safety planning tool that people can use individually just to throw that in there. It is wonderful to use and make sure that people are safe. Following that, I also agree with everyone that has mentioned that it is so important in how a person addresses that, to build that confidence and that trust and that empathy.

And it is really important to note that from a trauma-informed perspective, with it being so prevalent in society, so many of our staff who may be engaging in this work are living through it themselves or have lived through it themselves or a

family member. And sometimes that can color how they respond or how they think about things. So, knowing that we need to provide services or support, consultation and so forth is so important.

And then just finally, again, following that to also inquire what other kind of services do they need? Once we know that they're safe, they've got a plan for leaving that day and that sort of thing, that they have the resources that they need, just trying to find out what other kind of resources might they need. We know that this is so comorbid with other factors like homelessness and joblessness and poverty and even very comorbid with suicidality.

So, it's really important to assess and plug those people in, whether it's within your own system or in the community, just like you said, also building those partnerships. So, there's a really seamless plan in place and not fragmented.

Host
A lot of really, as someone else stated, very rich information in this conversation. Now, several of you mentioned using a trauma-informed approach. And I want to make sure that we've defined that and are all working kind of with the same understanding.
So, would you tell us a little bit more about the key elements of a trauma-informed approach when working with veterans who may have experienced gender-based violence?

Tovah
So, I'm happy to. SAMHSA has, for a long time, been very focused on trauma-informed care, trauma-informed approaches, trauma-responsive type systems. And I wanted to highlight a couple of our resources as listeners may be interested in them.
And these will also be provided in the resource document. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, what that does is it's developed a shared understanding of trauma and what it

means to provide services in a trauma-informed approach across a wide variety of populations, including veterans. And really what this document focuses on is the four Rs that a program, organization, or system that is trauma-informed really is focusing in on. And those are a system that is trauma-informed realizes the widespread impact of trauma, and understands potential paths for recovery, recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system, and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. And that's really key because you can imagine if someone has experienced such a life-changing event as an act of violence or patterned violence, that just the act of navigating systems can be very oppressive, can be very difficult under the best of circumstances. So, we really want to make sure that when a survivor enters any system, that they feel heard, that they feel supported, and that anything that the professional staff is doing, either overtly or not overtly, does not have the unintended consequence of re-traumatizing them.

The second guide I wanted to mention is SAMHSA's Practical Guide for Implementing a Trauma-Informed Approach. And that's really a detailed step-by-step way that organizations can prepare themselves to implement the trauma-informed approach. And that is by taking a look at everything from policies, procedures, practices at all levels of the organization, from who answers the phone to the highest governance body of that organization.

This whole organizational approach and willingness to assess, you know, even like the color of the walls when someone comes in, is it, you know, something that is mindful and not, you know, too actively abrupt. Those are all things that organizations can do to ensure that they're giving a client the most trauma-informed experience. So, while there's many ways we can talk about what trauma-informed means, those are some guides that are helpful for application in any number of settings, including helping veterans.

LeAnn

Well, I feel inadequate following Tovah and SAMHSA because it is those guides that we have used exhaustively in training ourselves and our own program staff to adopt those approaches within our system. As you all know, the VA healthcare system is the largest healthcare system in the nation, so adopting something is a big deal for us, but it really has been something that we've been able to take hold of. And I do really invite co-presenters to give any additional examples, but it is something, I came in the door about eight years ago, and this is something I had to educate myself on, and I utilize these materials. I utilize them, you know, daily or as I prepare presentations or trainings for our program, because people misunderstand this frequently. I think less and less now. SAMHSA's definitely done its work in getting this out there, what a trauma-informed approach really is, because so many people assume, especially providers, often assume what we're talking about is how do you treat, how do you identify and treat and work with somebody who has had trauma, but it's so much more than that.

And to what Tovah had already mentioned, we encourage our IPVAP coordinators to take this training and cascade it out to their medical centers to make sure that people do understand that it's more than that. It is the colors of the walls. It is how you, what your policies and procedures might say.

We've asked them to go through and read their policies and look at their procedures from the standpoint of a person who has this trauma, because it really speaks to how a person who's had these layers of trauma, how they're even able to interact with the healthcare system or the agency. So, it really is multifaceted, and we have seen a great deal of success, we believe, in adopting these tenants as basically our litmus test. If something comes to us and somebody says, you know, we'd like to try doing something this way, we run it past the trauma-informed care test.

