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Improving Disability Evaluations for Veterans Who Have Experienced Military Sexual Trauma (2026)

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CONTRIBUTORS

Hortensia Amaro and Leslie Y. Kwan, Editors; Committee on the Assessment of Department of Veterans Affairs Physical and Mental Health Examinations and The Department's Schedule of Rating Disabilities for Disability Compensation Claims Related to Military Sexual Trauma; Health Care and Public Health Program Area; Center for Health, People, and Places; National Academies of Sciences, Engineering, and Medicine

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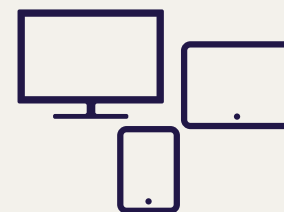
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Improving Disability Evaluations for Veterans Who Have Experienced Military Sexual Trauma

Hortensia Amaro and Leslie Y. Kwan, *Editors*

Committee on the Assessment of Department
of Veterans Affairs Physical and Mental Health
Examinations and the Department's Schedule of Rating
Disabilities for Disability Compensation Claims Related
to Military Sexual Trauma

Health Care and Public Health Program Area

Center for Health, People, and Places

Consensus Study Report

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COMMITTEE ON THE ASSESSMENT OF DEPARTMENT OF
VETERANS AFFAIRS PHYSICAL AND MENTAL HEALTH
EXAMINATIONS AND THE DEPARTMENT'S SCHEDULE OF
RATING DISABILITIES FOR DISABILITY COMPENSATION
CLAIMS RELATED TO MILITARY SEXUAL TRAUMA

HORTENSIA AMARO (*Chair*), Florida International University
SARA KINTZLE, University of Southern California
HEATHER KRULL, RAND
HAROLD KUDLER, Duke University
MARY JO LARSON, Brandeis University
SUSAN McCUTCHEON, Department of Veterans Affairs (*retired*)
MARIE-CHRISTINE NIZZI, Spaulding Rehabilitation Hospital
LOGAN C. PETERSON, Uniformed Services University of the Health
Sciences
CAROLYN M. PORTA, University of Minnesota
DAVID N. SMITH, Yale University

Study Staff

LESLIE Y. KWAN, Study Director (*from July 2025*)
CRYSTAL J. BELL, Study Director (*until July 2025*)
JENNIFER ZHU, Associate Program Officer (*from May 2025 until July 2025*)
ANNA ADLER, Research Associate
AJA DRAIN, Research Associate (*from September 2025 until January 2026*)
ABIAN HAILU, Senior Program Assistant (*from April 2025*)
ELIZA SOUSER, Senior Program Assistant (*until March 2025*)
SHARYL J. NASS, Senior Program Director

Reviewers

This Consensus Study Report was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published report as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process.

We thank the following individuals for their review of this report:

PHILIP ARMOUR, RAND

LAURINE CARSON, MITRE

CHRISTINE CLEMENS, Chisholm Chisholm & Kilpatrick

JASON DEVIVA, Yale School of Medicine

ROSE CARMEN GOLDBERG, University of Washington School of Law

LUCINDA LEUNG, UCLA David Geffen School of Medicine; West Los Angeles VA Medical Center

CHARLES MARMAR, New York University Langone Medical Center

LOUIS PANGARO, Uniformed Services University of the Health Sciences

TIARA WILLIE, Johns Hopkins Bloomberg School of Public Health

LAURIE ZEPHYRIN, The Commonwealth Fund

Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations of this report nor did they see the final draft before its release. The review of this report was overseen by **SANDRO GALEA**, Washington University in St. Louis, and **PAUL A. VOLBERDING**, University of California, San Francisco. They were responsible for making certain that an independent examination of this report was carried out in accordance with the standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the authoring committee and the National Academies.

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Contents

PREFACE	xv
ACRONYMS AND ABBREVIATIONS	xvii
SUMMARY	1
Statement of Task and Committee Approach, 2	
Competencies, Training, and Quality Assurance, 5	
Improving C&P Examinations, 10	
1 INTRODUCTION	19
Statement of Task, 21	
Committee Process and Approach, 24	
Overview of This Report, 26	
References, 27	
2 MILITARY SEXUAL TRAUMA AND HEALTH	31
Health Conditions Related to MST, 37	
Summary, 53	
References, 54	
3 COMPETENCIES FOR CONDUCTING MILITARY SEXUAL TRAUMA-RELATED DISABILITY EXAMINATIONS	67
C&P Examiner Competencies, 68	
MST Training, 74	

Training Assessment and Continuous Quality Improvement, 93	
Summary and Recommendations, 101	
References, 107	
4 THE COMPENSATION AND PENSION EXAMINATION PROCESS FOR DISABILITY COMPENSATION CLAIMS RELATED TO MILITARY SEXUAL TRAUMA	113
Filing an MST-Related Disability Claim, 115	
Claims Development, 117	
Examination and Medical Opinion Request, 120	
The C&P Examination, 123	
Reviewing the Claim and Rating the MST-Related Disability Using the VASRD, 136	
Claims Decision and Appeal, 139	
Summary, 140	
References, 145	
5 IMPROVING THE COMPENSATION AND PENSION EXAMINATION PROCESS FOR DISABILITY COMPENSATION CLAIMS RELATED TO MILITARY SEXUAL TRAUMA	151
Improving the C&P Examination, 153	
Standards of Evidence in Support of MST-Related Disability Compensation Claims, 163	
Concluding Remarks, 177	
References, 180	
APPENDIXES	
A Public Law 117-289	187
B Biographical Sketches of Committee Members and Staff	191
C Public Meeting Agendas	201
D Personal Trauma Development Checklist and Instructional Guide	205
E VA Form 21-0781	213
F Personal Trauma Incident/Marker Worksheet	221
G Medical Opinion Disability Benefits Questionnaire	231

Boxes, Figures, and Tables

BOXES

- S-1 Statement of Task, 4
- S-2 Trauma-Informed Principles, 5
- S-3 Examiner Competencies, 6

- 1-1 Statement of Task, 22
- 1-2 Trauma-Informed Principles, 26

- 3-1 Example Exemplar Medical Opinions of Service Connection for MST, 88
- 3-2 Contract Medical Disability Exam Checklist, 98

- 4-1 Example of a Typical Medical Opinion Request for PTSD Related to MST, 131

FIGURES

- S-1 Summary of the Department of Veterans Affairs disability determination process for military sexual trauma-related claims that include compensation and pension examinations, 11

3-1	Miller’s Competency Pyramid, 94
3-2	Medical Disability Examination Office fiscal year 2024 quality performance thresholds for financial incentives for contracted disability exams, 100
4-1	Summary of the Department of Veterans Affairs disability determination process for military sexual trauma-related claims that include compensation and pension examinations, 116

TABLES

3-1	Summary of Statutory Scope of Practice Authority for Selected Mental Health Professions Across States, 71
3-2	Summary of VHA and VBA MST Training Courses, 76
4-1	Monthly Veterans Disability Compensation Rates for 2026, 142
5-1	Ten Most Frequently Service-Connected Conditions for MST-Related Disability Claims, Fiscal Year 2025, 164
5-2	Ten Most Common Reasons for Rejection of MST-Related Claims, 165

Preface

Since the beginning of our Republic, U.S. presidents, leaders, and the public have expressed gratitude and sought to recognize the sacrifices of those who have served in the military. This has been considered a “sacred obligation” to veterans, their families, and survivors. Indeed, the motto of the Department of Veterans Affairs is “[t]o fulfill President Lincoln’s promise to care for those who have served in the nation’s military and for their families, caregivers, and survivors.” In the spirit of Theodore Roosevelt’s call to provide veterans with a “square deal” after their service to the country, there have been continuous efforts to deliver on this promise. This report is a continuation of efforts to assess specific aspects of the disability benefits processes, in this case for claims involving military sexual trauma.

Approximately one in three women and one in 50 men veterans report having experienced sexual trauma, including incidents of sexual assault and sexual harassment, during their service in the military. Many survivors of military sexual trauma experience adverse health outcomes that can be immediate and enduring or appear years after separation from military service. The Department of Veterans Affairs provides disability compensation related to these conditions, but veterans have reported challenges pursuing these benefits, including unclear and inconsistent processes and decision-making, burdens associated with providing multiple forms of proof, and retraumatization due to claims processors and clinicians who are insufficiently trained in trauma-informed approaches.

In accordance with Public Law 117-289, this committee was formed to conduct a study to assess tools and protocols of compensation and pension examinations for claims related to military sexual trauma, as well as

the credentials and training of the clinicians performing these exams. The multidisciplinary committee of nationally recognized scientists, clinicians, and veterans offers this report with recommendations for Congress and the Department of Veterans Affairs. We hope that the information and recommendations will reduce harms to veterans, improve the experience of veterans, simplify claims development and research, modernize and strengthen training, improve rating accuracy, and increase fairness in the disability compensation process for military sexual trauma-related claims.

Hortensia Amaro, *Chair*
Committee on the Assessment of Department of Veterans Affairs
Physical and Mental Health Examinations and the
Department's Schedule of Rating Disabilities for Disability
Compensation Claims Related to Military Sexual Trauma
April 2026

Acronyms and Abbreviations

AAN	American Academy of Nursing
ACE	Acceptable Clinical Evidence
ACEP	American College of Emergency Physicians
ACLU	American Civil Liberties Union
ACOG	American College of Obstetricians and Gynecologists
AI	artificial intelligence
APA	American Psychiatric Association
C&P	compensation and pension
CAPS-5	Clinician-Administered PTSD Scale for DSM-5
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CRS	Congressional Research Service
CVD	cardiovascular disease
DBQ	Disability Benefits Questionnaire
DMA	Office of Disability and Medical Assessment
DOD	Department of Defense
DOJ	Department of Justice
DSM-5	<i>Diagnostic and Statistical Manual of Mental Disorders, 5th Edition</i>
ENAU	Emergency Nurses Association University
EVAWI	End Violence Against Women International

FY	fiscal year
GAD	generalized anxiety disorder
GAO	Government Accountability Office
HIV	human immunodeficiency virus
HPV	human papillomavirus
HRSA	Health Resources and Services Administration
IBS	irritable bowel syndrome
IOM	Institute of Medicine
IPV	intimate partner violence
LGBT	lesbian, gay, bisexual, and transgender
LIP	licensed independent practitioner
LQTC	Leidos QTC Health Services
LSGS	Loyal Source Government Solutions
MDD	major depressive disorder
MDEO	Medical Disability Examination Office
MST	military sexual trauma
NHLBI	National Heart, Lung, and Blood Institute
NHRVS	National Health and Resilience in Veterans Study
NICHD	Eunice Kennedy Shriver National Institute of Child Health and Human Development
NIMH	National Institute of Mental Health
NINDS	National Institute of Neurological Disorders and Stroke
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OIG	Office of Inspector General
OND	Operation New Dawn
OSCE	Objective Structured Clinical Examination
PHQ-9	Patient Health Questionnaire-9
PI	principal investigator
PL	Public Law
POW	prisoner of war
PTSD	posttraumatic stress disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPRO	Sexual Assault Prevention and Response Office

ACRONYMS AND ABBREVIATIONS

xix

SHA	Separation Health Assessment
STB	suicidal thought and behavior
STI	sexually transmitted infection
SUD	substance use disorder
TBI	traumatic brain injury
USC	United States Code
VA	Department of Veterans Affairs
VASRD	VA Schedule for Rating Disabilities
VBA	Veterans Benefits Administration
VES	Veterans Evaluation Services
VHA	Veterans Health Administration
VSO	veterans service organization
WGR	Workplace and Gender Relations Survey of Military Members
WHO	World Health Organization

Summary¹

The Department of Veterans Affairs (VA) provides disability benefits to veterans for health conditions related to military sexual trauma (MST), which for the purposes of disability compensation refers to “a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment during active military, naval, air, or space service” (38 USC § 1166). Estimates of MST prevalence range from 15 percent to more than 70 percent, and evidence supports an elevated prevalence of sexual assault and sexual harassment in the military compared with the general population. Anyone can experience MST, but some groups including women and sexual minorities have higher risk of MST. MST is distinct from other forms of sexual trauma because it includes sexual assault and sexual harassment, thus capturing isolated incidents of assault as well as the cumulative impact of sexual harassment or a series of assaults of varying severity. It also includes experiences regardless of whether they were perpetrated by other service members or whether they occurred on or off base. MST further differs from other sexual trauma because elements of the military environment such as its emphasis on unity and hierarchical structure influence the risk of experiencing MST, the likelihood of disclosure, and the broad range of health consequences, including posttraumatic stress disorder (PTSD), depression, anxiety, injuries, sexually transmitted infections, chronic pain, fibromyalgia, and cardiovascular effects. In many cases, these conditions co-occur with overlapping symptoms, which makes identifying MST’s contributions to

¹ This summary does not include references. Citations to support the text and recommendations herein are provided in the respective chapters of the main report.

discrete impairments (or, the extent to which a condition affects a veteran's overall health and limits that person's ability to function in daily life) challenging.

MST is not a disability but an in-service event that can lead to compensable disabilities. Eligibility for MST-related disability compensation requires evidence of MST, current disability, and service connection (i.e., a link between the claimed disability and MST). Often, evidence in support of service connection comes from compensation and pension (C&P) exams, or disability evaluations that provide clinical evidence to inform VA's claims determination. The Veterans Benefits Administration (VBA), which oversees the delivery of disability benefits, requests these exams, which are performed by clinicians known as C&P examiners who are contracted by VBA or employed by the Veterans Health Administration (VHA). The proportion of exams performed by contracted examiners has increased from roughly 20 percent in 2013 to more than 90 percent in 2024, creating a new disability evaluation workforce that lacks the traditional competencies and experiences of VHA in-house clinicians, especially related to trauma-informed approaches and military cultural competence.

C&P examinations, especially those performed by contractors, have been the subject of prior VA Office of Inspector General (OIG) and Government Accountability Office (GAO) reviews, which have identified problems with exam quality, facilities, and providers and recommended improvements. Although VA has taken steps to improve its claims processes, veterans who have experienced MST continue to report concerns about their experiences undergoing disability examinations. This study builds on this prior work to improve the disability examination process for veterans to ensure that they receive timely and accurate compensation for disabilities related to MST. Specifically, this report makes recommendations to establish competencies for C&P examiners, align their training with best practices in graduate and continuing medical education, develop and implement new quality assurance procedures focused on MST-specific performance, ensure a trauma-informed approach to the clinical examinations, and ensure that conditions associated with MST are captured in VA's disability rating system. It further recommends legislative and regulatory changes to evidentiary requirements that create complexity, inaccuracies, and unfairness in the evaluation and rating of MST-related conditions compared with other conditions.

STATEMENT OF TASK AND COMMITTEE APPROACH

In accordance with Public Law 117-289, the National Academies of Sciences, Engineering, and Medicine convened an ad hoc committee to undertake a comprehensive review of VA's tools and protocols for the disability examinations used to determine compensation for mental and physical health conditions related to MST and to assess the training and

credentials of the health care providers performing these examinations (see Box S-1). The committee comprised 10 members with expertise in disability evaluations, gynecology, military and veterans' health, psychiatry, psychology, public policy, and sexual trauma. The committee's work was guided by the aim to ensure a high-quality (meaning, evidence-based, trauma-informed, accessible, accurate, and transparent) disability evaluation process for MST-related claims that has reproducible outcomes, minimizes burden on veterans, and awards claimants fairly. A trauma-informed approach incorporates six principles—safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural, historical, and gender issues (see Box S-2).

The committee found it necessary to review the entire claims process to understand the context in which C&P exams occur. To the extent that elements of the process beyond the examinations shape the examinations and their findings about impairment and service connection, the committee interpreted these elements to be within the scope of its evaluation. Conversely, systemic issues and challenges in parts of the claims process beyond the exam can contribute to an overall experience of the claims process but are beyond the scope of the committee's task. In evaluating all potential options for improving C&P examination tools and protocols, the committee considered their relative advantages and disadvantages, implementation challenges, and the extent to which each addressed problems with current protocols. The committee also assessed how each potential option relates to its goals.

The committee held four public information-gathering sessions with representatives from VA, veterans service organizations (VSOs), veterans' advocates, and a vendor of contract C&P examinations. The committee also received written feedback in response to requests for information from VA and each of the four contract exam vendors.² The committee carefully considered whether to request perspectives of individuals who had experience applying for disability compensation related to MST. Consistent with a trauma-informed approach and to limit potential retraumatization by asking veterans to retell their experiences in public forum (as would be required under the National Academies' obligations under Section 15 of the Federal Advisory Committee Act), the committee decided not to request direct input from survivors of MST, instead relying on input from VSOs and advocates, materials in the public record, and the scientific literature, where such perspectives and experiences are well documented.

² In accordance with the National Academies' obligations under Section 15 of the Federal Advisory Committee Act, responses are available in the project's Public Access File, available through the National Academies Public Access Records Office, as is all information from external sources provided to the committee.

BOX S-1
Statement of Task

An ad hoc committee under the auspices of the National Academies of Sciences, Engineering, and Medicine will assess the examinations given by the Department of Veterans Affairs (VA) to determine compensation for mental and physical conditions linked to military sexual trauma. The review of the way that impairments arising from military sexual trauma are assessed will examine:

1. The adequacy of tools and protocols to include:
 - a. The Disability Benefits Questionnaires;
 - b. The VA's schedule of rating disabilities;
 - c. Whether certain conditions linked to military sexual trauma require a referral for both a mental and physical health examination, and;
 - d. The necessity of internal pelvic examinations to diagnose certain conditions, and potential alternatives to these examinations.
2. What credentials and training are necessary for a health care specialist or provider to perform examinations related to physical health conditions linked to military sexual trauma for both men and women, to include:
 - a. Sexual dysfunction;
 - b. Pelvic pain;
 - c. Pelvic dysfunction;
 - d. Musculoskeletal disabilities;
 - e. Cardiovascular conditions, including stroke.
3. What credentials and training are necessary for a health care specialist or provider to perform examinations related to mental health conditions linked to military sexual trauma for both men and women.
4. The quality of military sexual trauma training for those who perform these examinations, including recommendations for improvement of the training.

The committee shall produce a final report detailing its process and offer any findings, conclusions, and recommendations, to include those on legislative or administrative action to improve the adjudication of claims.

BOX S-2 Trauma-Informed Principles

- **Safety:** Ensuring safe physical settings and interpersonal interactions.
- **Trustworthiness and Transparency:** Care and decisions made with clarity, consistency, respect, and fairness to build trust.
- **Peer Support:** Support from those with lived experiences of trauma.
- **Collaboration and Mutuality:** Partnerships and the leveling of power differences between and among providers and patients.
- **Empowerment:** The recognition and building upon of individuals' strengths and experiences.
- **Cultural, Historical, and Gender Issues:** Understanding the perspectives, beliefs, and other context that influence both how clinicians provide care and how patients receive it and applying gender inclusive and culturally responsive approaches to caring for patients.