Is it trauma-informed? How might somebody react to this? Let's say, for example, people want to be very efficient, and they want to mail out the

screening before somebody comes to their primary care appointment. Well, from an efficacy standpoint, that's great time management, but how is that person going to feel if they open up that envelope and they're faced with those questions in the midst of experiencing gender-based violence or other kinds of interpersonal trauma? Are they safe in even answering those questions? So that is one example where we really think through the application of trauma-informed care.

And you've heard, you know, in a lot of us, we've said those who experience intimate partner violence, those who use intimate partner violence, we apply this to everything, including the language that we use and, you know, how people are engaged and so forth. And in some of our interventions that are rising out of this work, you know, we make sure that, you know, we don't endorse something unless I can show how it's trauma-informed by empowering the person and giving them choice. So just some ideas about the way we've taken the work that SAMHSA has put out and others and applied it to our data.

Host

Wow. I am so glad that we drilled down a little bit more on what is meant by a trauma-informed approach, because that was definitely worth some more time and effort on.

Thank you both so much for that.

We know that women are disproportionately affected by gender-based violence. We've discussed that a bit in here already. We're also, of course, learning that other veteran populations might also be at higher risk.

We've talked about that some as we've talked about checking our biases a little bit. Could you discuss if other veteran groups are more likely to experience gender-based violence? Just discuss this topic for us in a bit more depth, please.

Jenny

Sure. Thanks for that question, Hannah. I think it's important when we think about clinicians and who we are screening and how we're asking questions.

Unfortunately, there are veterans in certain groups that are at higher risk for experiencing different kinds of gender-based violence, specifically intimate partner violence. We think about people, as you mentioned, to identify as women, also those identifying as Native American, lesbian, gay, bisexual, trans and queer people, people who identify as black, Native American, indigenous people. They are all in these higher risk groups.

Also, when we think about sexual assault and IPV, particularly those in rural, highly rural areas, are also evidencing a higher risk for experiencing these types of gender-based violence. We're still kind of new in the area of veterans and their experience of human trafficking, but I can definitely highlight IPV and sexual assault experience.

LeAnn

I agree. We're learning so much for a variety of reasons. One, I have to give a nod to Dr. Knetig and her work with the Megabus legislation two-year pilot where they really did focus in on experiences of different populations that are known to be at risk or underserved. We've learned a great deal from that pilot and are learning even more from the human trafficking pilots. Really trying to better understand that ourselves with regard to the vulnerable populations. I think it's so important that we are able to hold these things in our minds with regard to knowing that women are more likely, are disproportionately affected by gender-based violence. Oftentimes that violence is more extreme, potentially fatal. And that these populations and certainly additional populations as well are at higher risk. And then holding that with what we were just talking about in some pockets that not letting ourselves fall into the complete bias and just looking at women only.

What are those who identify as women and just being really inclusive with knowing that human beings are affected by this and some human beings might be in a population that is more prone to the violence or more severe violence. I just, you know, think about the fact that in my career, I'm getting toward the end, not totally end, but I've been in this for a while. And I just know that the perceptions of how things have changed from when I was a budding and brand-new social worker trained as a licensed clinical social worker in community mental health. And the, you know, what I was indoctrinated into when I would think about intimate partner violence or domestic violence or sexual assault, you know, immediately there's certain pictures that come to mind, the billboards, black and white billboards of a woman cowering in the corner and, you know, the black eyes and things like that. Those are still very true and concerning, but my, you know, my eyes have been opened to the enormity of this problem as a human plague basically. And that, you know, as people in the helping profession, we just, it's just really important to, I think, be able to hold both of those things in our minds and know that every person walking through the door may, may have, or are experiencing these issues and, and need somebody to tell that to, to get assistance.

Whereas we do know that some pockets are even more at risk. So, it's, it's a matter, I think, of trying to hold both of those truths in our minds as we continue our practice.

Kate

I really appreciate the conversation and agree with Dr. Bruce, just how far we've been coming within the last 20 years in terms of our understanding of gender-based violence. And I know it's true in the research that we are coming a long ways as well. I'll just share finding from some of our research regarding sexual orientation.

So, this is from a recent study of mine with colleagues in the National Center for PTSD that showed an important finding on intimate partner violence related to bisexuality. So, in a large national survey of veterans, we found that veterans who identify as bisexual are at the highest risk for IPV or intimate partner violence.

Specifically, over half of bisexual veterans experienced IPV or intimate partner violence during their lifetime compared to 38% of heterosexual veterans and a quarter of lesbian and gay veterans.

And this pattern of findings is actually very consistent with some data we've seen out of the National Intimate and Sexual Violence Survey, which was Tovah referenced earlier. And these findings really reinforce the importance of understanding differences within sexual and gender minority groups instead of lumping different groups together. And certainly, that would be true of race and ethnicity and veteran status and other personal characteristics.

Tovah
And I agree with all of the panelists' comments. I would only add that we're all comprised of multiple identities, intersectional identities. And so, again, just being mindful that there's not a one-size-fits-all, but that we really need to be alerted to the disproportionate impacts of communities of color.

And I wanted to especially call out American Indian, Alaska Native survivors and the growing awareness of missing and murdered indigenous people. It's very important to recognize that if you're not seen and heard because you're on the margins, then not every survivor is noted as, you know, with the same value. And that should not be.

So, when you just think about even news stories and things like that, who are the most profiled people who have gone missing or experiencing gender-based violence? They're oftentimes not people who would identify as diverse in the community. So, we really do need to change that lens if we're going to be supportive and aware of the disproportionate impact on those who are more marginalized.

Host

Very, very powerful point there at the end. Thank you. Thank you for making that. Now, recognizing that we are not talking monolithic and that every individual, as we've stressed in the conversation, must be taken individually, that these situations are going to be different, I do want to focus on some commonalities. And in this case, the common barriers that veterans can face in reporting gender-based violence. So, what are some of those common barriers and how can veteran service providers help to overcome these?

Jenny

Wow, Hannah. Yeah, those are some big and important questions. So, when I think about barriers, I think about cultural factors, systems factors, provider factors, and patient factors.

So, thinking about just in terms of what might get in my way of reporting, I've experienced gender-based violence or GBV. If I'm a woman of color, I might fear that if I make a report, harm may happen to my partner. If I am in the LGBTQ plus community, I may also be concerned about reporting, increasing safety risk to myself, to my partner, depending on my experiences with the legal system, depending on my experiences with healthcare. Have I experienced heterosexism? Have I experienced discrimination because of my race or ethnicity? Am I already not feeling very safe?
And we've talked pretty extensively today about safety as core to care delivery here. I would say that other systems factors that can impact a person, as Dr. Bruce mentioned earlier, is my system screening? Is my system providing universal education so that veterans know, “Hey, this is just part of the conversation I'm going to have with my physician, with my nurse”?

And so, are these systems making it a habit, and are providers getting comfortable with it? Are they versed, well versed in, as Tovah mentioned earlier, all the resources

available? So when a person discloses, they will be able to provide some care or have something to suggest.

When I think about marginalized groups as we've described and what may impact their disclosure, historically mental health hasn't done a great job of engaging and retaining people of color or LGBTQ+ veterans in care, particularly people identify as male. We've struggled. I think we are definitely doing better, and we can always do better. I think also when we're working cross-culturally, what is that client's view about relationship health and safety? What does that mean to them? It may not mean the same thing as it does to me.

So just being aware of their worldview and their perception of our system impacts disclosure potentially. When I think about some of those provider factors, again, not screening, not providing universal education, and feeling uncomfortable with the conversation, which is, again, pretty understandable. It's not easy to talk about gender-based violence.

It's not easy to hear stories, and it takes well-trained and highly motivated people to do this work who really care about their clients. And I think also, as Dr. Bruce mentioned, having a biased view about who can be the victim not only impacts whether or not we screen, but also can impact a person's sense of, like, what is my experience? What is gender-based violence? Is that really what I'm experiencing? For example, those who've been trafficked, I think, don't typically identify as, “Oh, this experience that I'm having, this life that I'm in right now, this is trafficking.” So really cultural views about these things, about relationship health and safety, impact not only the reporting, but also the response.

And I think transference, as I mentioned, provider transference and burnout, people who have been doing this too long or need supports themselves because it's really hard work, that can impact our ability to be effective with our

clients. So, we've talked a lot about what we can do, and I think I'm going to let my colleagues share their wisdom, but being mindful and focusing on our own transference, our own level of burnout, those are some good places to start. And I'm going to hand it off to Tovah. Thanks.