COMPETENCIES, TRAINING, AND QUALITY ASSURANCE

VA does not currently define any competencies necessary for providing C&P exams related to MST, requiring only that examiners are licensed and not barred from practice in any jurisdiction. However, licensure does not ensure competency to practice at the standard of care. The committee reviewed examiners' tasks, VA MST training courses, and best practices in medical education and clinical care and used its expertise to identify five competencies (see Box S-3) needed to conduct C&P examinations related to MST:

Recommendation 3-1: The Department of Veterans Affairs should ensure that all examiners, including trainees, who conduct compensation and pension examinations for claims related to military sexual trauma (MST) complete training and demonstrate proficiency in five core competencies prior to performing any MST-related examinations:

- a. MST and Health
- b. Trauma-Informed Approach
- c. Laws and Regulations Governing MST Claims
- d. Military Structure and Culture
- e. Medical Opinions

No clinical discipline requires proficiency in all the competencies needed to conduct MST-related C&P exams as a standard component of its education and training. Current VA policy restricts the providers who

BOX S-3 Examiner Competencies

1. **Military Sexual Trauma (MST) and Health:** Knowledge about MST and its health consequences and the application of that knowledge to assess claimed conditions, their effect on functioning, and relation to MST.
2. **Trauma-Informed Approach:** An approach to caring for patients to minimize the potentially harmful effects of the trauma and of health care encounters.
3. **Laws and Regulations Governing MST Claims:** The knowledge and application of the legal and regulatory context in which disability determinations for claims related to MST occur.
4. **Military Structure and Culture:** Knowledge of military structure, norms, culture, and values and the application of that knowledge in understanding how they may cause challenges for service members and veterans in health care encounters and how they affect the risk and disclosure of MST.
5. **Medical Opinions:** Skills to develop clinical opinions about service connection and impairment sufficient for the Department of Veterans Affairs to adjudicate claims.

can perform specialized C&P examinations (e.g., mental health, traumatic brain injury, hearing, dental) beyond those who may be competent and legally authorized to do so. In the context of a national behavioral health workforce shortage, such restrictions hinder timely access to C&P exams and timely processing of MST-related claims. Therefore, the committee recommends the following:

Recommendation 3-2: The Department of Veterans Affairs should identify the broadest possible range of clinicians who can effectively perform compensation and pension examinations related to military sexual trauma within their professional credentials, level of training, and legal and professional scope of practice and expand the health disciplines permitted to do so.

In some cases, licensed clinicians who demonstrate the core competencies for C&P exams related to MST include trainees such as medical residents. VA currently requires residents who perform mental health but not physical health exams to do so under close supervision and for both trainees and supervising clinicians to co-sign Disability Benefits Questionnaires

(DBQs), or body system–based forms that guide clinical examinations. The committee did not identify information showing differences in exam quality between trainees and licensed, credentialed, and privileged examiners, but this may reflect the lack of measures to document such differences. Ideally, VA would require training, competence, and direct supervision of all trainees to ensure they perform high-quality examinations related to MST, which are more sensitive and complex than other exams.

Recommendation 3-3: The Department of Veterans Affairs should require trainees to conduct compensation and pension examinations related to military sexual trauma, including physical and mental health examinations, under direct supervision and require both the trainee and the supervisor to co-sign all Disability Benefits Questionnaires.

Recommendation 3-4: The Department of Veterans Affairs should develop measures that allow it to monitor for differences in exam quality between trainees and licensed, credentialed, privileged, independent clinicians.

Training can facilitate proficiency in the five competencies and supplement the professional credentialing process. The existing MST and general certification training courses include some content related to these competencies, focusing on conceptual knowledge and lacking instruction on practical skills. The training uses limited modalities and lacks interactive approaches (e.g., videos, virtual standardized patients, simulations) that are the current evidence-based best practices for continuing professional education, which have been shown to increase skill acquisition, enhance knowledge retention, and improve performance. Consequently, these courses are likely insufficient for learners to apply concepts in practice.

VA assesses examiners after the initial training using a written-only format. A skills-based assessment that complements the knowledge assessment as part of a multi-dimensional and multi-modal approach is needed for VA to assess examiner competence and provide learners with an opportunity to apply their knowledge and skills in an environment that does not risk harm to veterans or cause inaccurate disability determinations. Successful assessment development involves stakeholders and includes strategies such as blueprinting (i.e., alignment of content and goals), standard setting (i.e., criteria to assess minimal competence), and calibration (i.e., assessment of reliability and validity). Contracted examiners are reassessed every five years, while VHA examiners are assessed only once. Annual refresher courses would ensure that examiners have the latest evidence-based information on the health effects of MST and current information on VA policies and procedures. To align the MST training with best practices in graduate

and continuing professional education, better engage examiners in completing the training courses, and ensure proficiency in the five competencies, the committee recommends the following:

Recommendation 3-5: The Veterans Health Administration Office of Disability and Medical Assessment and Veterans Benefits Administration Medical Disability Examination Office should collaborate to modify the training goals of the military sexual trauma (MST) training course to reflect the five core competencies. In particular, they should collaborate to develop and provide training to both claims processors (including those involved in development and rating) and examiners on requesting, drafting, and reviewing medical opinions specific to MST-related claims.

Recommendation 3-6: The Department of Veterans Affairs should develop a new format for its training course on providing compensation and pension examinations related to military sexual trauma that uses a range of modalities including greater use of video, simulations, and virtual standardized patients.

Recommendation 3-7: The Department of Veterans Affairs should assess all examiners who conduct compensation and pension exams related to military sexual trauma after their initial training and annually thereafter. The initial training assessment should include a written knowledge assessment and a skills-based assessment that provides an opportunity for learners to demonstrate the five core competencies.

VA can ensure examiners maintain competence through quality assurance. The VBA Medical Disability Examination Office (MDEO) performs a range of quality assurance activities for contracted exams, including quality action plans, a quality checklist, special focused reviews for complex claims (including MST), technical assistance, vendor guidance memos, and stakeholder feedback. Contract exam vendors and VHA have additional quality assurance processes for their examiners.

The quality of contracted exams, which has been strongly criticized in prior VA OIG and GAO reviews, has improved over time; nonetheless, the committee identified several areas for continued improvement. MDEO has unclear and incomplete procedures for reviewing contractor quality improvement plans and ensuring contractors have completed requested corrective actions. In addition, MDEO does not have mechanisms to routinely monitor MST-specific performance or provide such data to contractors, VHA, or the public. Moreover, the committee determined that data on several metrics MDEO provided were not reliable (e.g., strata did not sum

to totals), which heightened concerns about MDEO's ability to accurately assess and monitor MST-specific performance. Additionally, MDEO does not review, monitor, or require feedback on individual examiner performance or have measures to hold vendors accountable for prolonged periods of poor MST-specific performance. The lack of these procedures increases risk of errors associated with MST-related examinations and claims. Therefore, to ensure VA's capability to monitor performance on and ensure high quality of MST-specific claims and exams, the committee recommends the following:

Recommendation 3-8: The Veterans Health Administration (VHA) Office of Disability and Medical Assessment (DMA) and Veterans Benefits Administration Medical Disability Examination Office (MDEO) should produce annual reports on individual compensation and pension examiners that contribute to a high volume of insufficient or incomplete military sexual trauma (MST)-related claims. High volume should be defined as a proportion (e.g., top tenth percentile) of all VHA-specific or vendor-specific MST-related claims or a high proportion (e.g., substantially above average) of an individual provider's MST-related claims. Based on these annual reports, DMA and MDEO should require VHA or the vendor to develop corrective action plans for these examiners and maintain continuous monitoring of these examiners until the number of insufficient or incomplete MST-related examinations is within normative values.

Recommendation 3-9: The Veterans Benefits Administration Medical Disability Examination Office should develop data collection and processing mechanisms that allow for comprehensive analysis of data from examinations performed by Veterans Health Administration and contracted vendors including the following:

- a. Accurate disaggregation of performance on military sexual trauma (MST)-related claims, compensation and pension (C&P) examinations, Disability Benefits Questionnaires (DBQs), and medical opinions, as compared with other claims, C&P exams, DBQs, and medical opinions;
- b. Separate sampling and analysis of satisfaction surveys from veterans whose claims are related to MST; and
- c. Annual monitoring and reporting on performance on MST-related claims, exams, DBQs, and medical opinions to identify trends and improve examination quality.

Recommendation 3-10: For inclusion in any new contracts executed between the Veterans Benefits Administration Medical Disability Examination Office (MDEO) and the contract compensation and pension

(C&P) examination vendors, MDEO should develop and implement a system of financial incentives and disincentives (such as risk corridors) based on annual performance on military sexual trauma (MST)-related claims and C&P exams (including corresponding Disability Benefits Questionnaires and medical opinions) and on satisfaction surveys from veterans whose claims are related to MST (as described in Recommendation 3-9).

IMPROVING C&P EXAMINATIONS

Figure S-1 summarizes the process for MST-related claims that include a C&P exam. First, a veteran files a disability claim with VBA and works with VBA representatives to gather evidence from service records to support the claim (i.e., claims development). VA applies two evidentiary standards to MST-related claims. For PTSD claims related to personal trauma including MST, VA recognizes the difficulty of providing evidence of the traumatic event and allows use of lay evidence and behavioral changes following the trauma known as markers (e.g., requests for changes in duty assignment, changes in performance, disciplinary or legal challenges). For all other (non-PTSD) claims related to MST, VA requires evidence from military and in-service medical records, such as a formal report or diagnosis. This creates additional challenges for establishing service connection for physical or non-PTSD mental health conditions linked to MST. This dual system also adds complexity to MST-related claims and may result in potentially inaccurate ratings for non-PTSD conditions related to MST, as compared with PTSD ratings related to MST.

If the evidence of record identified during the claims development process is sufficient to decide a claim, the claims developer refers the claim for rating. If the evidence is insufficient for VBA to adjudicate the claim, claims processors request a clinical examination to obtain a diagnosis, assess impairment, and, in most cases, request a clinical opinion of service connection. Although there have been improvements to support claims processor decision-making over time, medical opinion requests may be unclear or not follow VA procedures, which causes inaccurate or insufficient medical opinions, incorrect claims determinations, and claims delays. Claims developers use a standardized tool to determine whether a VHA clinician or a clinician from one of the four VBA-contracted vendors will perform the exam based on the availability and capacity of nearby VHA providers. Then, the designated provider will contact the veteran to schedule an exam. In most cases, one examiner can fully assess a specific condition in a single examination, though this might require completing multiple DBQs. In rare cases, multiple diagnoses co-occur with overlapping symptoms. For

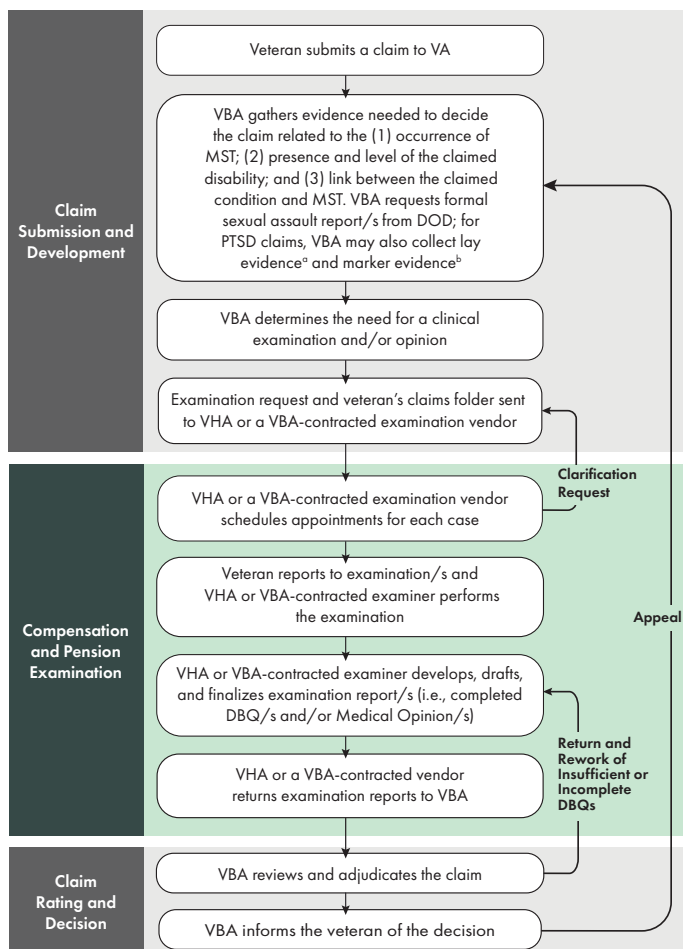


FIGURE S-1 Summary of the Department of Veterans Affairs disability determination process for military sexual trauma-related claims that include compensation and pension examinations.

NOTES: To focus on the examination process, this diagram simplifies claims processes that do not require examinations and the appeals process, which are beyond the scope of the committee's Statement of Task. DBQ = Disability Benefits Questionnaire; DOD = Department of Defense; MST = military sexual trauma; PTSD = posttraumatic stress disorder; VA = Department of Veterans Affairs; VBA = Veterans Benefits Administration; VHA = Veterans Health Administration.

^a Lay evidence is evidence not requiring specialized education, licensing, or experience and is considered competent when it is provided by a person with knowledge of facts or circumstances and relates to matters that can be observed and described by a layperson.

^b Marker evidence refers to behavioral changes following trauma (e.g., requests for a change in duty assignment, shifts in performance/performance evaluations, disciplinary or legal problems, substance use, tests for pregnancy or sexually transmitted infections).

example, there is no chronic pain DBQ, and the physical symptoms (e.g., pelvic pain) would be assessed separately from the psychological symptoms (e.g., depressive symptoms). In such cases, assessing the full spectrum of functioning may require multiple examiners with different expertise to conduct separate examinations, which can be burdensome for veterans and contribute to claims processing delays. Therefore, the committee recommends the following:

Recommendation 5-1: When assessment of the full spectrum of impairments requires multiple, separate compensation and pension examinations, scheduling should be coordinated to reduce burden on the veteran, whenever possible. To facilitate this coordination, the Department of Veterans Affairs should consider scheduling examinations at a proximate location and time, using telehealth when feasible.

Prior reviews of the facilities that contract examiners use for C&P examinations identified deficiencies in accessibility, safety, and cleanliness. Furthermore, a physically and psychologically safe environment (encompassing the entire facility, e.g., lobbies, waiting rooms, exam rooms) is critical as part of a trauma-informed approach to C&P exams related to MST, but veterans have reported feeling unwelcome and unsafe in C&P exam facilities. Providing veterans with the option of having a virtual C&P examination conducted remotely such as from a safe space of their choosing could lessen the potential for retraumatization and promote collaboration, mutuality, and empowerment, while also increasing accessibility. To align C&P exams with best practices in trauma-informed care, the committee recommends the following:

Recommendation 5-2: The Department of Veterans Affairs (VA) should define and set standards (e.g., well-lit exteriors, low noise levels, access to private areas) to ensure physical and psychological safety in environments where compensation and pension examinations related to military sexual trauma (MST) are conducted. For contracted exams, the Veterans Benefits Administration Medical Disability Examination Office should prioritize referring veterans whose claims are related to MST to examinations at facilities that meet these standards, produce annual reports on their adequacy, and articulate a process for evaluating and rectifying deficiencies identified in such facilities within a year of receiving this report. As an accommodation for individuals with claims related to MST, VA should also inform claimants of the right to request a remote, virtual examination when clinically appropriate.

The C&P exam typically includes a review of the claims folder, medical interview, and clinical examination. Examiners are responsible for reviewing

the veteran's claims folder for relevant evidence. However, because claims folders average between 2,000 and 4,000 pages per claim, and vendors face challenges with incompatible systems, examiners may miss relevant evidence. Establishing standards and ensuring that vendors meet information system requirements could mitigate these challenges and ensure timely and accurate claims processing.

Recommendation 5-3: The Veterans Benefits Administration Medical Disability Examination Office (MDEO) should develop minimum standards for information systems of contract compensation and pension examination vendors (including interoperability requirements to view Department of Veterans Affairs bookmarks and annotations) and incorporate these standards as requirements in any new contracts executed between MDEO and contract examination vendors.

C&P examiners follow DBQs that guide clinical examinations. Because MST is an experience and not a diagnosis, examiners follow the DBQs for the relevant body system or condition. The lack of prompts to identify MST markers and otherwise link an MST experience to a condition in the DBQs may result in inaccurate or incomplete DBQs. Additionally, most DBQs do not adequately capture MST-related symptoms and conditions or provide examiners with instructions for linking these to the MST experience, leading to potential missed diagnoses or inaccurate opinions of service connection. The committee considered three alternative options for improving DBQs: VA could edit all DBQs to include specific MST exam prompts to collect required information for MST claims; develop a DBQ that is specific to MST claims, which would include evaluation of all potential physical and mental health challenges that result from MST in one DBQ; or develop a form for claims developers and examiners to document evidence and facilitate the development of clinical opinions about the occurrence of MST and service connection. Each of these options would guide examiners through MST-specific C&P exam requirements and could incorporate MST-specific prompts and instructions including trauma-informed strategies. However, each had notable disadvantages, and none address the underlying complexity of MST claims or the key obstacle of providing formal or informal evidence of MST, for which reason the committee does not prefer any of these strategies.

The committee was tasked with assessing the necessity of internal pelvic exams, which can be especially triggering for veterans with MST histories due to their sensitive nature, and considering potential alternatives. Pelvic exams are not common for MST-related claims. Nevertheless, most—if not all—gynecological conditions associated with MST can be adequately evaluated for their presence and impairment from history and medical record

review alone. Therefore, compared with diagnostic or therapeutic health care encounters where internal pelvic exams can inform diagnosis or treatment and consistent with clinical guidelines that recommend against routine pelvic exams in asymptomatic, nonpregnant adult women, conducting pelvic examinations for C&P examinations would rarely benefit disability assessment. If an examiner who is appropriately credentialed to perform pelvic exams determines that a pelvic exam may be needed to assess and document a claimed condition, (e.g., when a new condition requires diagnosis during the C&P exam), applying trauma-informed principles such as shared decision-making, practicing clear communication, and informing claimants of their right to a chaperone could minimize retraumatization.