Tovah

Thank you so much. Excellent points. And the only thing I would add, agree with everything that was said, is just to unpack a little bit about stigma. I would also say that there's a pervasive stigma in our society about survivors not reporting in what society feels is the time frame that would make someone credible or believable. And we see this play out in the news. We see this play out in courtrooms, which we'll get to next.

And it's really important to recognize there are so many barriers, especially for marginalized communities to not come forward. And those barriers are both in terms of safety, just in terms of being able to survive, having the ability, not everyone's ability to just walk away. And so I feel like there's this immense stigma that if someone comes forward and talks about something that's happened to them in the past, that it's like, well, why didn't you say something before?

And so our systems are not very trauma-informed in understanding as to the barriers that survivors wrestle with when they come forward or don't come forward. And so we need a greater understanding about why that is.

LeAnn

And I would reiterate, we've talked about how difficult it already is on a personal level with stigma, shame, guilt, fear, not being sure what would happen if they speak out, as you all have already mentioned. And I think in a lot of cases, I mean, certainly in the health care setting, there are a lot of other things going on as well. So their reticence can be exacerbated by the fact that they're there because of a medical issue, or they

have PTSD, they might have a traumatic brain injury, dealing with substance use, mental health issues.

There's a lot of things that kind of come to the forefront that people obviously need to focus on, or maybe their providers are focusing on. And it's really hard to say, oh, by the way, I've got all this going on too. And one of the things I want to mention also in our system that is being promoted through the Care Management and Social Work Department is an emphasis on social drivers of health and whole health.

And it's really helping to help the health care system, which is very much a medical model, understand that these other things are so important too. So I think we've got like two sides to work on. One is the providers themselves and the system itself to continue educating the system that these things are important too.

We oftentimes with regard to screening for some of these issues, screening for trauma, screening for interpersonal trauma, MST, and so forth, you know, we likened it to we know it's important to screen for suicidality in our population, but these things can kill people just as much. You know, the numbers are there that would warrant screening for these kind of traumas and knowing that that's going on in someone's life is directly relevant to their health care, their overall well-being, and potentially their life. So, I think just continuing to do that and educating that side while also educating the veteran population or the patient population that that we do understand that we are an empathetic ear, that it is okay to tell us about it, that you are safe. And, you know, those are big things to do, but we do a lot of that through a lot of campaigns and education and trying to make sure that we're creating a safe system.

Host

As we're probably hearing here, it's important to be aware that legal protections and reporting requirements vary by state. So, you do want to be aware specifically of what your state says. Are there any legal protections and

supportive resources available for veterans experiencing gender-based violence that you all can speak to today?

LeAnn

Yeah, I think that is another layer of consideration. And I would like to mention that the VA does have a program, VHA, Veterans Health Care Administration, is delving into the development of medical-legal partnerships and in a variety of pockets. It's a national program, but it's stronger in some places.

That is a wonderful collaboration with legal experts, and so they can provide consultation. And so that's something to check into if somebody is needing something like that. Certainly, I would recommend that they use local resources, the Intimate Partner Violence Coordinators, and other staff, social workers across the primary care settings and other settings can talk.

And that's the greatest reason that somebody might want to disclose to someone that this is going on, because we really do have a lot of subject matter expertise and connections and connections with the community, and we know what resources are there to help plug them into some of these things. A lot of times people don't know where to even go to try to file an EPO. The requirements for an emergency protection order or things like that or to get the VA police involved or the community police involved, or is this something that needs to be reported? Is it a mandatory report? It varies from state to state, and so it is really important to reach out to the facility-based IPVAP coordinators who are the subject matter experts for their areas, and they know what's available in the community, and they can really help walk with that person through this journey that might be really, really difficult.

Jenny

Yeah. Dr. Bruce highlighted a number of resources. I think I would just add that it's okay.

As you mentioned, Hannah, legal protections, reporting requirements do vary, and it can be, if it's not your area of expertise, it can be Greek, and it's okay that you don't know. We can't know all the requirements, all the protections, all the statutes. So just connect with, if you can't reach your Intimate Partner Violence Assistance Program Coordinator, connect with any VA social worker, and they can get you to the right place.

Tovah

And I would just add, in terms of legal protections outside of the VA, that there's a process in every state to get a protection order. It may be called something different depending on the state. It could be called a restraining order, and so there are legal protections if survivors are eligible to petition for a protection order in their state.

And how that is enforced on the VA side, I defer to the VA colleagues because there are some technicalities at times, but any person who is eligible can apply for a protection order. There may be some safety and strategy reasons why a person may elect to not do that. And so it's really important that someone has good legal counsel and advice.

And again, the importance of community relationships are there are many legal service programs that may be able to assist survivors to be able to get the help that they need in the court system. And there are many survivors as well who have children, and so family court systems are also involved in addition to the civil protection order that I mentioned. And if there's a qualifying case for a criminal case, like an assault, then the criminal system may be involved as well.

So you may have multiple court systems and multiple cases going through a legal system at the same time if a survivor wants to use, you know, those types of legal protections. But it's complicated, so I would advise that you get legal counsel and guidance to be able to go through that process.

Host

Thank you all so much for that. I want to take a moment just to remind all our listeners again that we've got a resource guide that accompanies this podcast. You should be able to access it in exactly the same location.

It has scads of resources, some that we're not even going to have a chance to really delve into in depth today, but please do make use of that resource guide.

Now let's talk a little bit about what preventative strategies can be implemented within veteran services to reduce the occurrence of gender-based violence? So, we're talking very proactively now instead of a reactive approach, but within veteran services, what can be done to reduce the occurrence of gender-based violence?

Tovah

I would offer that universal education, training, screening, and coordinated community responses and collaborations are really the best way to make sure that survivors feel connected to the resources that they need to stay safe.

Jenny

I concur with Tovah's comments about, you know, knowledge being power, and I would highlight that another way to prevent gender-based violence is through reducing barriers to care. So, using a no-wrong-door approach like we strive to do in VA, where if you feel safe talking to a provider, that person can provide a warm handoff if needed to a specialist, that I think really is critical to breaking cycles, interrupting cycles of violence, saving lives.

LeAnn

I would also agree, education, campaigns, awareness, there's all kinds of things that we can do to put that out across the whole system and reach those who might be experiencing working, you know, with the community doing

some collaborative approaches and so forth. I think another thing is, you know, we do a lot of training and so forth and continuing to do that. The earlier we get involved, so we want to prevent certainly, and if not prevent, be involved very early.

The earlier we get involved, the more we have the chance of helping to turn things around, and a lot of the things that we do are framed under the terms of relationship health and safety, because not only are we worried about identifying safety risks and making sure we get those people to safety and that they have a plan, we have a lot of veterans in our system who might engage in what we might consider to be the lower level of intimate partner violence behaviors with some of the verbal issues and things like that, and we believe that to engage couples, when appropriate, to identify some of those lower level issues is so important that we can get people who want better relationships. They want to communicate better. They want to reduce the conflict. They want to learn problem solving. We have a really strong need for that, and we see a lot of it, and we do have some internal programs that can address it and or refer it into the community. The earlier we get involved, the more we make it an open thing to come and let us know if you're arguing more with your spouse or the shouting or the name calling is happening more and more. There are some amazing programs and workshops and things that we have to help couples enhance those relationship skills, which we're really proud of, and I think that that is certainly part of prevention, not going further down that path. I think other things is that we're lucky.

We're very lucky in our VA healthcare system that our program is based on addressing all factors, not only addressing those who are at risk or experiencing gender-based violence and intimate partner violence, MST. We're addressing those things. We're also looking at people who are using those behaviors. People come out, and you wouldn't think it, but people do identify that, hey, I'm using behaviors in my relationship that I'm not proud of. I want some help with this. I want to have healthier relationships, so really being open to listening to that, too, and helping people find a pathway to better relationship behaviors.

Host

That is a fantastic input because that's often not something I would even think about is that pathway to improved behaviors and really having those conversations early and often with your veteran clients. Really, really great input. Now, on this one, I think we've touched on this a little bit, but given the widespread issue of gender-based violence, it is entirely possible that veteran service providers may have personally experienced this trauma or are close to someone who has.

What advice can you all give to help these veteran service providers navigate and support their clients through challenging and potentially triggering discussions effectively?

LeAnn

That is such a great question. I think we have mentioned it in talking about stance of trauma-informed care. We recognize and try to incorporate that recognition into our work that whether it's mental health staff, primary care providers, nurses, anyone who's working with the veteran, we really try to achieve a no-wrong-door approach through widespread screening, making sure that wherever the veteran comes in that they are trained and staff that are comfortable talking about this. Yet, one of the things that we have learned a lot about along the way, and I have to give props to Kate Iverson and some of her work, some of the focus groups that they've had in trying to identify some implementation issues. It really does come down to, Kate, I don't want to speak for you, so please chime in, but staff perceptions about this topic as a whole. Again, there are biases, but maybe their biases are ingrained in having some of these experiences themselves.