If requested, examiners use the findings from the exam and the documentation in the veteran's claims folder to draft an opinion of service connection. The different evidentiary standards for PTSD and non-PTSD claims related to MST result in different requirements for medical opinions. Nonetheless, requiring examiners to provide medical opinions about whether evidence is consistent with an MST experience (for PTSD claims) and whether the claimed condition is related to MST (for all claims) is likely to lead examiners to ask veterans to retell their stories during an examination. Because corroborating traumatic events is not standard clinical practice and VA does not provide sufficient training, requiring examiners to do so may lead to rating inaccuracies and retraumatization. To that end, limited training, and guidance and an evolving evidence base on the health effects of MST make developing and drafting MST nexus opinions difficult. Additional training and standardized guidance as well as VA-vetted scientific resources developed with VHA expertise could improve consistency and evidence-based decision-making. A particular concern relates to the lack of clarity about when to provide medical opinions for conditions that a veteran does not claim but are identified during a C&P examination, which results in differing interpretations of rules by vendors and VHA as well as different protocols to address the ambiguity. These differing interpretations and protocols result in inconsistent decision-making, lack of transparency in the MST claims process, and inaccurate ratings. To ensure that examiners assess and provide information on the full spectrum of a veteran's impairment related to MST, that examination reports are comprehensive and fully considerate of their clinical findings and opinions, and that VA has timely information on a veteran's impairments required to accurately and efficiently rate and adjudicate an MST-related disability claim, the committee recommends the following:

Recommendation 5-4: The Veterans Benefits Administration Medical Disability Examination Office (MDEO) should clarify and provide consolidated guidance and training for examiners about when Disability Benefits Questionnaires (DBQs) or medical opinions for additional

conditions diagnosed during the examination or identified based on a review of the veteran's records are required, permitted, or prohibited. In cases where such DBQs or medical opinions are required or permitted, MDEO should establish standardized processes for examiners to do the following:

- a. Clarify the examination and/or medical opinion request prior to any examination, and
- b. Submit unrequested DBQs and/or medical opinions for additional conditions identified.

Examiners submit completed documents to VBA for review of the full claims folder to determine if there is complete and sufficient evidence for adjudication. If additional information is needed, VBA can request clarification or correction from examiners. If complete, VBA reviews the evidence, evaluates the claim with respect to service connection and impairment, and applies the VA Schedule for Rating Disabilities (VASRD) to assign a disability rating. The VASRD is a system codified in federal regulations (38 CFR Part 4) that assigns a percentage rating from 0 to 100 percent to each disability, reflecting the extent to which it affects the veteran's daily functioning. The VASRD is organized into sections corresponding to different body systems and conditions, which comprise many codes (i.e., four-digit code numbers assigned to medical diagnoses). When a veteran has multiple disabling conditions, the individual ratings are combined using a combined rating table to ensure the total rating does not exceed 100 percent. Most DBQs gather information on multiple diagnoses (e.g., for foot, plantar fasciitis, hammer toes, flat foot, etc.), each with its own VASRD code. In addition, a single VASRD can map to multiple DBQs. Thus, with multiple conditions, as is common for MST-related claims, disability ratings become very complex.

The VASRD has several limitations with respect to conditions associated with MST. It does not include some conditions associated with MST, especially physical health conditions such as chronic pelvic pain and injuries. Additionally, lack of standardized terminology and descriptions of conditions and symptoms, limited guidance on how responses in the DBQs translate to criteria in the VASRD, poor alignment between the level of disability described in some DBQs and the corresponding sections of the VASRD, and the omission of common health conditions associated with MST in the VASRD may result in inaccurate or incomplete disability ratings for conditions related to MST. Therefore, the committee recommends the following:

Recommendation 5-5: Within one year of this report and at least every five years thereafter, the Department of Veterans Affairs should review and revise Disability Benefits Questionnaires and the corresponding

sections of its Schedule for Rating Disabilities to ensure that they capture health conditions, including both physical and mental health conditions, that emerging scientific evidence has shown are associated with military sexual trauma and for optimal alignment, especially regarding specific rating thresholds.

Once VBA has assigned a rating, it notifies the veteran of the claim decision. If approved, veterans receive benefits; if denied or if veterans disagree with the decision, they may appeal through VBA and the Board of Veterans' Appeals. The appeals process can require additional C&P examinations, requests for information, and testimony, which can be retraumatizing.

Evidentiary requirements have been a major barrier to substantiating MST-related disability claims. Military service itself elevates the risk of sexual trauma while elements of the military context pressure service members not to disclose MST experiences. This makes MST not only a personal trauma but a service-related trauma. VA's evidentiary standards for MST are higher than those for other service-related exposures where there is a low likelihood of evidence corroborating a known exposure such as combat-related trauma, other in-service trauma exposures (i.e., fear of hostile military or terrorist activity, prisoner-of-war experiences), and toxic military exposures. Having not reported MST experiences contemporaneously currently impedes a veteran's subsequent access to VA disability. Evidence shows that MST-related claims are more likely to be denied than combat-related claims and that men and Black claimants were more likely to have MST-related claims denied, which suggests that the evidentiary standards are a barrier to service connection. Furthermore, VA's two standards of evidence for MST-related claims result in different processes for PTSD and non-PTSD claims, which makes MST-related claims more complicated than other claims and results in inconsistent decision-making and potentially inaccurate ratings and compensation for non-PTSD conditions compared with PTSD. VA could allow the use of lay evidence and behavioral markers for non-PTSD claims as is done for PTSD claims. This would establish a single standard and significantly improve the MST disability determination process but nonetheless fails to address significant inconsistencies between the standards for disability evaluations related to MST experiences and those for other traumatic experiences during military service. Therefore, to reduce burden on and potential harms to veterans, simplify the claims development and research procedures, improve the timely processing of disability claims related to MST, improve rating accuracy, and ensure fairness in compensating veterans for disabilities related to MST, the committee recommends the following:

Recommendation 5-6: The Department of Veterans Affairs should use a single evidentiary standard and process for assessing military sexual trauma-related claims.

Recommendation 5-7: Congress should enact legislation directing the Secretary of Veterans Affairs to accept evidence from laypersons or other sources as sufficient proof of service connection of any condition claimed to have been incurred or aggravated by experiencing military sexual trauma (MST), regardless of whether there is an official service record of the MST experience or an associated condition. The Secretary should amend adjudication regulations to eliminate the requirement for corroborating a veteran's lay testimony of MST as an in-service event with evidence and allow service connection to be established if the following apply:

- a. A Department of Veterans Affairs (VA) provider or a provider with whom VA has contracted confirms that MST is adequate to support the diagnosis of a claimed disability (i.e., the veteran's diagnosis and symptoms are related to the MST experience),
- b. The MST experience is consistent with the circumstances and conditions of the veteran's service, and
- c. There is no clear and convincing evidence to the contrary in the veteran's record.

Eliminating the requirement to prove MST occurred with evidence aligns VBA's disability evaluation process with standards of care for clinical and forensic examinations for patients who have experienced sexual trauma (including VHA policy for providing care for conditions related to MST, the Department of Justice's *A National Protocol for Sexual Assault Medical Forensic Examinations*, and clinical and policy guidelines of the World Health Organization and medical specialty societies), none of which require corroborating experiences of sexual trauma with proof. It is also consistent with best practices for clinical care related to trauma more broadly, including VA and Department of Defense's clinical practice guidelines for treating trauma-related health conditions and the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, diagnostic criteria for trauma- and stress-related disorders. It also addresses the requirement to document a single incident of MST when MST may result from the cumulative effect of sexual harassment and a series of incidents of assault at various levels of severity. The recommendation recognizes that military service is associated with an increased risk of MST, just as VA recognizes that veterans who have served in combat or in a combat zone are at higher risk of traumatic exposure, and speaks to a principle that when military service is found to be associated with traumatic experiences, it is reasonable to assume that

such traumatic events are as likely to have occurred as not. Thus, this policy change aligns the MST claims process with VBA's disability compensation process for combat-related trauma exposures, and the committee's proposed legislative and regulatory changes could be similar to the exceptions set out in 38 USC § 1154(b) and 38 CFR § 3.304.

Eliminating the requirement to provide proof of MST involves a trade-off between increased sensitivity (i.e., ensuring that veterans with MST-related disability receive service-connected disability benefits) and decreased specificity (i.e., the potential risk of fraud associated with unfounded reports of MST). The financial compensation and other benefits available to veterans with service-connected disabilities can create an incentive for veterans to malingering or commit fraud. The committee was not tasked with examining fraud in the disability compensation program, but in the evidence it examined, it did not identify evidence of systemic, widespread, or otherwise notable fraud specific to disability compensation related to MST or where VA has changed evidentiary standards for service connection. Additionally, VA would still require evidence of a current diagnosis or symptoms and would scrutinize the link between the reported MST and the related disability. Thus, the committee expects the risk of fraud from reducing the requirement to corroborate MST for disability compensation to be similarly low. Furthermore, any considerations of fraud would be balanced against the potential advantages of relaxing this requirement to include reducing retraumatization and other harms to veterans, simplifying the claims development and research procedures, improving the timely processing of disability claims related to MST, improving rating accuracy, and ensuring fairness in compensating veterans for disabilities related to MST. Finally, to the extent that systemic issues with the disability compensation process and challenges in parts of the process beyond the examination adversely affect veterans with MST-related claims remain unaddressed, the disability compensation process may continue to retraumatize veterans who have experienced MST, inaccurately and inconsistently rate their disabilities, and contribute to an overall experience that is not trauma informed. Improving veterans' overall experience would require a comprehensive assessment of and improvements to the claims process encompassing claims filing, research and development, adjudication, and appeals.

1

Introduction

The Department of Veterans Affairs (VA) provides disability compensation in the form of a monetary benefit to veterans for health conditions related to military service.¹ Service-connected disability can also facilitate access to additional benefits including health care and educational support. VA provides this benefit for conditions related to military sexual trauma (MST), which for the purposes of disability compensation refers to “a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment during active military, naval, air, or space service.”² MST is distinct from other forms of sexual trauma because it includes both sexual assault and harassment, thus capturing not only isolated incidents of assault but also the cumulative impact of sexual harassment or a series of assaults of varying severity. Notably, MST includes experiences of sexual assault or harassment regardless of whether they were perpetrated by other service members or whether they occur on or off base. MST differs from other forms of sexual trauma because it occurs within the unique military context. Some aspects of military norms, values, and culture uniquely influence the risk of experiencing sexual assault and sexual harassment, the likelihood of disclosure, and the consequences of the MST experience on health and well-being. Anyone can experience MST, but some groups including women and sexual minorities have higher risk of MST and different groups may experience different barriers to reporting (such as by gender, race/ethnicity, and sexual orientation) (Barth et al., 2016; Biskupski-Mujanovic et al.,

¹ 38 USC § 1110, Basic entitlement; 38 USC § 1131, Basic entitlement.

² 38 USC § 1166, Claims involving military sexual trauma.

2025; Bourke, 2022; Brown et al., 2021; Grau et al., 2022; Gurung et al., 2018; Nichter et al., 2022; Schuyler et al., 2020; Webermann et al., 2023).

MST is not a diagnosis or a disability but a qualifying in-service event that can lead to physical and mental health conditions for which VA provides disability benefits. To be eligible for disability compensation related to MST, VA requires evidence of (1) the occurrence of MST, (2) current symptoms or conditions, and (3) a link between the claimed condition and MST (i.e., service connection) (VA, 2025).³ Evidence to support VA decision-making with respect to these three criteria often includes findings from compensation and pension (C&P) exams, or disability evaluations that provide clinical evidence to inform VA's claims determination. Importantly, these exams differ from regular medical exams conducted for diagnosis or treatment because they are typically performed only once for the purpose of confirming the presence and extent of functional impairment due to the claimed disabling condition(s) and to establish service connection. The Veterans Benefits Administration (VBA), which oversees the delivery of disability benefits, requests these exams, which are performed by clinicians known as C&P examiners who are primarily contracted by VBA and, less commonly, employed by the Veterans Health Administration (VHA). Notably, the proportion of exams performed by VHA in-house compared with those conducted by contracted examiners has shifted substantially over time, concurrent with an overall increase in the number of disability compensation claims and corresponding C&P examinations; contracted examiners conducted 20 percent of exams in 2013 and more than 90 percent in 2024 (CRS, 2022; GAO, 2025). This has created a new disability evaluation workforce that lacks the traditional competencies and experiences of VHA in-house clinicians, especially related to trauma-informed approaches and military cultural competence.

C&P examinations, especially those performed by contractors, have been subject to prior scrutiny in multiple reviews of the VA Office of Inspector General and the Government Accountability Office, some of which were specific to MST claims (GAO, 2018, 2021, 2024; VA OIG, 2021a, 2021b, 2022a, 2024, 2025). These prior reviews identified a range of issues and problems with the exams related to their quality, the facilities where they occur, and the training of the clinicians performing the exams, as well as recommended remedies. In response to these reports, VA has reported improvements to the claims process overall and specific to MST exams. For example, VA has reported improving its platform for training contracted examiners, improving the collection and review of contractor performance data, implementing new policies and procedures (including those related

³ 38 CFR § 3.303, Principles relating to service connection; 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service.

to complex claims such as MST), and implementing and applying financial incentives and disincentives tied to contractor performance (GAO, 2018, 2021; VA OIG, 2022a, 2022b, 2024). Specific to MST, VBA also reports targeted improvements to MST claims processing, such as updating materials to incorporate trauma-informed language, updating the tool used to guide claims processors to determine whether and when to request clinical opinions of service connection for MST claims to better reflect when they should be requested, and consolidating the processing of MST claims to be performed by MST-trained claims processors at designated claims processing sites (Hutchinson and Hyberger, 2025). Nonetheless, veterans who have experienced MST continue to raise concerns about their experiences undergoing disability examinations. For example, specific concerns and barriers include insufficient examiner training, especially for contractors; retraumatization owing to poor and inconsistent application of trauma-informed care; lack of parity between claims for mental health and physical sequelae of MST; claims processing delays for MST claims compared with other claims; and the administrative and emotional burdens associated with providing multiple forms of proof that the veteran experienced MST (Breuer, 2025; Clemens, 2025; Howell, 2025; Mathis, 2025; McGuire, 2025; Noel, 2025). Focusing on the tools and protocols used for mental health and physical C&P examinations, as well as on the credentialing and training necessary for the clinicians who perform these exams, this study builds on the work of prior reviews aimed at improving the disability compensation process to ensure that veterans are able to receive timely and accurate compensation for health conditions related to their military service.

STATEMENT OF TASK

In accordance with Public Law 117-289 (see Appendix A), the National Academies of Sciences, Engineering, and Medicine convened an ad hoc committee to undertake a comprehensive review of VA's protocols for the disability examinations used to determine compensation for mental and physical health conditions related to MST. In addition, the committee is tasked with assessing the training and credentials of the health care providers performing these examinations. The complete Statement of Task is in Box 1-1.

Interpreting the Statement of Task

The committee's charge focuses on VA disability examinations for MST-related claims, including related tools, protocols, and the credentialing and training of providers performing these exams. To understand the context in which these disability exams occur, the committee found it necessary to

BOX 1-1
Statement of Task

An ad hoc committee under the auspices of the National Academies of Sciences, Engineering, and Medicine will assess the examinations given by the Department of Veterans Affairs (VA) to determine compensation for mental and physical conditions linked to military sexual trauma. The review of the way that impairments arising from military sexual trauma are assessed will examine:

1. The adequacy of tools and protocols to include:
 - a. The Disability Benefits Questionnaires;
 - b. The VA's schedule of rating disabilities;
 - c. Whether certain conditions linked to military sexual trauma require a referral for both a mental and physical health examination; and
 - d. The necessity of internal pelvic examinations to diagnose certain conditions, and potential alternatives to these examinations.
2. What credentials and training are necessary for a health care specialist or provider to perform examinations related to physical health conditions linked to military sexual trauma for both men and women, to include:
 - a. Sexual dysfunction;
 - b. Pelvic pain;
 - c. Pelvic dysfunction;
 - d. Musculoskeletal disabilities;
 - e. Cardiovascular conditions, including stroke.
3. What credentials and training are necessary for a health care specialist or provider to perform examinations related to mental health conditions linked to military sexual trauma for both men and women.
4. The quality of military sexual trauma training for those who perform these examinations, including recommendations for improvement of the training.

The committee shall produce a final report detailing its process and offer any findings, conclusions, and recommendations, to include those on legislative or administrative action to improve the adjudication of claims.

review the entire claims process from a veteran filing a claim to VA making a claims decision. Moreover, to the extent that certain elements of the disability determination process beyond the clinical examinations themselves shape the conduct of the examinations and the resultant clinical findings about impairment and service connection, the committee interpreted these elements to be within the scope of its evaluation. For example, insofar as VA collects and provides C&P examiners with the records that they are encouraged or required to review when developing their clinical opinions about impairment and service connection, the committee interpreted the contents of such records and the methods by which VA identifies and transmits these records to the examiners as within its charge. Similarly, because the standards of evidence VA uses to determine eligibility for disability benefits dictate examiner protocols in providing such evidence (in the form of a clinical opinion), the committee also interpreted these standards as within scope. At the same time, the committee acknowledges that elements of the claims process beyond the exam (e.g., during claims development, adjudication, and appeal) comprise part of a continuum of exposure and care for veterans who have experienced MST and contribute to an overall experience of the claims process but are beyond the scope of the committee's task. Relatedly, the committee also acknowledges that there are certain issues for C&P exams related to MST claims that are associated with the disability compensation or VA's health care delivery systems more broadly and for which remedies targeted at improving the disability evaluation process for MST-related claims could produce unintended second-order effects in other areas of veterans' benefits or health care delivery. The committee interpreted such issues as out of scope for its assessment. To that end, two inconsistent statutes define "military sexual trauma" as applied to health care and benefits for veterans. For the purposes of VHA health care delivery, MST refers to experiences that "occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination,"⁴ and thus includes MST that National Guard and Military Reserve members experience while on inactive duty training. In comparison, for the purposes of disability benefits, MST refers to experiences that occurred "during active military, naval, air, or space service"⁵ and are therefore limited to MST experienced while on active duty, which reflects the more restrictive requirements for disability compensation more broadly. Although the committee acknowledges this inconsistency and opportunity for alignment, it is not within the committee's scope to address how disability compensation related to MST applies to line of duty determinations for members of the National Guard and Military Reserves.

⁴ 38 USC § 1720D, Counseling and treatment for sexual trauma.

⁵ 38 USC § 1166, Claims involving military sexual trauma.

The committee is also narrowly charged with assessing “[w]hether certain conditions linked to military sexual trauma require a referral for both a mental and physical health examination.” The committee interpreted this to mean whether there are conditions that require the claims developers to refer a veteran for both a physical (medical) and mental health C&P exam to determine whether that single condition is present and service-connected and to assess the level of impairment associated with that single condition. For example, the committee’s interpretation would mean that to assess chronic pain, it would assess whether separate exams are needed to assess the physical causes of chronic pain (traumatic, vascular, neurological, etc.) and psychological symptoms (posttraumatic, anxiety, depression, etc.). The committee addresses this task in Chapters 4 and 5.