It's really important that we take that into consideration and that we work through our local facility coordinators to make sure that they're sensitive to those issues. If they've gone in and trained a clinic to do screening and suddenly one provider in that clinic just isn't screening, or they do some chart reviews and things like

that, if they identify someone who's just not comfortable doing that, we need to really be sensitive and take into consideration that they might not be in a place themselves to do that kind of work. I know really our co-presenters probably have some additional information about that.

The other thing to think about before I turn it over, though, is in the VA system, we know that I think it's over 60% of our staff either are veterans, or maybe even a higher percentage of that are also family members of veterans. Everything we say about the risks to the veteran population is transferred into our staff because they are veterans, too, or they are family members of veterans. We really have a high degree of realizing that when somebody is triggered themselves, they fall into the trauma themselves, we need to be just as sensitive to our staff.

Jenny
Yes, I would agree, Dr. Bruce. Thinking about your question, Hannah, about what kind of advice can we provide to service providers who are navigating these really turbulent waters that can be trauma-focused work? I think about how can it impact those providers?

We know from some of the research in this area that providers who serve clients who've experienced gender-based violence may be at increased risk for compassion fatigue, vicarious traumatization, burnout. What does this look like? An increased psychological response, so it can look like PTSD. It can impact your body. It can negatively impact your own sexual health as a clinician. It can impact your parenting style.

I recently looked at a paper on sexual assault service providers and noting how they can be more kind of hovering, helicopter-ish in their parenting through just dealing with the challenges of gender-based violence. So, what can we do about it? Clinicians can, number one, really pay attention. Pay attention to your own signs of stress. Are you feeling numb? Are you feeling disconnected? Are you feeling

really on edge? And do your best to take care of yourself. Do your best to take breaks when you're able.

I would challenge systems that systems need to be doing this, too. We need to be looking out for our clinicians. We need to be thinking about how they have breaks, what is in place to promote their well-being, because they are a critical resource in this area. We, as clinicians, think about, you know, what is the balance I have? Am I overly engaged in work? What does life look like outside of work? And I think realism is really important. I think we all get into this field because we want to help, and there are limits to what help can be, and it can hurt deeply. Clinicians who feel like they haven't helped, that someone is still unsafe or still being harmed, it can be demoralizing. And so striving to be realistic about what can I actually accomplish here as a clinician is really important. There's more, but I want to turn it over back to you so we can hear from others. Thanks.

Host

Thank you. It really resonates with me that you all have shared so much about vicarious burnout and vicarious trauma because we know that that's a big deal for service providers, and we actually developed a course, 9612: Preventing and Healing Burnout in Veteran Service Providers, that provides in-depth information and some practical application best practices to help veteran service providers who are faced with burnout themselves, or even when they recognize it in colleagues, because it is just such a big deal, and it impacts so many individuals. And that whole idea of you can't take care of others unless you take care of yourself first. You really do have to care for yourself. And I'm sorry to take up space here because it's really you all I want to hear from. Tovah, you have not had a chance to weigh in on this one. You want to jump in here?

Tovah

Sure. And just what we're talking about with experiencing vicarious trauma as a

provider, as a supportive partner, as someone who may be supporting a friend or be a bystander, it's important to recognize that this very much can impact your well-being.

And so with all the guidance that the panelists gave so expertly, it's important to get the help that you need. And also, if something feels too much to refer that person to another provider who can help them, because we don't want you to feel that impact. And then that's not good for you. And that's not good for the person that you're trying to assist.

Host
Absolutely. Thank you. Now, as we look ahead, what changes or improvements do you think would be most beneficial in addressing gender-based violence in the veteran community?