COMMITTEE PROCESS AND APPROACH

The committee comprises expertise in gynecology, military and veterans’ health, psychiatry, psychology, physical and mental health evaluations (including forensic examinations), public policy, and sexual trauma. The committee includes individuals with direct experience performing C&P examinations, including for claims related to MST. Appendix B includes biographical sketches of the committee members. The committee held four public information-gathering sessions (see Appendix C). Representatives from VA, including representatives from multiple offices in VHA and from the VBA Medical Disability Examination Office, shared information about VA’s disability determination process, C&P examinations, examiner training and credentials, and MST at the first and third information-gathering meetings. At the second information-gathering meeting, the committee heard the perspectives of veterans and those supporting them through the disability compensation process from representatives (including VA Accredited Representatives) of veterans service organizations and other veterans’ advocates, including Disabled American Veterans, the National Organization of Veterans’ Advocates, Paralyzed Veterans of America, Veterans of Foreign Wars, Ward Circle Strategies, and the Wounded Warrior Project. At the fourth information-gathering session, the committee heard from representatives of Optum Serve, one of the vendors of contracted disability examinations. The committee also received written feedback in response to requests for information from VA and each of the four vendors who contract with VA to provide C&P exams: Leidos QTC Health Services,

Loyal Source Government Solutions, Optum Serve, and Veterans Evaluation Services.⁶ These representatives include individuals who have regular, practical experience supporting veterans to file claims and request decision reviews for disability compensation related to MST as well as clinicians who perform C&P examinations for MST-related claims. VA also provided access to its MST training courses.

The committee carefully considered whether to solicit direct input from veterans who experienced MST and had experience applying for disability compensation and undergoing C&P exams. Consistent with principles of a trauma-informed approach, to limit potential retraumatization by asking veterans to retell their MST experiences and experiences with VA's disability claims process, the committee decided not to request direct input from survivors of MST. Because all consensus committees of the National Academies are subject to Section 15 of the Federal Advisory Committee Act, which requires that information-gathering meetings are open to the public and material (written and other media) that external individuals or organizations present to the committee at any time during the course of the study must be made available to the public, the committee's options for ensuring a confidential and safe forum for individuals who have MST histories to share their lived experiences were limited. To learn about the perspective of individuals who had experienced MST and applied for disability compensation, the committee heard from veterans' representatives and advocates (at its third information-gathering meeting, as described above), reviewed materials in the public record (e.g., in reports, videos, transcripts, and other media from congressional testimony, veterans service organizations, and VA) that documented MST survivors' voices and experiences, and reviewed the scientific literature. The committee did not believe that asking veterans with MST histories to retell their MST experiences to the committee in open forum would significantly add to the evidence and perspectives already shared in these sources. Nonetheless, the committee welcomed additional written input from all members of the public via its project website.

The committee's work was guided by the aim to ensure a high-quality disability evaluation process for MST-related claims that has reproducible outcomes, minimizes burden on veterans, and awards claimants fairly. The committee defined a high-quality process as one that is evidence-based, trauma-informed, accessible in place and time, accurate (meaning it facilitates the correct assessment of impairment and service connection), and transparent (meaning the process and decision-making are clear for

⁶ In accordance with the National Academies' obligations under Section 15 of the Federal Advisory Committee Act, responses are available in the project's Public Access File, available through the National Academies Public Access Records Office, as is all information from external sources provided to the committee.

claimants, examiners, and VA). A trauma-informed approach incorporates six principles—safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural, historical, and gender issues (see Box 1-2) (SAMHSA, 2014, 2024). Having “reproducible outcomes” refers to a process in which variation is associated with the presentation of a claimant’s case and not with the examiner who conducts the examinations or the location of the exam. In addition, “minimizing burden” refers to lessening administrative burdens such as the collection of multiple forms of evidence, as well as emotional ones like retraumatization. Lastly, “fair compensation” means that veterans receive compensation based on accurate assessments of impairment and service connection within existing rules and regulations. Having defined these criteria, the committee then evaluated the existing examination process and the potential alternatives and improvements relative to these goals.

OVERVIEW OF THIS REPORT

Chapter 2 provides an overview of MST, including how it is defined and measured, risk factors of MST, how it differs from other forms of sexual trauma, and its wide-ranging health consequences. Chapter 3 presents current credentialing and training requirements, as well as the committee’s recommendations for improving credentialing and training. Chapter 4

BOX 1-2 Trauma-Informed Principles

- **Safety:** Ensuring safe physical settings and interpersonal interactions.
- **Trustworthiness and Transparency:** Care and decisions made with clarity, consistency, respect, and fairness to build trust.
- **Peer Support:** Support from those with lived experiences of trauma.
- **Collaboration and Mutuality:** Partnerships and the leveling of power differences between and among providers and patients.
- **Empowerment:** The recognition of and building upon individuals’ strengths and experiences.
- **Cultural, Historical, and Gender Issues:** Understanding the perspectives, beliefs, and other context that influence both how clinicians provide care and how patients receive it and applying gender inclusive and culturally responsive approaches to caring for patients.

SOURCES: Purkey et al., 2018; SAMHSA, 2014, 2024.

provides an overview of the existing claims and C&P examination process and the committee's assessment of the process. Chapter 5 presents potential alternatives to existing tools and protocols for the C&P examinations, which are intended to support high-quality disability evaluations for MST-related claims, as well as additional recommendations.

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2

Military Sexual Trauma and Health

Military sexual trauma (MST) is a statutorily defined term that the Department of Veterans Affairs (VA) uses, which, for the purposes of disability claims, refers to “a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment during active military, naval, air, or space service,”¹ where sexual harassment refers to “unsolicited verbal or physical contact of a sexual nature which is threatening in character.”² The definition of MST includes any sexual assault or harassment that occurs while serving in the U.S. Armed Forces regardless of whether the experience happened on a military base or whether the perpetrator is also a member of the military (Galovski et al., 2022). Examples of MST include pressure or coercion to engage in sexual activities, sexual contact without consent, being overpowered or forced to have sex, hazing with sexual elements, ongoing comments about someone’s body or sexual behavior, and unwanted sexual advances (VA, n.d.–b).

Estimates of MST prevalence vary by study but range from approximately 15 percent to more than 70 percent. Estimating MST prevalence is challenging because it relies on personal disclosure, and service members and veterans may be reluctant to report or disclose a traumatic event, especially during service, due to stigma, the status of perpetrators, fear of retaliation, and fear of disrupting team cohesion (described in more detail below) (Andresen and Blais, 2019; Lofgreen et al., 2017; Mengeling et al., 2014). The most recent meta-analysis on MST prevalence included 69 studies

¹ 38 USC § 1166, Claims involving military sexual trauma.

² 38 USC § 1720D, Counseling and treatment for sexual trauma.

published before 2018 and found that 15.7 percent of service members and veterans reported any MST, of whom 13.9 percent reported sexual assault only and 31.2 percent reported sexual harassment only (Wilson, 2018). Prevalence was substantially higher among women (38.4 percent any MST, 23.6 percent assault only, 52.5 percent harassment only) than men (3.9 percent any MST, 1.9 percent assault only, 8.9 percent harassment only) (Wilson, 2018). Veterans Health Administration (VHA) policy mandates universal screening for MST for all veterans receiving care at VHA, and prevalence estimates based on these data are similar to those in the 2018 meta-analysis.³ Data provided by VHA show approximately one in three women veterans ($n = 211,071$) and one in 50 men ($n = 102,644$) veterans who completed the MST screening reported ever having experienced MST (Eggers, 2026). Recent studies have also reported similar estimates based on VHA electronic health record data (where screening results are documented) but higher estimates based on surveys, which suggest that the MST screen may underestimate the true prevalence of MST (Gaffey et al., 2025; Hargrave et al., 2022). Using 2001–2021 VHA data and 2016–2020 data from the Women Veterans Cohort Study, Gaffey and colleagues (2025) found that 29 percent of women and 2 percent of men had a positive VHA MST screen, but 64 percent of women and 9 percent of men reported experiencing MST when surveyed. Similarly, in a study of women veterans aged 45–64 enrolled in VHA care, Hargrave and colleagues (2022) found that 40 percent had a positive VHA MST screen, but 74 percent of women had survey-reported MST. An analysis of data from the 2019–2020 National Health and Resilience in Veterans Study (NHRVS), a nationally representative sample of U.S. veterans, found that 44.2 percent of female survey respondents and 3.5 percent of male respondents reported experiencing MST (Nichter et al., 2022). The Department of Defense (DOD)⁴ does not use the term “military sexual trauma,” instead referring to military sexual assault and military sexual harassment separately. Analyses of the 2023 Workplace and Gender Relations Survey of Military Members (WGR), a congressionally mandated study that provides official estimates of sexual discrimination, sexual harassment, and unwanted sexual contact in DOD, found that among active-duty respondents, 24.7 percent of women and 5.8 percent of men reported experiencing sexual harassment, and 6.8 percent

³ VHA Directive 1115, Military Sexual Trauma (MST) Program (2018).

⁴ The committee acknowledges that the Department of Defense uses the name Department of War per Executive Order 14347, Restoring the United States Department of War (September 5, 2025). The committee chose to use the term Department of Defense throughout this report for clarity and consistency, as that was the department’s official name when the policies, procedures, training courses, reports, and other materials reviewed by the committee were published and how it was referred to in those materials.

of women and 1.3 percent of men reported experiencing unwanted sexual contact (comprising different forms of sexual assault) in 2023 (Samuelson et al., 2024).

Anyone can experience MST, and some groups are at higher risk than others. As described in the previous paragraph, women are much more likely to experience MST than men. Two studies reported small differences in MST prevalence by race and ethnicity. In a large retrospective cohort study of more than 30,000 veterans, the highest proportion of women who screened positive for MST were non-Hispanic White women (43 percent), followed by Hispanic women (42 percent), those with unknown race or ethnicity (42 percent), and non-Hispanic Black women (38 percent) (Barth et al., 2016). Among men, non-Hispanic Black men reported the highest prevalence (6 percent), followed by non-Hispanic other race (just under 6 percent), Hispanic (4 percent), and non-Hispanic White men (3 percent) (Barth et al., 2016). Another large population-based survey of veterans showed that the distribution of race and ethnicity did not differ between those who experienced MST and those who did not (Nichter et al., 2022). Evidence also shows that sexual minorities are at a higher risk for experiencing MST. In a nationally representative survey of veterans, sexual minority veterans had higher prevalence of MST than heterosexual veterans (22.7 percent among bisexual, pansexual, or queer veterans; 17 percent among lesbian or gay veterans; and 6.5 percent among heterosexual veterans) (Webermann et al., 2023). In a mixed-methods study of 500 active military service members, lesbian, gay, bisexual, or transgender (LGBT) service members were approximately four times more likely than heterosexual peers to experience sexual harassment and approximately twice as likely to experience sexual assault (Schuyler et al., 2020). A smaller study of veterans who identified as LGBT showed similar rates of MST; 83 percent of lesbian or bisexual women reported one incident of MST, and 74 percent of the men who identified as gay or bisexual reported one incident of MST (Gurung et al., 2018).

MST often occurs in the context of cumulative trauma, which refers to the interaction of multiple, repeated harmful experiences over the veteran's life course, including that person's time in service, that can exacerbate the physical and mental health outcomes of MST (Seamone and Traskey, 2014). Research shows that individuals who experience MST often report higher levels of adverse childhood experiences, particularly childhood sexual and physical abuse, compared with the general population (Lofgreen et al., 2017). Experiencing MST can exacerbate existing health effects of trauma experienced prior to entering the military. This is notable in the context of disability compensation because pre-service trauma does not negate the presence of traumatic effects of MST, and MST can aggravate the existing health effects of pre-service trauma. MST is also associated with elevated

rates of sexual assault in adulthood outside the military (Lofgreen et al., 2017).

MST is distinct from other forms of sexual trauma because it occurs in the context of military structure, culture, and norms. Military culture prioritizes norms such as masculinity, violence, and dominance, which may increase tolerance for sexual violence and minimize consequences of sexual trauma—for example, framing it as “hazing” (Castro et al., 2015; Lofgreen et al., 2017). At the same time, the military also emphasizes values such as loyalty, teamwork, sacrifice, and trust, creating an environment in which reporting a fellow service member may be perceived as a betrayal of the unit and disruptive to team cohesion (Castro et al., 2015; Lofgreen et al., 2017; Suris and Lind, 2008). It is difficult for survivors of sexual violence to report any form of sexual trauma regardless of whether it occurs in the military, but certain elements of military structure and culture can add to these obstacles. Barriers to reporting sexual trauma experienced during military service include stigma, the status of perpetrators, fear of retaliation, or beliefs that nothing will be done (Samuelson et al., 2024). Stigma often results from the persistence of harmful myths, including the belief that only women can be victims of sexual assault or that an assault is not credible if it was not reported immediately or lacks physical evidence (Castro et al., 2015). These myths can deter survivors from coming forward and contribute to disbelief or questioning when reports are made (Castro et al., 2015). Perceived retaliation for reporting MST experiences is common. In the 2023 WGR, more than 60 percent of service members who reported unwanted sexual contact to a DOD authority perceived at least one retaliatory behavior associated with their report (Samuelson et al., 2024). Beliefs that no action will result from reporting MST is also common. In addition, not thinking anything would be done was the most common reason (50 percent) women and the second most common reason (39 percent) men provided for not reporting the MST (Samuelson et al., 2024). These perceptions are grounded in evidence and experience. In 2024, the *Department of Defense Annual Report on Sexual Assault in the Military* showed that more than 1,000 of the 8,195 filed reports resulted in no action due to evidentiary limitations, statutes of limitations, victim preferences, or determinations that allegations were unfounded (DOD, 2025). Other aspects of the military that may discourage formal reporting include negative interactions with investigators (which can discourage reporting of future incidents), an emphasis on resolving interpersonal issues at the lowest possible level rather than involving higher-ranking personnel (which can discourage reporting to authorities), and practical challenges such as deployment and frequent geographic relocation (Castro et al., 2015; Goodman-Williams et al., 2024). Some of these challenges are exemplified in the testimony of the veteran

Victoria Sanders in a hearing before the health subcommittee of the U.S. House of Representatives Committee on Veterans' Affairs, who stated,

My rapist confessed to enough of his crimes that he was reduced in rank, lost pay, and was confined to barracks. This is an example of chain of command harassment because the barracks he was confined to was the one where I worked and he still worked in the office next door. When you report a rape you become public enemy number one. No one will talk to you. And if they do, it is to tell you, you got what you deserved. You are called names, you internalize what happened, and it feels like it is your fault. Even if your rapist is punished, harassment is limitless. (U.S. Congress, 2013)

A veteran's identity, such as that person's gender, race, ethnicity, and sexual orientation, can also be associated with specific challenges during military service that influence risk and likelihood of reporting MST. Women experience heightened scrutiny during their military service (such as having their competence and abilities questioned in ways that their male counterparts rarely experience); encounter barriers to advancement, fewer leadership roles, and limited recognition for their achievements; and encounter social isolation and difficulty forming supportive networks in predominantly male environments (Brown et al., 2021). These factors can elevate the risk of harassment and assault, decrease likelihood of reporting MST, and intensify the psychological and professional consequences for those affected (Bourke, 2022; Brown et al., 2021). Similarly, LGBT service members have historically experienced institutional disadvantages, such as the 1993 "Don't Ask, Don't Tell" policy, which perpetuated stigma and discrimination against this population (Biskupski-Mujanovic et al., 2025; Gurung et al., 2018; Schuyler et al., 2020). Experiences of harassment or assault are frequently intertwined with sexual orientation, which can make the trauma feel more personal, isolating, and difficult to process (Biskupski-Mujanovic et al., 2025; Gurung et al., 2018). This overlap contributes to more severe and persistent health consequences, including heightened risks of posttraumatic stress disorder (PTSD), depression, and substance use, even when compared with others who have experienced similar trauma (Schuyler et al., 2020; Webermann et al., 2023). The effects are further compounded by minority stress, where ongoing exposure to prejudice and barriers to support can deepen psychological distress and make recovery more challenging (Biskupski-Mujanovic et al., 2025; Webermann et al., 2023). Relatedly, racialized stereotypes and historical discrimination can shape how veterans who belong to racial and ethnic minorities experience and respond to MST, including leading to higher levels of institutional distrust, resulting in lower reporting of assaults and reduced engagement with treatment,

and creating additional barriers to recovery for affected veterans (Grau et al., 2022). Finally, men who experience MST may feel gender-based shame, stigma, and exacerbated institutional betrayal associated with violations of masculinity and sexuality (Yahalom et al., 2023).

The cultural pressures of the military can compound the trauma experienced by survivors, producing complex emotional and physical health consequences that are not adequately captured when MST is evaluated solely through frameworks used for general or combat trauma (Galovski et al., 2022; Lofgreen et al., 2017). Consequently, MST is associated with a constellation of consequences for health and well-being. Taking a Whole Health approach, which a prior National Academies of Sciences, Engineering, and Medicine committee defined as encapsulating “physical, behavioral, spiritual, and socioeconomic wellbeing as defined by individuals, families, and communities” (NASEM, 2023), the committee acknowledges that the adverse consequences of MST include medical conditions and downstream socioeconomic effects. Health consequences include short-term, acute effects such as injuries and sexually transmitted infections (STIs) and long-term effects, which may include both conditions with latency periods such as infertility and chronic pain syndromes, as well as secondary effects such as cardiovascular disease (CVD). Beyond medical diagnoses, MST is also associated with adverse effects on socioeconomic well-being, such as homelessness and unemployment, which can exacerbate health problems (Brignone et al., 2016; Millegan et al., 2015; Millegan et al., 2016).

The current VA disability compensation system is designed to compensate for the health and economic consequences of medical (physical and mental health) diagnoses, which are related to military service. Therefore, although the committee acknowledges that MST is associated with a wide range of adverse effects on health and well-being, this chapter focuses on describing diagnoses that are currently compensated by VA and where the evidence about the effects of MST on those conditions is most robust, followed by those with a growing body of evidence. As described in Chapter 1, the committee was tasked with assessing VA’s disability examination process for MST-related disability compensation claims. It is beyond the scope of the committee’s task to conduct a comprehensive and systematic review of the association between MST and health conditions or to identify additional conditions for VA disability compensation. The committee also acknowledges and briefly describes other symptoms and downstream sequelae of MST that are not currently captured by diagnoses but that may cause impairment. Moreover, this chapter describes individual relationships between MST and single conditions, but the committee acknowledges that these health conditions are multiple and overlapping, and the processes by which they develop are dynamic (Leroux, 2015; Spinhoven et al., 2014; Stander et al., 2014). For example, comorbid conditions such as chronic

pain and PTSD may have a potentially synergistic relationship such that those with comorbid pain and PTSD have reported significantly increased overall symptom severity and poorer quality of life than those with either disorder alone (Shapiro et al., 2023). This can make isolating the impairment and service connection associated with individual conditions, as VA's disability rating system requires, challenging.