Jenny
Thank you for that. I think a few things. Number one, we need we need more clinicians who can do this work. Our larger culture we've heard of the mental health crisis post-COVID. Rates of intimate partner violence of definitely increased since pre-COVID times, so we need to increase our capacity and look at how are we using the capacity, the existing capacity. #2, I'm really hopeful about this. Our ability to make changes. We're already working on it. I think one example of this is the National Plan to End Gender-Based Violence. Federal agencies are participating in implementing this national plan developed out of the White House. I think the plan focuses on, for those not familiar, 7 pillars. It focuses on gender-based violence prevention, gender-based violence response, online safety, addressing some of those social drivers of health we've been talking about, like economic security, housing stability. It focuses on legal and justice systems around gender-based violence and how we respond and prepare for emergencies. And it focuses on research and data regarding gender-based violence.

So, I'm really hopeful about that. VA is definitely participating, as well as other agencies and as we've been talking, I think just striving to continue to

promote a culture of safety and inclusion as we have described, certain groups are at higher risk and so doing that as a system can only help.

LeAnn

I agree, Dr. Knetig. It really is going to take a lot of, you know, coordination, comprehensive response. I think it's wonderful that we have the National Plan to End Gender-Based Violence. It's a wonderful resource, and it's been a catalyst for us coming together on calls like this, across different agencies, and talking about what we're doing. And recently, you were very instrumental in hosting a gender-based violence summit, you know, to honor the one-year anniversary of the plan coming out. And I think that's just the beginning, because we've created more partnerships.

We know people across different agencies. We're starting to talk about some of the things we're doing that are similar and working together. Those are great things that have come out as a result of this, and continuing, you know, to work on the awareness, the education, and the training.

And hopefully, we will eventually merge into working a lot more collaboratively and sending out more consistent messages across our different, you know, programs. So people start gaining that, you know, I hate to say brand recognition, but you know what I mean when people are starting to see that they're not seeing it in fragmented ways. And I think that makes a huge difference.

But also, really talking to each other about ways that we can adopt in concrete ways and apply, you know, these principles into the work that we're doing. And really leading to that, again, as Dr. Knetig mentioned, that cultural paradigm shift where we recognize this is a real thing, that it's really prevalent, that it's really hurting people, and that it's preventable, this is something we can do something about.

Tovah

And I think it would be really helpful to have ongoing education, awareness building, and relationship building all of the time. We need some baseline points of collaboration, cross-training, and interception to really move the needle because the workforce changes, and the nonprofit domestic violence and sexual assault provider workforce changes frequently. So we can't just say, oh, we trained them last year, but we really have to be mindful of our partnerships as an ongoing asset that needs to be nurtured and cared for so that these relationships endure and survivors get the best services.

Host

This has been just a phenomenal and important conversation. And I cannot thank you all enough for being here to lend your expertise to this. As we close out this podcast, I just want to know, are there any final thoughts that you want to leave our listeners with? Any last nuggets, any last thoughts you'd like to bring up?

LeAnn

Well, I can't pass up the opportunity to say that if someone listening is a veteran, works with veterans, is a family member of a veteran, or you think you might be experiencing interpersonal violence or gender-based violence, please do reach out to your local IPVAP coordinator. You can find the directory on our website if you're a provider and you want to touch base with the VA side of the house and talk with them about what resources they have locally. It would be highly welcomed. So I know that our directory and our website are in the resource list.

Tovah

And I would add that even if you personally are not experiencing gender-based violence, knowing these resources helps you be an effective ally and really important partner in the prevention of further violence. So knowing where to go is really helpful in terms of helping others who are experiencing violence.

Jenny

Love these ideas. I would add, you know, you've heard from us today. We'd love to hear from you. We want to hear your voice, the clinicians who serve veterans who've experienced gender-based violence, veterans, survivors. Dr. Bruce mentioned our website and how you can get connected to the VA and social work and the Intimate Partner Violence Assistance Program. We'd love to hear from you about how we're doing and how we can do better. Thanks for this opportunity to talk.

Host

Thank you, all of you, for joining us today for the podcast and providing all of this valuable information and these resources about gender-based violence in the veteran community. To our listeners, if you would like more information about serving veterans, please visit NVTI.org to access resources such as this podcast. We're also constantly adding new materials, so check back often. And, of course, we invite you to continue the conversation at the Making Careers Happen for Veterans Community of Practice.

Thank you all so much for joining us today.

OUTRO

This podcast is brought to you by the National Veterans' Training Institute, whose mission is to further develop and enhance the professional skills of veterans, employment, and training service providers throughout the United States. This program is funded by the U.S. Department of Labor Veterans' Employment and Training Service and administered by Management Concepts. For more episodes, visit the NVTI website at www.nvti.org.