HEALTH CONDITIONS RELATED TO MST

Mental, Behavioral, and Neurologic Health Conditions

MST has far-ranging mental, behavioral, and neurologic health consequences. According to DOD, veterans who have experienced sexual assault in the past year are more likely to receive a mental health diagnosis, have a mental health-related health care encounter, and receive a mental health-related prescription compared with veterans who did not report experiencing a sexual assault in the past year (DOD, 2025). MST has been linked to greater risk of mental and behavioral health conditions including PTSD, depression, generalized anxiety disorder (GAD), substance use disorders (SUDs), eating disorders, and suicidal thoughts and behaviors (STBs) (Blais et al., 2017; Gibson et al., 2020; Gilmore et al., 2016; Godfrey et al., 2015; Iverson et al., 2020; Kimerling et al., 2010; Kimerling et al., 2016; Klingensmith et al., 2014; Monteith et al., 2016; Street et al., 2008; Sumner et al., 2021). MST is also associated with neurologic health conditions, such as chronic pain and migraines (Cichowski et al., 2017; Gibson et al., 2020; Kimerling et al., 2007; Street et al., 2008; Sumner et al., 2021; Suris and Lind, 2008). Notably, these conditions often co-occur. For example, PTSD, depression, and anxiety are frequently comorbid (Spinoven et al., 2014; Stander et al., 2014). In addition, symptoms of multiple, discrete mental health conditions such as PTSD and personality disorder or PTSD and depression often overlap, making it difficult to assess and differentiate the timing and cause of onset or aggravation of each mental health condition separately (Leroux, 2015; Stander et al., 2014). These dynamic processes have important implications for VA disability evaluations because clinicians are often tasked with assessing whether individual disabilities were incurred or aggravated during service. The associations between MST and mental health and neurologic conditions are described in more detail individually in the sections that follow.

Posttraumatic Stress Disorder

PTSD is a condition that arises after exposure to actual or threatened death, serious injury, or sexual violence (APA, 2013). The traumatic

exposure can be direct or indirect (e.g., by witnessing the trauma, through close relations, or via repeated exposure in a professional context) (APA, 2013). Symptoms of PTSD include involuntary flashbacks and nightmares, avoidance of certain situations to avoid distressing memories, persistent negative beliefs or emotional state, and irrational or erratic behaviors (APA, 2013). PTSD onset can vary depending on the type of trauma and the intensity of the event. Symptoms usually begin within three months of the event but can also occur later (NIMH, 2023).

PTSD is one of the most common conditions among veterans who have experienced MST and service members who have experienced sexual assault or sexual harassment during service (Galovski et al., 2022). Large studies of veterans have shown that nearly half of veterans with a history of MST meet criteria for PTSD, and it is consistently the most frequently claimed disabling condition among veterans claiming disability related to MST (Kimerling et al., 2010). Evidence suggests that the risk of PTSD related to MST differs by gender. In an analysis of the 2019–2020 NHRVS, one-quarter of male veterans and nearly one-half of women veterans who screened positive for MST met criteria for current PTSD, representing two-to-three times greater odds of PTSD among men and five-times higher odds among women, as compared with those without MST histories (Nichter et al., 2022).

A large VHA study of women veterans found that a positive MST screen was associated with a significant fivefold increase in the odds of PTSD after accounting for demographic and military characteristics, as well as health care use (Sumner et al., 2021). In age-stratified results, a positive MST screen increased the odds of PTSD fivefold among women under age 55 but sevenfold among women age 55 and older, indicating that MST was more strongly associated with greater odds of PTSD among older women than younger women (Sumner et al., 2021). Consistent with these age-stratified analyses, a study of women veterans age 55 and older receiving VHA care also found a significant sevenfold increase in the odds of PTSD associated with MST in this older population (Gibson et al., 2020). In addition, MST is strongly associated with greater PTSD symptom severity compared with those who experienced other trauma exposures, including combat trauma. A 2024 literature review of MST, combat exposure, and mental health outcomes found that this association was robust across study designs and samples from different eras of service and of different gender composition (Yancey et al., 2024).

Evidence also suggests that PTSD risk and presentation may differ by gender and race/ethnicity. Some evidence indicates that veterans who are racial and ethnic minorities have higher odds of PTSD compared with White veterans, and this disparity is partially explained by differences in health behaviors, life stressors, and social support (McClendon et al., 2019;

Sharifian et al., 2024). One study found that Asian Pacific Islander women and Black men had higher odds of screening positive for PTSD and generally reported a broader range of symptoms (Koo et al., 2016). Other studies have shown that women are slightly more likely to report problems such as difficulty concentrating, distress, and avoidance, while men are somewhat more likely to report nightmares, emotional numbing, and hypervigilance (Hourani et al., 2015; King et al., 2013). Specific to MST, a small study of 126 veterans who screened positive for MST and were receiving treatment for PTSD showed that male and Black/African American veterans had significantly increased PTSD symptom severity compared with female and White/Caucasian veterans (Ceroni et al., 2023).

Anxiety

Anxiety disorders involve excessive feelings of fear and anxiety and can be categorized into subtypes such as GAD, panic disorder, and phobias (APA, 2013). Data on the association between MST and anxiety are mixed, and the association may vary by gender. Up to 30 percent of veterans who have experienced MST meet criteria for anxiety diagnoses. Results of the 2019–2020 NHRVS show that approximately 30 percent of men and 16 percent of women who have experienced MST met criteria for GAD (Nichter et al., 2022). Studies of veterans who received care at a VA facility have reported that approximately one-third of both men and women who screened positive for MST had an anxiety diagnosis (Gibson et al., 2020; Kimerling et al., 2010; Sumner et al., 2021). An analysis of cross-sectional data from the Millenium Cohort Study, a large prospective cohort study of U.S. service members and veterans, found differences in anxiety risk by gender and race/ethnicity. The elevated odds of anxiety among women persisted even after accounting for other factors, but, as with PTSD, the racial/ethnic disparities attenuated after accounting for health behaviors, life stressors, and social support (Merians et al., 2023; Sharifian et al., 2024; Yancey et al., 2024).

In the studies of veterans receiving VHA care, veterans with a positive MST screen have approximately double the odds of anxiety diagnoses compared with veterans who screened negative for MST, even after accounting for demographics, health care use, and military service characteristics (Gibson et al., 2020; Kimerling et al., 2010; Sumner et al., 2021). By contrast, the analysis of the population-based NHRVS showed that among men, MST was significantly associated with 2.67 greater odds of GAD, whereas the increased odds did not reach statistical significance among women after accounting for social and demographic characteristics, military service, and health care use (Nichter et al., 2022). The 2024 literature review of MST, combat exposure, and mental health outcomes reported similarly mixed

results, with some studies reporting an increased risk of anxiety associated with MST while others reported null results (Yancey et al., 2024).

Depression

Depression, or major depressive disorder (MDD), is characterized by symptoms that range from mild to severe and that negatively affect how patients feel, think, act, and perceive the world. The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* outlines symptoms, including persistent low moods, decreased interest in pleasurable activities, feelings of guilt, lack of energy, poor concentration, and sleep disturbances as common characteristics of MDD (APA, 2013). Depression in veterans is also associated with significant functional impairment, including reduced odds of employment, diminished social engagement, and greater difficulty sustaining roles in family and community contexts (Mosalpuria et al., 2024; Rattray et al., 2023; Vogt et al., 2019; Ziobrowski et al., 2021). The transition from military service to civilian life represents a vulnerable period for depressive symptoms; veterans shortly before or after discharge report poorer mental health and more depressive symptoms relative to normative samples, along with challenges such as financial stress and lower life satisfaction (Bond et al., 2022). Similar to patterns observed for PTSD and anxiety, some studies have found that women and certain racial and ethnic minority groups experience higher rates of MDD compared with men and White veterans, although these differences attenuate after accounting for health behaviors, life stressors, and social support (Merians et al., 2023; Sharifian et al., 2024). Depression is common among veterans who have experienced MST. In the 2019–2020 NHRVS, 27 percent of men and 14 percent of women who screened positive for MST met criteria for MDD (Nichter et al., 2022). Estimates are higher in studies of veterans receiving care from a VA facility, ranging from 44 to 56 percent for women and around 45 percent for men (Gibson et al., 2020; Kimerling et al., 2010; Sumner et al., 2021). MST has generally been found to be associated with increased depression symptoms and diagnoses, with some differences by gender. The 2024 systematic literature review investigating MST, combat exposure, and mental health symptoms found that MST was consistently associated with elevated depression diagnoses and symptoms in most studies, and MST was more strongly associated with depression (Yancey et al., 2024). Similar to the association with anxiety, multiple studies of VHA users have found that a positive MST screen is significantly associated with more than double the odds of depressive disorder diagnoses among both men and women (Gibson et al., 2020; Kimerling et al., 2010; Sumner et al., 2021), whereas men but not women who experienced MST had

significantly greater odds of meeting criteria for MDD in the population-based 2019–2020 NHRVS (Nichter et al., 2022).

Suicidal Thoughts and Behaviors

STBs include suicidal ideation, suicidal plans, suicide attempts, and completed suicides. Suicide is death resulting from self-inflicted harm with intent to die, while a suicide attempt involves self-directed behavior with intent to die that may not cause death or injury, and suicidal ideation encompasses thoughts, considerations, or plans of suicide (NIMH, 2025). Veterans have a substantially higher rate of STBs than the general population due to their increased exposure to risk factors such as mental health conditions, trauma exposures and traumatic brain injury (TBI), life disruptions, homelessness, and poverty (Ruiz et al., 2023). In 2022, there were 6,407 veteran suicide deaths, equaling roughly 17.6 suicides per day among veterans (VA, 2024). After adjusting for age, this equals more than 40 deaths per 100,000 persons among men veterans and nearly 15 deaths per 100,000 among women veterans. This contrasts with a rate of nearly 30 deaths per 100,000 among nonveteran men and fewer than 10 per 100,000 among nonveteran women (VA, 2024). While the absolute number of suicide deaths is greater in men than women, the difference in suicide rates between veterans and nonveterans is greater among women than men. An analysis of vital statistics death data linked to VA data found that the suicide rate for men veterans is 1.2 times higher than that of nonveteran men, whereas the rate for women veterans is nearly twice as high as that of nonveteran women (Ramchand, 2022). Suicide deaths were highest among veterans who identify as Multiple Race, followed by American Indian or Alaska Native, White, Native Hawaiian or Pacific Islander, Asian, and Black or African American veterans (VA, 2024).

MST is also associated with increased risk of STBs. Among 15 studies of service members and veterans assessing the relationship between MST and STBs included in a systematic review, all found that suicidal ideation, plans, and attempts were significantly associated with MST, except in one study that reported no association with suicidal ideation in the past year (Forkus et al., 2021). In each year between 2009 and 2022, the suicide rate was substantially higher among veterans receiving care at a VHA facility who screened positive for MST compared with those without MST experiences (VA, 2024). Specifically, in 2022, the rate was approximately 75 percent higher among both men (75.5 per 100,000 among those with a positive MST screen versus 43.2 per 100,000 for those with negative screens) and women (25.0 per 100,000 for positive screens versus 14.3 per 100,000 among those with negative screens) (VA, 2024). Similarly, studies of women veterans receiving care from VHA show between twofold and

threefold increased odds of suicidal ideation among those with positive MST screens compared with those with negative screens (Gibson et al., 2020; Sumner et al., 2021).

Eating Disorders

Eating disorders are serious medical conditions in which a person's thoughts about food, eating, body shape, or weight become deeply negative, leading to unhealthy eating behaviors such as extreme restriction, bingeing, or purging (Guarda, 2023). Common types include anorexia nervosa, bulimia nervosa, and binge eating disorder (Guarda, 2023). Eating disorders may lead to physical conditions and symptoms such as malnutrition, bone loss, digestive problems, cardiac issues, and other organ-system complications (Carlson and Lemly, 2024). Individuals with eating disorders are also more likely to experience depression, anxiety, difficulties with emotion regulation, substance use, and, in some cases, STBs (Attia and Walsh, 2025).

Multiple studies show that veterans who experience MST have approximately twice the likelihood of developing an eating disorder. In a sample of women veterans receiving VHA care, rape during service was linked to more than double the odds of having a diagnosed eating disorder and elevated odds of self-reporting one without diagnosis (Forman-Hoffman et al., 2012). Similarly, a large study of Afghanistan and Iraq veterans receiving VHA care showed that those with a positive MST screen were nearly twice as likely to have an eating disorder at both one and five years after deployment, compared with veterans who screened negative, after controlling for demographic and military service characteristics and psychiatric comorbidities (Blais et al., 2017). This study also found an interaction between MST and sex, with a stronger association between MST and eating disorder diagnoses among men than women (Blais et al., 2017).

Sleep Disorders

Sleep disorders are clinically recognized conditions that disrupt the ability to obtain healthy, restorative sleep, which can impair cognitive functioning, mood, physical health, and overall quality of life (Karna et al., 2023). Common sleep conditions include insomnia disorders and sleep-related breathing disorders (e.g., sleep apnea) (Karna et al., 2023). MST has been shown to be associated with increased sleep disturbances and disorders, though studies are limited. In a 2020 cross-sectional study of more than 70,000 women veterans receiving VA health care, Gibson and colleagues found that veterans with a positive MST screen had 1.61 times higher odds of insomnia and 1.48 times higher odds of sleep apnea compared with

those who screened negative for MST (Gibson et al., 2020). An earlier cross-sectional study of Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) veterans reported that 61 percent of veterans with a positive MST screen met criteria for insomnia compared with 53 percent of those without MST, and the MST-positive group also had greater insomnia severity (Jenkins et al., 2015).

Fibromyalgia

Fibromyalgia is a chronic condition involving widespread musculoskeletal pain, fatigue, disrupted sleep, and heightened pain sensitivity, which results from altered pain processing in the central nervous system (Jahan et al., 2012). It often also involves cognitive difficulties, such as problems with memory, concentration, and mental clarity, as well as mood disturbances and other symptoms such as headaches, irritable bowel symptoms, or stiffness (Jahan et al., 2012; Kravitz and Katz, 2015). People living with fibromyalgia face persistent symptoms that affect aspects of daily life: maintaining employment, managing physical tasks, coping with fatigue, and keeping up social relationships (Iannuccelli et al., 2025). The prevalence of fibromyalgia differs across veteran subgroups, but those with specific characteristics and experiences such as PTSD (Lawrence-Wolff et al., 2023), serving in the Gulf War (Eisen et al., 2005), Black active service members (Hulse et al., 2020), and women active service members and veterans (D'Aoust et al., 2017; Hulse et al., 2020) have increased risk. Limited evidence also shows an association between fibromyalgia and MST. In a large study of women veterans enrolled in VHA health care, those who screened positive for MST had 1.19 higher odds of fibromyalgia compared with those who screened negative (Cichowski et al., 2017). This elevated risk is consistent with findings about the association between fibromyalgia and sexual trauma in civilian populations. For example, in a meta-analysis that pooled data from four case-control studies, adults with fibromyalgia were more than twice as likely to report having experienced sexual abuse in adulthood compared with control groups (Häuser et al., 2011).

Chronic Pain

Chronic pain is defined by persistent pain that lasts longer than three to six months (Stretanski et al., 2025). Pain can originate from disease, injury, or other unknown causes and is frequently accompanied by coexisting psychiatric conditions such as depression and anxiety (Stretanski et al., 2025). Chronic pain reduces quality of life and heightens the risk of substance abuse, suicidal ideation, and other adverse outcomes (Stretanski et al., 2025). Limited research shows that women with a history of MST

tend to report and experience high levels of pain. For example, in a study of women veterans age 55 and older receiving VHA care, those with a positive MST screen had significantly higher odds of chronic pain conditions and back pain compared with those with a negative screen (Gibson et al., 2020). The location of pain varies, with the most common being chronic pelvic and back pain (Cichowski et al., 2017; Shapiro et al., 2023).

Traumatic Brain Injury

TBI is a disruption in normal brain function that results from an external mechanical force such as a blow to the head or a penetrating injury (NINDS, n.d.). Service members and veterans may also experience TBI from exposure to blast overpressure from explosions and firing weapons (Rutter et al., 2021). TBI can cause immediate symptoms such as confusion, headaches, dizziness, seizures, or loss of consciousness, but its effects often continue long after the initial injury (NINDS, n.d.). Many patients experience persistent cognitive difficulties that involve memory, attention, learning, and executive functioning (McInnes et al., 2017). Emotional and behavioral changes are also common and may include irritability and anxiety (Dikmen et al., 2010). These long-term effects can significantly interfere with a person's daily life, relationships, employment, and overall quality of life. Even individuals with mild TBI frequently report ongoing symptoms months or years later (McIntosh et al., 2025).

TBI is extremely common among veteran populations. More than 185,000 veterans who use VHA health care have at least one TBI diagnosis (VA, n.d.-a), and an estimated 12 to 23 percent of service members and veterans who served in OEF/OIF/OND experienced TBI while deployed (O'Neil et al., 2013). Evidence on the relationship between MST and TBI is lacking, but research on intimate partner violence (IPV) offers useful context. TBI can occur due to head, neck, and face injuries that occur during a physical assault (NASEM, 2024). Estimates of possible TBI among women who have experienced IPV vary widely (19 to 75 percent) (Haag et al., 2022). Studies of veterans who have experienced IPV show that violence-related TBIs can be associated with more persistent and severe psychological and physical symptoms over time (Iverson et al., 2020). Relatedly, IPV is common among women veterans who screen positive for TBI (Iverson et al., 2019). Evidence from broader research on sexual assault also supports a connection between TBI and violence. A large population-level analysis showed that people reporting lifetime sexual violence have increased odds of a recent TBI even after adjusting for age and sex (Waltzman et al., 2024).

Migraines and Headaches

Migraine is a common neurological condition that causes recurring headaches of moderate to severe intensity, often lasting from several hours to a few days. The pain is typically on one side of the head and throbbing, can worsen with physical activity, and is often accompanied by nausea, vomiting, or sensitivity to light and sound (Ruschel and De Jesus, 2024). Migraines are linked to substantial disability, limiting work or school performance, social participation, and daily routines, with many individuals reporting reduced productivity and impaired quality of life (Pradeep et al., 2020). Frequent migraines can heighten emotional distress and contribute to anxiety or depressive symptoms (Battista et al., 2023).

Among veterans, migraines are common and co-occur with other service-related exposures and stressors (Gasperi et al., 2024). However, there is not a significant body of evidence linking MST to migraines. One large study using VHA administrative data reported that approximately one in eight veterans with diagnosed migraine screened positive for MST, and positive screens were significantly more common among women (35 percent) than men (3.5 percent) (Seng et al., 2022). Notably, although women with migraines were more likely to screen positive for MST, this rate was similar to rates in the VHA population overall. By contrast, the proportion of men who screened positive for MST was nearly double that observed in prior studies. This study is consistent with evidence from civilian populations, which shows that sexual assault and other forms of abuse are associated with a higher likelihood of a migraine diagnosis and more severe migraine symptoms. For example, clinical evidence indicates that people with chronic or disabling headaches are more likely to report past sexual or physical abuse than those who report experiencing migraines (Peterlin et al., 2007). Population-based data similarly link experiences of sexual violence or IPV with elevated odds of migraine (Cripe et al., 2011). More recent migraine registry research shows that individuals with a history of abuse tend to have more frequent headaches, greater sensory hypersensitivity, and higher migraine-related disability, even after accounting for other factors (Trivedi et al., 2021). Collectively, these findings suggest that sexual assault and related forms of abuse are risk factors for both the development and worsening of migraine.

Sexual, Reproductive, and Genitourinary Conditions

Sexual and reproductive health outcomes are an important consequence of MST. A growing body of research shows that MST is associated with a range of gynecological conditions, including sexual dysfunction, STIs, pelvic pain, pelvic floor disorders, and menstrual disturbances (As-Sanie

et al., 2014; Pulverman et al., 2019a; Pulverman and Creech, 2021; Takahashi et al., 2025; Travis et al., 2024). These conditions can significantly affect quality of life, interpersonal relationships, and well-being, and they often present differently across genders. In addition, there is some evidence on the associations of military service, MST, and infertility (Katon et al., 2014; Ryan et al., 2014; Ryan et al., 2021). VA does not provide disability compensation for infertility per se but instead for health conditions related to infertility (e.g., endometriosis, STIs, and dyspareunia). Therefore, the following sections focus on these conditions and their association with MST.

Sexual Dysfunction

Sexual dysfunction refers to conditions characterized by significant problems with sexual response or sexual enjoyment (Lewis et al., 2004). Specific types of sexual dysfunction include early ejaculation, delayed ejaculation, erectile difficulties, and low sexual desire in men, and problems with orgasm, low sexual desire or arousal, and pain or difficulty during penetration in women (Lewis et al., 2004). Sexual dysfunction is common among veterans with a history of MST and presents differently among men and women (Pulverman et al., 2019a). Women veterans who have experienced MST are at increased risk of sexual pain, arousal disorders, and lower sexual satisfaction (Pulverman et al., 2019a, 2019b; Rosebrock and Carroll, 2017). Sexual pain symptoms frequently associated with MST include dyspareunia (painful intercourse), vaginismus, vulvodynia, and other symptoms that substantially affect sexual functioning and satisfaction (Faye and Mikes, 2025; Kolaja et al., 2021; Lewis et al., 2004; Pulverman and Creech, 2021). A systematic review by Pulverman and colleagues (2019a) examined the relationship between MST and sexual health outcomes and found that women who screened positive for MST were significantly more likely to have a diagnosed sexual dysfunction compared with those who screened negative. Additionally, among women and men, the review found that MST was associated with lower levels of sexual satisfaction and greater sexual difficulties (e.g., reduced desire, heightened or dysregulated sexual behavior, discomfort during sexual activity). Another study found that men who experienced MST had higher erectile dysfunction than men without MST histories (Blais et al., 2022). This is supported by findings on the association between sexual trauma and sexual dysfunction in the general population. A meta-analysis of 38 studies reported that women with a history of sexual assault had a 42 percent higher risk of a composite measure of nine gynecological conditions compared with women with no history of sexual assault (Hassam et al., 2020). Notably, women who had experienced sexual assault had a more than 70 percent higher risk of conditions such as dyspareunia

and vaginismus and a nearly 50 percent higher risk of vulvodynia (Hassam et al., 2020).

Sexually Transmitted Infections

STIs are infections caused by bacteria, viruses, or parasites that pass from one person to another, mainly through sexual contact (CDC, 2024). The most common STIs include curable infections such as gonorrhea, chlamydia, syphilis, and trichomoniasis, as well as treatable viral infections like herpes, human papillomavirus (HPV), and human immunodeficiency virus (HIV) (Garcia et al., 2020). Untreated STIs can cause a range of complications such as vaginal discharge, abnormal vaginal bleeding, lower pelvic pain, urinary frequency, or dysuria, along with serious health outcomes such as infertility, chronic pain, pregnancy complications, or increased risk of acquiring other infections (Garcia et al., 2020; Tuddenham et al., 2022). On the psychological and social side, people living with STIs often report anxiety, depression, feelings of shame, stigma, isolation, and sexual distress, which can harm overall well-being and interpersonal relationships (Ciccarese et al., 2021; Haapa et al., 2019).

MST has been linked to increased risk of STIs across the veteran population. Takahashi and colleagues (2025) reported that among 6 million veterans receiving VHA care in 2022 who completed MST screening, 0.2 percent tested positive for at least one STI, including chlamydia, gonorrhea, syphilis, or HIV. Among women, STI positivity rates were similar regardless of MST screening status. After adjusting for patient demographics and relevant health factors, men with MST had a 23 percent higher likelihood of acquiring an STI during the study period. MST was not significantly linked to higher STI risk during the study period among women.

Earlier work examining over 420,000 OEF/OIF veterans in VHA care found that after adjusting for age and time receiving care from VHA, both men and women who screened positive for MST had higher odds of being diagnosed with a range of STIs (Turchik et al., 2012b). Among women, a positive MST screen was associated with increased odds of HPV, pelvic inflammatory disease, herpes simplex, and HIV or AIDS (acquired immunodeficiency syndrome). Among men, those who screened positive for MST had higher odds of HPV, herpes simplex, scabies or pubic lice, syphilis, and other venereal diseases than men who screened negative (Turchik et al., 2012b).

Pelvic Pain and Pelvic Floor Dysfunction

Pelvic floor disorders occur when the muscles and connective tissues that support pelvic organs lose strength or coordination, leading to urinary incontinence, fecal incontinence, pelvic organ prolapse, or chronic pelvic

pain (Good and Solomon, 2019; Grimes and Stratton, 2020). These disorders often interfere with daily life and can impair bladder or bowel control, cause discomfort or pressure in the pelvis, and impact self-image and quality of life (Good and Solomon, 2019). In many cases these dysfunctions are associated with impaired sexual function, such as higher rates of dyspareunia, reduced sexual arousal, and infrequent orgasm compared with women without such disorders (Handa et al., 2008). Although evidence directly linking MST to specific pelvic conditions is limited, research shows that chronic pelvic pain and pelvic floor dysfunction occur more often among individuals with a history of sexual assault. One large retrospective study found that veterans with a history of MST had 1.16 greater odds of being diagnosed with a chronic pelvic pain condition (classified as either endometriosis or interstitial cystitis) compared with women who did not report a history of MST (Cichowski et al., 2017). In a small cross-sectional study of women receiving care for pelvic pain, As-Sanie and colleagues (2014) found that after controlling for age and education, adult sexual abuse was significantly associated with high pain-related disability, while the association with pain severity was not statistically significant. In a cross-sectional study of women referred to a pelvic floor treatment center, those with a self-reported history of sexual abuse were much more likely to report symptoms across all three pelvic floor domains assessed (urological, gastrointestinal, and sexual) (Beck et al., 2009). More than 80 percent of women with sexual abuse histories reported symptoms in all three areas, compared with fewer than half of women without such histories (Beck et al., 2009). A retrospective cohort study observed that women who reported sexual abuse had roughly double the odds of chronic pelvic pain, while associations with other pelvic floor conditions were not significant (Cichowski et al., 2013).

Menstrual Disorders

Menstrual disorders are conditions that interfere with the menstrual cycle, such as irregular, missing, extended, heavy, or painful periods (McKenna and Fogleman, 2021; NICHD, n.d., 2017). Symptoms vary by disorder and may include pelvic or abdominal cramps, lower-back pain, mood swings, fatigue, heavy bleeding with clots or frequent pad/tampon changes, or the absence of menstruation. These disorders can significantly affect quality of life, interfering with daily activities, work, or school and causing physical discomfort or pain, emotional distress, and heavy bleeding (Davies and Kadir, 2017; Odongo et al., 2023; Schoep et al., 2019). There is limited and inconsistent evidence specifically linking MST to these types of disorders. One small study by Travis and colleagues (2024) found that women who had experienced military sexual assault had increased menopausal

symptoms, including nearly three times the odds of vaginal symptoms. By contrast, a study of women veterans age 55 and older receiving VHA care found no significant differences in menopause symptoms between those who screened positive and negative for MST (Gibson et al., 2020). However, the relationship between MST and menstrual disorders is supported by evidence in the general population. For example, a 2020 meta-analysis that included 38 studies found that sexual assault increased risk of dysmenorrhea (painful periods) and abnormal menstrual bleeding (Hassam et al., 2020).

Musculoskeletal Injury

Musculoskeletal injuries are often generally referred to as bodily injuries, altered physical function, and mild, moderate, or severe physical injuries (Ponkilainen et al., 2022). They include bruises, sprains and strains, and fractures and result from the often physically forceful nature of sexual assault and physical efforts to resist assault (McCormack et al., 2022; Oesterle et al., 2024; WHO, 2003; Zilkens et al., 2017). Although they have been identified as one of the many health sequelae of MST, literature on the relationship between MST and specific musculoskeletal conditions is limited; most studies assess general terms or classifications rather than specific disorders or injuries (Galovski et al., 2022; Turchik et al., 2012a). For example, a 2012 study examining VHA outpatient care utilization among OEF/OIF veterans found that among veterans who had MST-related care visits, the second most common primary, non-mental health diagnosis was musculoskeletal or connective tissue disorder (after symptoms, signs, and ill-defined conditions) (Turchik et al., 2012a). The association between MST and musculoskeletal injuries is supported by evidence on sexual assault and such injuries in the general population. Multiple studies have shown that sexual assault is associated with musculoskeletal injuries and that these injuries are most common in the extremities (arms and legs) and the head and neck region (Loder and Momper, 2020; Luong et al., 2022; Song and Fernandes, 2017; Zilkens et al., 2017). The acute musculoskeletal injuries associated with experiencing MST can lead to chronic health conditions. Injuries to the joints, including fractures, dislocations, and ligament injuries such as sprains and dislocations significantly increase risk for developing osteoarthritis, including posttraumatic osteoarthritis (Allen et al., 2022; Dilley et al., 2023; Thomas et al., 2017). Osteoarthritis and posttraumatic osteoarthritis create pain, swelling, stiffness, and loss of normal function in the affected joint (Allen et al., 2022; Thomas et al., 2017).

Gastrointestinal Disorders and Symptoms

Gastrointestinal disorders, which affect the digestive tract and can cause symptoms such as abdominal pain, bloating, and altered bowel habits, may be linked to military service due to the high prevalence of physical and psychological stressors experienced by service members, including MST (Jabłońska and Mrowiec, 2023; Kent, 2024; Malhotra et al., 2023). In a small cross-sectional study of veterans receiving outpatient VA care, women who reported MST had significantly greater odds of meeting criteria for irritable bowel syndrome (IBS) compared with those without such histories after adjusting for age, ethnicity, PTSD, and depression (White et al., 2010). Studies in civilian populations have shown similar relationships between abuse and gastrointestinal disorders and also suggest that this relationship may be mediated by psychological factors. For example, in a study of patients at an outpatient gastroenterology clinic, Kanuri and colleagues (2016) found that prevalence of physical, sexual, and emotional abuse was higher among the patients with IBS (35 percent) compared with those without gastrointestinal disorders (20 percent). In addition, among patients with IBS, gastrointestinal symptoms were more severe and frequent among those who had abuse compared with those who did not (Kanuri et al., 2016). The study also included mediation analyses that indicated that anxiety, depression, and somatic symptoms partially explained the relationship between sexual abuse and IBS symptom severity (Kanuri et al., 2016). Similarly, another small cross-sectional study found that self-reported adult sexual abuse was significantly associated with increased gastrointestinal symptoms in unadjusted models, but this relationship was no longer significant after accounting for psychological symptoms (Melchior et al., 2022). This finding supports psychological symptoms and disorders as a mediator between sexual trauma exposure and gastrointestinal disorders and symptoms (Melchior et al., 2022).

Cardiovascular Conditions

Cardiovascular conditions or diseases include hypertension (elevated blood pressure), coronary heart disease, stroke/cerebrovascular accident (sudden bleeding in or blockages of blood flow to the brain), coronary artery disease or ischemic heart disease (arterial narrowing due to buildup of fatty deposits restricting blood flow to the heart muscle), arrhythmia, and heart attacks (sudden blockages of blood flow to the heart muscle) (NHLBI, 2022, 2023, 2024; Shams et al., 2025). Conditions related to trauma, mental health disorders, and chronic stress frequently co-occur with CVD and are increasingly recognized as contributors to onset and progression. A substantial body of evidence indicates that disorders such as depression,

anxiety, and PTSD are highly prevalent among individuals with CVD; these associations persist even after accounting for traditional cardiovascular risk factors, such as smoking, alcohol use, and obesity, suggesting that underlying physiological mechanisms related to these conditions contribute directly to cardiovascular problems (Celano et al., 2016; Edmondson and Cohen, 2013; Gradus, 2017; Krittanawong et al., 2023; Lagraauw et al., 2015; Sandrini et al., 2020).

Limited evidence has shown a direct association between MST and CVDs. A large analysis of VHA electronic health records of women veterans reported significantly higher odds of myocardial infarction, congestive heart failure, and cerebrovascular disease among women who screened positive for MST than women who screened negative, and this relationship persisted even after accounting for demographic and service characteristics and health care use (Sumner et al., 2021). Another study of women veterans age 55 and older found increased odds of myocardial infarction, cerebrovascular disease, and congestive heart failure among those with a positive MST screen compared with those with a negative screen (Gibson et al., 2020). Similarly, a large prospective cohort study reported that screening positive for MST was associated with a 15 percent greater risk of hypertension, even after accounting for demographics, lifestyle factors, other cardiovascular factors, and psychiatric diagnoses, and this association differed among men and women (Gaffey et al., 2022). Among men, screening positive for MST was associated with a 6 percent higher risk of developing hypertension, while among women, screening positive for MST was associated with a 20 percent higher risk (Gaffey et al., 2022).

The relationship between MST and CVD is supported by evidence on the association between psychological trauma (and PTSD in particular) and adverse cardiovascular outcomes (Edmondson et al., 2013; Jacquet-Smailovic et al., 2022; Sumner et al., 2023). Although further research is needed to elucidate the mechanisms linking psychological trauma including MST and CVD, potential pathways include shared genetic risk factors and the dysregulation of biological stress response systems which can contribute to immune dysregulation and accelerated biological aging (Sumner et al., 2023). In addition, MST is associated with documented CVD risk factors including substance use, obesity, sedentary lifestyle, and hysterectomy before 40 years of age presumably mediated via loss of estrogen protection (Frayne et al., 2003; Goldberg et al., 2019). In addition, there is an established relationship between STIs and CVD (including coronary artery disease, heart failure, inflammation, valvular disease, and cardiomyopathy) (Liblik et al., 2023), and the elevated risk of STIs associated with MST may contribute to subsequent development of CVD.

Conditions and Symptoms Related to MST Not Included in VA's Schedule for Rating Disabilities

Obesity

Obesity is a chronic, complex condition influenced by genetic, environmental, and behavioral factors. Defined by the World Health Organization as excess body fat that increases health risks, commonly measured as a body mass index over 30 kg/m², obesity is linked to serious health consequences including type 2 diabetes, CVD, hypertension, and certain cancers (Busebee et al., 2023). Obesity is not recognized as a compensable primary condition in the current VA Schedule for Rating Disabilities. However, a recent decision by the Court of Appeals for Veterans Claims established that obesity may be considered a secondary condition, meaning it can qualify as a disability if it is medically linked to a service-connected condition.⁵

MST may influence obesity through disordered eating as a negative coping strategy, or as sequelae to psychological symptoms and conditions such as PTSD. A scoping review investigating risk factors of obesity in OEF/OIF/OND women veterans found that MST was associated with elevated obesity risk in two studies (Wischik et al., 2019). A more recent study of women veterans age 55 and older receiving VHA health care found that 38.1 percent of these older women veterans who had a positive MST screen had obesity, compared with 28.5 percent among those with a negative screen (Gibson et al., 2020). After accounting for age, race/ethnicity, and marital status, MST was significantly associated with roughly 15 percent increased odds of obesity (Gibson et al., 2020).

Substance Use Disorder

SUD is a group of psychological symptoms where an individual continues to use a substance even though it is causing significant harm or problems to that person's physical and social health (APA, 2013). This section focuses on three classes of substances (drugs, opioids, and alcohol) most likely to be related to MST. Federal law does not permit VA to provide disability compensation related to "abuse of alcohol or drugs," but VA will compensate for SUD as a secondary condition if a service-connected condition caused or worsened the substance use (e.g., alcohol use as a coping mechanism for service-connected PTSD).

Forkus and colleagues conducted a systematic review on MST and risky behaviors, which assessed 30 studies on the relationship between MST and substance use (Forkus et al., 2021). This study found the association

⁵ *Adams v. Collins*, 38 Vet. App. 273, 287 (2025).

between MST and SUD was mixed. In all cases, some studies showed that MST was associated with increased substance use and misuse, while other studies showed null results (Forkus et al., 2021). Some of these null findings may be partially explained by the high prevalence of comorbid conditions among individuals with MST and SUD; while research often controls for these conditions to examine a direct association, doing so may underestimate indirect relationships occurring through comorbidities (Forkus et al., 2021).

There are clear racial, ethnic, and gender differences in substance use among veterans. Black, Hispanic, American Indian/Alaska Native, and multiracial veterans showed higher risk for multiple disorders, whereas Asian American veterans consistently showed lower risk compared with White veterans (Lawson et al., 2024). Men veterans consistently have higher rates of SUD than women veterans (Beckman et al., 2022; Hoggatt et al., 2023; Teeters et al., 2017).

SUMMARY

Although prevalence estimates vary across studies, sexual assault and sexual harassment are consistently documented as common experiences among service members and veterans (Nichter et al., 2022; Wilson, 2018). MST prevalence is difficult to measure because it depends on self reporting, and many service members and veterans do not disclose incidents due to stigma, power dynamics, fear of retaliation, and concerns about unit cohesion, with estimates also varying by assessment method and sample (Andresen and Blais, 2019; Lofgreen et al., 2017; Mengeling et al., 2014). Cultural pressure associated with military service can intensify a survivor's trauma and contribute to distinct emotional and physical health effects that are not well captured by general trauma or combat trauma frameworks (Castro et al., 2015; Lofgreen et al., 2017). Sexual assault in the military is highly associated with poor mental health outcomes, most notably PTSD, as well as depression, anxiety, eating disorders, and STBs (Blais et al., 2017; Gibson et al., 2020; Gilmore et al., 2016; Godfrey et al., 2015; Iverson et al., 2020; Kimerling et al., 2016; Klingensmith et al., 2014; Kimerling et al., 2010; Monteith et al., 2015; Sumner et al., 2023). In addition to these psychological consequences, MST is associated with a broad range of physical health outcomes affecting multiple body systems, including reproductive, musculoskeletal, gastrointestinal, and cardiovascular disorders (Gibson et al., 2020; Pulverman and Creech, 2021; Sumner et al., 2021).

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3

Competencies for Conducting Military Sexual Trauma-Related Disability Examinations

The Department of Veterans Affairs (VA) awards monetary disability compensation to veterans who have a disease or injury incurred or exacerbated due to or during military service that results in disability (CRS, 2024). Service-connected disability can also convey access to other benefits, including health care and educational assistance. To assess veterans' eligibility, the Veterans Benefits Administration (VBA) often requests compensation and pension (C&P) exams, or disability evaluations. The purpose of these examinations is to assess functional impairments and determine whether the claimed condition is associated with a qualifying in-service disease, injury, or event (CRS, 2024). This contrasts with clinical encounters that focus on diagnosing and treating conditions. In addition, a key outcome of C&P examinations is a clinical opinion about impairment and service connection, which informs VA claims adjudication and must be written in legal language. Therefore, clinicians require specialized training to conduct C&P examinations and to provide these key clinical opinions.¹ Clinicians who perform these exams, known as C&P examiners, include those contracted by VBA as well as Veterans Health Administration (VHA) clinicians. The proportion of contract and VHA examiners has shifted over the past decade, with contracted examiners performing more than nine in ten C&P exams in 2024, up from just one in five in 2013 (CRS, 2022; GAO, 2025). This represents a new disability evaluation workforce that lacks the traditional competencies and experiences working with military and veteran patients compared with VHA-trained and -employed clinicians. VA establishes the

¹ VHA Directive 1046(1), Compensation and Pension Disability Examination (2023).

credentials required to perform these examinations and provides training to all examiners. This chapter presents key knowledge, skills, and attitudes (competencies) required to provide C&P examinations; best practices for training examiners to become proficient in these competencies; and quality assurance mechanisms for examiners to maintain proficiency in them. The chapter also assesses VA's existing credentialing and training requirements relative to those best practices and presents recommendations to improve examiner training and competence.

C&P EXAMINER COMPETENCIES

In graduate and continuing medical education, best practices suggest that health care providers demonstrate proficiency in core competencies (or, observable and measurable abilities that integrate knowledge, skills, and attitudes) to show that they possess the minimum qualifications needed to provide clinical care (Campbell et al., 2010; Cooper and Holmboe, 2025; Frank et al., 2010a, 2010b). To prepare medical trainees for practice, this approach to education de-emphasizes time spent learning and emphasizes the abilities attained through learning (Cooper and Holmboe, 2025; Frank et al., 2010b). In contrast to traditional models where competence is static and attained once a clinician is certified to practice, in a competence-based approach, a clinician's competence is understood as dynamic, progressive, and contextual (Cooper and Holmboe, 2025; Frank et al., 2010b). Thus, competence may change based on the environment in which a clinician practices and over time. For example, applied to the disability compensation process, clinicians who are competent to provide medical treatment in a clinical care setting may nonetheless lack competencies needed to conduct disability examinations. Competency-based curricula start with goals, or the desired abilities needed to provide care in a specific setting, and then develop instructional content, methods, and assessments aligned with those goals (Cooper and Holmboe, 2025; Frank et al., 2010b). In contrast to traditional medical education in which assessment is infrequent and limited, a competence-based framework requires assessment at frequent defined milestones, which must be met before advancing from one stage to the next (Cooper and Holmboe, 2025; Frank et al., 2010b).

Based on a review of the examiner's tasks in performing a C&P mental or physical health examination for an a military sexual trauma (MST)-related claim, a review of the VHA and VBA general certification courses (including the MST course), best practices in medical education, best practices for providing health care to military and veterans, and its expertise, the committee identified and refined competencies needed to conduct these exams through an iterative and deliberative process. The committee identified five core competencies needed to perform C&P exams related to MST claims:

1. MST and Health
2. Trauma-Informed Approach
3. Laws and Regulations Governing MST Claims
4. Military Structure and Culture
5. Medical Opinions

MST and Health refers to clinical knowledge about the health consequences of MST, the application of this knowledge to assess whether a claimed condition is present and related to MST, and MST's potential effects on a veteran's functioning. Trauma-Informed Approach is a specialized clinical approach to patients who may have a trauma history, with the aim of minimizing the potential harm inherent in inquiring about traumatic experiences as well as the challenges in obtaining a complete and accurate history from a person who has experienced trauma (Chu et al., 2024; Machtinger et al., 2015). Laws and Regulations Governing MST Claims refers to the knowledge and application of the legal and regulatory frameworks within which disability processes are conducted for MST-related claims. Military Structure and Culture refers to knowledge of military environments, norms, and identity constructs, and the application of this knowledge in understanding how they affect disclosure of MST experience and outcomes (e.g., how stigma and fear of retaliation affect reporting). Lastly, the Medical Opinions domain includes key skills needed for C&P examiners to draft the two required clinical opinions regarding (1) the likelihood that MST caused or contributed to the claimed disabling condition and (2) the extent to which an MST-related condition or symptoms affect a veteran's normal functioning. Competency in this domain requires skills in identifying relevant evidence related to these opinions from the claimant's medical history, the physical examination, and the scientific evidence needed to complete VA Disability Benefits Questionnaires (DBQs), standardized forms that guide examination reports. This domain also includes the ability to clearly and properly provide documentation of opinion statements and supporting rationales about service connection and level of disability, with sufficient information for VA claims adjudicators to make claims decisions and ratings.

There is variation in what clinicians must demonstrate in the professional credentialing process for different disciplines. However, the committee did not identify any profession which requires proficiency in all the competencies needed to conduct MST-related C&P exams as a standard component of their education and training. Some professionals may develop competencies in some of the domains for conducting C&P exams related to MST claims based on specialized medical education and training. For example, clinicians who train in the Military Health System or VHA gain knowledge and experience of military structure and culture and gain

competencies over the course of providing care to service members and veterans (Burns et al., 2022; Cerceo et al., 2026; Pierre-Wright et al., 2026; Royce et al., 2026; Shamaskin-Garroway et al., 2020). Similarly, some mental health and primary care providers receive training in and follow trauma-informed approaches in their care (VA, n.d.–b). No discipline is expected to acquire all the required competencies without specialized C&P training and experience in MST-related claims.

In addition to professional standards, legal statutes define the scope of practice for different health professions based on clinical functions. For clinicians in the community, each state defines the legal scope of practice. Using psychology and mental health as an example, key clinical and forensic activities include the following:

- Using *Diagnostic and Statistical Manual of Mental Disorders* (DSM) criteria for clinical diagnosis;
- Using screening tools (e.g., the Patient Health Questionnaire-9 [PHQ-9]) to diagnose and monitor depression;
- Conducting forensic mental health evaluations for legal and/or administrative purposes (such as C&P examinations); and
- Conducting complex psychological tests (e.g., Clinician-Administered [Posttraumatic Stress Disorder] PTSD Scale for DSM-5 [CAPS-5]).

Different mental health professions are authorized to perform different functions. In general, states authorize licensed psychologists to perform all of these activities. By contrast, counselors, therapists, and social workers are typically not authorized to perform psychological testing but can diagnose patients, use screening tools, and, in limited contexts (such as when court appointed and no psychological tests are performed), conduct forensic mental health interviews. Table 3-1 provides an example of statutory practice authority for these selected mental health professionals.

In contrast to health care providers in the community, whose scope of practice is governed by state law, federal regulations permit VA to establish national standards of practice and direct VA health care professionals to follow the scope VA defines, regardless of conflicting state laws.² VHA employs a wide variety of health care providers as licensed independent practitioners (LIPs), defined as “individual[s] permitted by law and the VA medical facility through its medical staff bylaws to provide patient care services independently, without supervision or direction, within the scope of the individual’s license and in accordance with privileges granted by the VA

² 38 CFR § 17.419, Health care professionals’ practice in VA; VHA Directive 1900(5), VA National Standards of Practice (2023).

TABLE 3-1 Summary of Statutory Scope of Practice Authority for Selected Mental Health Professions Across States

Activity/ Function	Licensed Psychologist ^a	Licensed Professional Counselors ^b	Licensed Marriage and Family Therapists ^c	Licensed Clinical Social Workers ^d
DSM diagnosis	Authorized	Authorized	Authorized	Authorized
Use of screening tools	Authorized	Permitted as part of clinical assessment	Permitted as part of clinical assessment	Permitted as part of clinical assessment
Standardized psychological testing	Authorized	Not authorized	Not authorized	Not authorized
Complex psychological assessment	Authorized	Not authorized	Not authorized	Not authorized
Forensic psychological testing	Authorized	Not authorized	Not authorized	Not authorized
Forensic mental health interview only	Authorized	Context- limited (Court appointed, no testing)	Context- limited (Court appointed, no testing)	Context- limited (Court appointed, no testing)
VA C&P mental health exams – review only	Authorized	Not authorized	Not authorized	Permitted only when VA- credentialed and under supervision, no testing
VA C&P exams involving testing	Authorized	Not authorized	Not authorized	Not authorized

NOTE: C&P = compensation and pension; DSM = *Diagnostic and Statistical Manual of Mental Disorders*; VA = Department of Veterans Affairs.

^a Example statutes: California Business and Professions Code §2903.1; Texas Occupation Code §501.003; Florida Statute §490.003; New York Education Law §7601-a; Virginia Code §54.1-3600.

^b Example statutes: California Business and Professions Code §4999.20; Texas Occupation Code §503.003; Florida Statute §491.003; New York Education Law §8402; 262 Code of Massachusetts Regulations 2.01.

^c Example statutes: California Business and Professions Code §4980.02; Texas Occupation Code § 502.002; Florida Statute §491.003; New York Education Law §8401; Virginia Code §54.1-3700.

^d Example statutes: California Business and Professions Code §4996.9; Texas Occupation Code §505.002; Florida Statute §491.003; New York Education Law §7701; 258 Code of Massachusetts Regulations 12.02.

medical facility.”³ The mental health disciplines that may serve as VA LIPs and that practice clinical care include psychiatrists, psychologists, licensed clinical social workers, licensed professional mental health counselors, marriage and family therapists, and psychiatric nurses (including psychiatric clinical nurse specialists and psychiatric nurse practitioners).⁴ VA policy requires that providers seeking initial credentialing and privileging at a VA medical facility submit documentation demonstrating their licensure, education, training, experience, and other qualifications relevant to their professional discipline and that this be validated during the VA credentialing process.⁵ VHA also requires that licensure, registration, or certification (if applicable) be maintained and that credentials and privileges be reviewed at regular intervals.⁶ These differing statutory authorities—between clinicians practicing in the community (as contracted examiners do) and VHA-employed clinicians—have important implications for the professions able to conduct C&P examinations. For instance, VA can establish national standards for VHA C&P examiners regardless of state-level restrictions, while state statutes may limit the scope of practice of contract examiners.

The VA Adjudication Procedures Manual defines the education, licensing, and credentialing requirements that examiners must meet to conduct C&P exams, and additional legal rulings have determined that examiners must be qualified and trained appropriately (VA, 2026b, 2026c).⁷ However, VA has no clearly defined competencies for conducting C&P examinations generally or for MST-related claims specifically. Rather, VA currently requires C&P examiners to have all legally required credentials appropriate to the services which they provide; be licensed graduates of an accredited school; have a current and unrestricted license to practice; and not be barred from practicing in any state, territory, or the District of Columbia (VA, 2026b). Licensure alone does not, however, ensure competency to practice at the standard of care in all domains of practice.

In most cases, a range of licensed providers, including medical doctors (MDs), doctors of osteopathic medicine (DOs), psychologists (PhDs), licensed social workers, nurse practitioners, and physician assistants/associates can conduct C&P exams. However, VA restricts certain types of C&P exams to specialists. MST-related exams must be conducted by examiners who have completed the MST training course. In addition, VA currently restricts initial traumatic brain injury (TBI) diagnoses to psychiatrists, neurosurgeons, or neurologists; hearing loss examinations

³ VHA Directive 1100.20(2), Credentialing of Health Care Providers (2021).

⁴ VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service (2023).

⁵ VHA Directive 1100.20(2), Credentialing of Health Care Providers (2021).

⁶ VHA Handbook 1100.19, Credentialing and Privileging (2007); VHA Directive 1100.20(2), Credentialing of Health Care Providers (2021).

⁷ *Wise v. Shinseki*, 26 Vet. App. 517, 531 (2014).

to audiologists; and PTSD examinations to board-certified psychiatrists, licensed doctorate-level psychologists, non-licensed doctorate-level psychologists working toward licensure, psychiatry residents, and clinical or counseling psychologists completing a one-year internship or residency under close supervision of a board-certified psychiatrist or licensed doctoral-level psychologist (VA, 2024, 2026d, 2026e, 2026f). The VA Adjudication Procedures Manual defines “close supervision” as the supervising psychiatrist or psychologist met with the veteran and conferred with the examining mental health professional in providing the diagnosis and the final assessment (VA, 2026d). The supervising psychiatrist or psychologist must co-sign the examination report. Because VA policies require examiners to undergo supplemental VA training prior to conducting C&P exams but trainees may not fall under the definition of examiners, particularly in contractual language, it is feasible that trainees could conduct examinations without having completed required MST trainings. The committee did not identify information indicating differences in exam quality between trainees and licensed, credentialed, and privileged examiners, but this may reflect the lack of measures and a mechanism to document such differences. Ideally, a licensed, credentialed, privileged, independent health care professional of the same discipline as the trainee who has demonstrated core competencies to conduct C&P examinations for MST-related claims would provide direct rather than close supervision. If no such clinician is available, supervision by a licensed, credentialed, and privileged clinician of a different discipline who has demonstrated those MST competencies would also be appropriate.

Given that VHA permits a broad range of mental health disciplines to make diagnoses and provide mental health care as LIPs to veterans who screen positive for MST, as well as those who receive treatment related to MST (as described earlier in this section), VBA policy is currently more restrictive regarding the disciplines that can perform mental health C&P exams than VHA about disciplines that can provide treatment. This unnecessarily limits access for claims related to MST because there are VHA providers who may have the competence to perform these select examinations but are not allowed to do so under current policy. Furthermore, in the context of a national behavioral health workforce shortage that is associated with high levels of unmet demand for behavioral health care (Health Resources and Services Administration, 2025), any additional and unnecessary restrictions to mental health disability evaluations would be expected to hinder timely access to C&P exams and timely processing and adjudication of MST-related claims. Consistent with the shift from a credential-based provider requirement to a competence-based one, any clinician who demonstrates the required core competencies would be qualified to conduct the exams within their legal and professional scope of practice.

MST TRAINING

VA requires all C&P examiners to complete MST training as part of their general certification training.⁸ This section provides an overview of the training claims processors and C&P examiners receive related to MST. It then describes the five core competencies identified by the committee, best practices for their instruction, and the extent to which the current VA MST training courses provide instruction on those competencies. It also examines the modes of instruction and assessments used in the training courses.

VA requires claims processors and clinical examiners to complete MST-specific training before developing or adjudicating claims or performing examinations for MST-related disability claims.⁹ VA procedures limit the processing of MST disability claims to individuals who have completed claims processor training; are designated MST claims processors; and are assigned to a centralized MST claims processing site, a special mission station responsible for claims due to other special circumstances (such as prisoner-of-war claims), or work on pre-discharge claims (VA, 2025c, 2025d). Claims processors must complete an initial training course and annual refreshers, each of which have assessments with a pass rate requirement of 80 percent or higher.¹⁰ All examiners are required to complete and pass C&P certification training before conducting any exams (Eggers, 2025b; Hutchinson and Hyberger, 2025). In addition to the general certification courses, VA also requires supplemental training for all examiners on topics specific to military culture, suicide awareness, the veteran experience, and assessment of deployment-related environmental exposures. C&P exams for certain conditions—such as TBI and mental health disorders—are restricted to certain disciplines and examiners who have completed additional condition-specific courses (VA, 2026d, 2026e, 2026f).

Although all examiners are required to complete an MST course as part of their general certification training (Hutchinson and Hyberger, 2025),¹¹ trainees are not specifically required to complete supplemental training. Furthermore, VHA examiners and VBA-contracted examiners currently complete different MST courses. VHA's Office of Disability and Medical Assessment (DMA) provides guidance for and oversees delivery of training for VHA C&P examiners, while VBA's Medical Disability Examination Office (MDEO) oversees and provides training for contract examiners (Statton, 2025b). In contrast to the claims processors who VA requires to complete annual refresher training, VBA requires contract examiners to

⁸ VHA Directive 1046(1), Compensation and Pension Disability Examinations (2023).

⁹ Ibid.

¹⁰ Section A. Fiscal Year 2025 (FY25) Compensation Service National Training Curriculum (CSNTC) Overview, Article ID: 554400000035051 (2026).

¹¹ VHA Directive 1046(1), Compensation and Pension Disability Examinations (2023).

recertify only every five years, or sooner if they have not conducted an exam in over a year (Statton, 2025b). VHA requires its examiners to take the certification training just once (Eggers, 2025a). VBA delegates to VHA and VBA-contracted vendors the responsibility for ensuring that their examiners meet the qualification standards.

The VHA MST training course, *DMA Military Sexual Trauma and the Disability Examination Process*, was most recently updated on December 17, 2022, and includes five lessons (VA, 2022b). The VBA MST training, *MDE [Medical Disability Exam] | Military Sexual Trauma (MST) & the Disability Examination Process: (Certification)*, was most recently updated on May 13, 2025, and includes four lessons (VA, 2025a). Table 3-2 summarizes the lessons and objectives in both MST training courses. The VHA and VBA courses provide instruction on similar content, and both are heavily focused on concepts and knowledge. However, the training courses lack instruction on practical skills, especially related to the application of legal and regulatory frameworks, the practice of trauma-informed care, identifying and reviewing evidence related to establishing service connection and assessing impairment, and documenting medical findings in a sufficient medical opinion about service connection and impairment within the required legal language. In addition, VA also provides an MST job aid to help examiners to avoid retraumatizing veterans during C&P exams who have experienced MST (Statton, 2025b). At the committee's first meeting, VBA shared that MDEO is developing a job aid for contract examiners on trauma-informed communication with service members and veterans who have experienced MST (Hutchinson and Hyberger, 2025). MDEO creates and updates job aids when new topics or problems arise that need to be addressed among examiners (Hutchinson and Hyberger, 2025).

The MST training courses include instruction on several topics of less relevance to performing C&P exams for MST-related claims. Specifically, the MST training courses devote extensive pages to conducting the Separation Health Assessment (SHA), which C&P examiners rarely perform (VA, 2026a). Thus, substantial time is spent on an examination that will be performed by a selected group of examiners. Furthermore, the content is confusing because the guidance for this exam with active-duty military personnel is very different from the purpose of the MST module. The MST-specific content related to the SHA would be better placed in the module on the SHA.

Several contract exam vendors reported providing their examiners with additional training and job aids specific to C&P examinations for MST-related claims. Veterans Evaluation Services (VES) provides guidance through quarterly provider newsletter publications (including several focused specifically on MST-related topics), an MST Marker Checklist for

TABLE 3-2 Summary of VHA and VBA MST Training Courses

Lesson	Objective	Description
VHA MST Training Course, DMA: Military Sexual Trauma and the Disability Examination Process - Update 2022		
1. An Overview of Military Sexual Trauma	Understand the prevalence and impact of MST.	Explores the prevalence of MST across military and veteran populations by examining patterns and variations in its occurrence and by analyzing the emotional, psychological, and physical effects it can have.
2. VA and DOD Policies and Procedures	Understand DOD and VA policies and programs for assisting individuals who experience MST.	Presents key DOD programs and contacts that offer immediate support for sexual assault and harassment, along with details about VA health care services for MST survivors, and information to share with veterans and service members who have experienced assault.
3. MST-Related Disability Claims	Understand methods of supporting MST survivors through the disability claims process.	Offers an overview of processes for MST-related disability claims, explains VBA programs that strengthen the claims pathway and the collaboration between VHA and VBA, and provides practical guidance to help examiners conduct trauma-sensitive evaluations for all individuals.
4. MST and the Separation Health Assessment	Understand guidelines, including MST-specific guidance, for conducting an SHA.	Explains the purpose and scope of the SHA from an examiner's standpoint. SHAs are performed with service members before separation, and examiners are instructed to advise service members that information shared will be retained in their military record.
5. Considerations for MST-Related PTSD Examinations	Understand a disability examiner's responsibilities for evaluating marker evidence for MST-related PTSD examinations.	Explains to examiners how to assess MST markers, evaluate the stressor under DSM Criterion A, and give related medical opinions.

TABLE 3-2 Continued

Lesson	Objective	Description
VBA MST Training Course, MDE Military Sexual Trauma (MST) & the Disability Examination Process: (Certification)		
1. MDE Military Sexual Trauma (MST) and the VA Examination Process - Lesson One - MST	Prepare for and conduct an MST-related examination in a trauma-sensitive manner and properly document findings in a high-quality examination report.	Instruction for examiners on the definition, prevalence, clinical impacts, and regulatory context of MST to support trauma-sensitive assessment, evaluation, and documentation within the VA disability examination process.
2. MDE Military Sexual Trauma (MST) and the VA Examination Process - Lesson Two - MST	Describe policies and programs implemented by DOD and VA to address the experiences of sexual assault and sexual harassment in service members and veterans.	Guidance on policies, survivor support programs, eligibility criteria for MST-related health care, and the examiner’s role in conducting trauma-sensitive evaluations and supporting MST-related disability claims within the VA adjudication framework.
3. MDE Military Sexual Trauma (MST) and the VA Examination Process - Lesson Three - MST	Identify the implications for service members disclosing MST during an SHA, be familiar with the contents of the MST handout, and be able to identify the requirements and best practices for sharing these VA-designated MST-related materials during the SHA examination process.	Training on conducting SHA involving MST, including confidentiality and documentation requirements, DOD and VA information sharing implications, appropriate response to MST disclosures during active duty, and mandatory delivery and acknowledgment of VA-designated MST educational materials.
4. MDE Military Sexual Trauma (MST) and the VA Examination Process - Lesson Four - MST	Understand the definition of “marker evidence” and be able to explain how marker evidence is identified, evaluated, and documented for MST-related PTSD claims.	Regulatory and clinical instruction for evaluating MST-related PTSD claims, including identification and analysis of marker evidence under applicable federal regulations, clinical assessment of stressor consistency, and documentation of well-reasoned medical opinions linking markers, stressors, and PTSD diagnoses for VA adjudication purposes.

NOTE: DOD = Department of Defense; DMA = Office of Disability and Medical Assessment; DSM = *Diagnostic and Statistical Manual of Mental Disorders*; MDE = medical disability exam; MST = military sexual trauma; PTSD = posttraumatic stress disorder; SHA = Separation Health Assessment; VA = Department of Veterans Affairs; VBA = Veterans Benefits Administration; VHA = Veterans Health Administration.

SOURCES: VA, 2022b, 2025a.

use by providers and quality control analysts, and individual MST training for low performers (Skloss, 2025). Loyal Source Government Solutions (LSGS) provides its examiners with general medicine training and structured guidance, as well as standardized templates on medical opinions to guide examiners on how to structure medical opinion rationales, both of which include information specific to MST claims (Mirza, 2026). LSGS also provides targeted updates to share changes in VA policy or statutory guidance in real time. Leidos QTC Health Services examiners receive initial training and ongoing training in the form of monthly MST workshops to address case-specific questions. They also receive structured instruction on developing clinical opinions related to MST claims, including identifying marker evidence, relevant medical records, and literature related to MST (Dean, 2026). Optum Serve provides examiners with job aids and tools, many of which were developed by MDEO, through its Provider Portal Knowledge Center (Carter-Visscher and Seymore, 2025). These resources include reference handouts tied to the certification training so examiners can review and refresh their knowledge independently, along with supplemental trainings that have been offered over time (Carter-Visscher and Seymore, 2025).

MST and Health

As with other disability claims, claims related to MST require C&P examiners to confirm the presence of the claimed condition and assess its effect on functioning. These determinations require clinical expertise. Performing C&P examinations for MST-related claims requires basic knowledge of MST and its health effects. This includes the general epidemiology of sexual trauma, including knowledge of its prevalence, risk factors, and potential health consequences overall and among subgroups (e.g., by sex and age). It also includes understanding factors unique to experiencing sexual trauma and harassment during military service, such as how MST presents, and how military culture may influence disclosure, assessment, treatment, and recovery (Yancey et al., 2024). In particular, examiners need knowledge of and skills to recognize the unique ways in which MST can manifest, including behavioral markers of MST such as hypersexuality; sudden changes in behavior noted by family and friends; changes in job performance and requests to change duty station; difficulties with body image, intimacy, and relationships; and withdrawal from social interactions (Bourke, 2022). Understanding these relationships is critical for developing a clinical opinion of service connection, in which providers need to describe the relationship between a claimed condition and an MST experience.

The first lessons in both the VHA and VBA training modules provide comprehensive background information on MST, including defining MST

as an event or experience rather than a diagnosis, potential effects of MST overall and by subgroups, and potential barriers to reporting or disclosing MST (VA, 2022b, 2025a). In addition, case studies in the VBA training module illustrate the potential short- and long-term effects of MST well (VA, 2025a). However, the learner is not requested to apply the information from the lesson.

Both training modules lack information on the physical health consequences of MST, which leaves examiners unprepared to assess the presence of MST physical health symptoms and disabilities, and may hinder their ability to link the full range of diagnoses and health consequences to the MST experience (VA, 2022b, 2025a). The VHA training emphasizes PTSD claims and does not explore the link between MST and physical health conditions, including the five conditions named in the committee's Statement of Task (sexual dysfunction, pelvic pain, pelvic dysfunction, musculoskeletal disabilities, and cardiovascular conditions including stroke; see Chapter 1) (VA, 2022b). The more recently issued VBA training has an appropriate and comprehensive list of physical effects of MST in its first lesson but does not provide sufficient guidance on how to evaluate and connect these physical symptoms and conditions to MST (VA, 2025a). The trainings also lack instruction on what distinguishes an MST exam from other exams and on practical information for examiners, such as time constraints, competing priorities, and the emotional toll of the exam on examiners (Carter-Visscher and Seymore, 2025). To that end, there is no mention of self-care for clinicians who, in taking an MST history, may be subject to secondary trauma/vicarious traumatization that could interfere with their conduct of the examination and with their ability to continue to work with traumatized veterans (Cieslak et al., 2013; Ullman, 2026). Similarly, neither training course provides instruction on skills needed to assess and document impairment (e.g., functional status or ability to work) due to conditions related to MST and whether or how this might differ from assessing and documenting impairments from other claims.

Trauma-Informed Approach

Trauma experiences can affect patients' interactions with the health care system, including claimants' disclosures during C&P exams, by complicating the presenting symptoms of disorders or triggering retraumatization (SAMHSA, 2014). Patients who have experienced trauma may also decline needed care or procedures (Ades et al., 2019; Sharkansky, 2025). Trauma-informed care recognizes how trauma impacts potential patients (Gerber and Adger Antonikowski, 2025). Importantly, trauma-informed care is not health care provided to address the physical or emotional effects of trauma exposure but rather guidance for caring for patients whose trauma history

may cause challenges in medical interactions. Through delivery of a trauma-informed approach to care, clinicians can minimize the potentially harmful effects of health care encounters and of the trauma itself (Chu et al., 2024; SAMHSA, 2023).

The Substance Abuse and Mental Health Services Administration identifies six principles that guide a trauma-informed approach to care (SAMHSA, 2014, 2024). The principles were developed for organizations but are readily adaptable to direct patient care:

1. **Safety:** Ensuring safe physical settings and interpersonal interactions.
2. **Trustworthiness and Transparency:** Care and decisions made with clarity, consistency, respect, and fairness to build trust.
3. **Peer Support:** Support from those with lived experiences of trauma.
4. **Collaboration and Mutuality:** Partnerships and the leveling of power differences between and among providers and patients.
5. **Empowerment:** Recognition and building upon of individuals' strengths and experiences.
6. **Cultural, Historical, and Gender Issues:** Understanding the perspectives, beliefs, and other context that influence both how clinicians provide care and how patients receive it and applying gender inclusive and culturally responsive approaches to caring for patients (Purkey et al., 2018; SAMHSA, 2014, 2024).

Examiners can integrate these principles of trauma-informed care into C&P exams by providing a safe, private, and comfortable environment; validating the veteran's feelings to foster emotional safety; avoiding retraumatization by engaging respectfully and transparently; and using respectful, non-judgmental, and non-technical language (Soran, 2024; Webermann et al., 2023). In addition, examiners can allow veterans to describe their traumatic experiences in their own words and not question whether a traumatic event occurred (Webermann et al., 2023). A trauma-informed examination also creates an environment that acknowledges the challenges individuals from different backgrounds and experiences face (e.g., by gender, race/ethnicity, sexual orientation), and how those challenges might influence MST and subsequent disability (Carney et al., 2026; Dhillon et al., 2023).

Trauma-informed physical examinations begin with the patient fully clothed and seated at eye level with a discussion of the examination plan and who will be in the room for the exam, including chaperone options (Soran, 2024). Managing expectations can help build trust and feelings of collaboration and mutuality between veterans and examiners. In a small qualitative study investigating the experiences of veterans filing MST-related disability claims, one participant said that the examiner simply describing the purpose and plan for the examination upfront made her feel supported

(Webermann et al., 2026b). Aspects of the exam can minimize feelings of interrogation and confrontation and thus can promote safety and mutuality in the encounter. Such strategies may include ensuring the claimant has unobstructed views of the exit, using an L-shaped seating arrangement for the claimant and the examiner, and establishing a respectful physical distance. Then, practitioners can seek patient input regarding the exam and receive verbal consent before starting (Soran, 2024). During exams, best practices for providers include acknowledging any previously disclosed trauma, empathetically responding to trauma disclosure, using appropriate draping, providing updates on the progress of the exam, asking patients whether they have questions or concerns about the exam, monitoring for signs of distress, and reminding the patient that the exam can be stopped at any time (Soran, 2024). Providers can practice clear communication by mirroring patient language and using medical terminology to describe the exam (Soran, 2024). After an examination, providers explicitly state the exam findings, step out of the exam room to allow the patient to re-dress before discussing results or making a care plan, and end with any patient questions and a follow-up plan (SAMHSA, 2023; Soran, 2024). Applied to C&P examinations, a trauma-informed approach would begin with the claimant seated and fully clothed with an explanation of the nature and purpose of the exam (i.e., to determine service connection and impairment); involve the veteran in collaborative, autonomy-respecting decision-making; and connect the veteran with appropriate support services such as evidence-based treatments for health conditions related to MST, including cognitive-based therapy and eye movement desensitization and reprocessing treatment, housing, advocacy, and legal aid (VA, 2025b).

Best practices suggest that increasing provider knowledge about trauma and trauma-informed care requires ongoing training and professional development (Purtle, 2020; SAMHSA, 2014). Although rigorous evaluations are limited, a systematic review of 23 evaluations of trauma-informed organizational interventions that include staff training found both staff and client outcomes improved significantly following the interventions (Purtle, 2020). Among 14 studies that assessed staff outcomes, including knowledge, attitudes, or behaviors, 12 reported a statistically significant increase in at least one outcome, and the magnitude of the association increased with the duration of training. In addition, among 9 of these 14 studies that assessed outcomes at one or more months after the training occurred, seven reported that staff maintained these improvements. This review also found that of two studies that assessed patient perceptions of care, one found that the trauma training evaluation found a significant improvement in patients' perceptions of shared decision-making, but no meaningful change in perceptions of patient-provider rapport or communication, while another found no significant improvement in patients' views of staff sensitivity

(Purtle, 2020). Despite these promising results, most of the studies were limited by weak study designs, such as single-group pre-/post-training designs, and analytic approaches, such as not accounting for potential confounders, which reduces confidence in these findings (Purtle, 2020).

A Department of Justice guidance document, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Third Edition*, identifies several existing high-quality education courses for health care professionals who provide sexual assault medical forensic examinations (DOJ, 2024). These courses include information relevant to performing C&P examinations, such as person-centered and trauma-informed medical/forensic history taking and conducting trauma-informed physical examinations, and may serve as high-quality models. The *Sexual Assault Medical Forensic Exam: Virtual Practicum* hosted by End Violence Against Women International (EVAWI), an organization that provides training and technical assistance to support law enforcement responses to gender-based violence including multidisciplinary training for health care providers, prosecutors, and advocates, incorporates interactive approaches—such as patient simulations with five patients from different populations—and an opportunity to observe and conduct a virtual medical forensic examination (EVAWI, n.d.). A free online course for clinicians without sexual assault examination training developed by the International Association of Forensic Nurses (since dissolved) and now available through the Emergency Nurses Association called *Caring for the Sexually Assaulted Patient When There Is No SANE in Sight: A Training for ALL Healthcare Providers* helps them to care for patients who have experienced sexual assault using a trauma-informed and patient-centered approach (ENAU, n.d.).

The VBA training module describes the concept of trauma-informed care on multiple slides across multiple lessons, including an informative overview of trauma-sensitive examinations and a well-articulated example of trauma-informed communication (VA, 2025a). However, unlike the EVAWI Virtual Practicum, there is no opportunity for learners to practice trauma-informed approaches in a low-risk setting. As will be discussed in greater detail (below), a passing grade on a short set of multiple-choice questions may indicate that the learner has successfully absorbed a set of facts and abstract principles, but this falls short of demonstrating competence in applying those facts and principles in the tense and complex clinical setting of a disability examination involving MST. Thus, the total amount of education on trauma-informed practices across both VHA and VBA MST courses is inadequate to prepare the learner to apply these lessons in practice.

Legal and Regulatory Frameworks Governing MST

The protocols and standards governing the conduct of MST-related C&P exams are defined in laws, regulations, and VA policies. These include laws and regulations defining unique eligibility criteria and evidentiary standards, as well as general frameworks for all VA disability determination, such as VA's policies on presumption of soundness and benefit of the doubt that govern the adjudication of VA disability compensation claims. Additionally, legal cases have helped define how evidence is used and interpreted in determining disability compensation for veterans. For example, the absence of evidence is not affirmative evidence to the contrary.¹² Examiners may not attribute a gap in treatment or lack of diagnosis during service as evidence that a claimed condition is not service-connected.¹³ Relatedly, a lack of service records documenting an MST experience may not be used to conclude it did not happen, and a failure to report MST during service is also not evidence that it did not occur.¹⁴ Such absence of evidence cannot be used to disprove a claimant's position without "a proper foundation . . . to demonstrate that such silence has a tendency to prove or disprove a relevant fact."¹⁵ Additional rulings have determined that a lack of behavioral changes during or after an in-service event is not conclusive evidence against the occurrence of that traumatic experience; further, opinions from medical providers, including those made after an event, can be used to corroborate the occurrence of the stressor.^{16,17}

Conducting MST-related C&P examinations requires knowledge and application of these legal and regulatory concepts. The current MST training for C&P examiners lacks instruction on these legal and regulatory concepts, especially in regard to their application in the development and drafting of the medical opinions about a claimed condition's connection to service and its effects on functioning. Additionally, although the VBA training includes a lesson on Department of Defense (DOD) and VA policies and programs for MST, it does not sufficiently describe the policies specific to MST and best practices for assessing and documenting evidence of behavioral markers (i.e., behavioral changes experienced after traumatic experiences) and lay statements that may be essential for linking MST to military service for PTSD claims (VA, 2025a). Finally, both training modules include a lesson encompassing DOD programs and policies. While these

¹² *Buczynski v. Shinseki*, 24 Vet. App. 221, 224 (2011).

¹³ *Cosman v. Principi*, 3 Vet. App. 503, 505 (1992).

¹⁴ *AZ v. Shinseki*, 731 F.3d 1303, 1318, 1322 (Fed. Cir. 2013).

¹⁵ *Fountain v. McDonald*, 27 Vet. App. 258, 272 (2015) (citing *Horn v. Shinseki*, 25. Vet. App. 231, 239 (2012)); See also, *Buczynski v. Shinseki*, 24 Vet. App. 221, 224 (2011).

¹⁶ *Molitor v. Shulkin*, 28 Vet. App. 397, 410–11 (2017).

¹⁷ *Menegassi v. Shinseki*, 638 F.3d 1379, 1382 (Fed. Cir. 2011).

are relevant to examinations with active-duty service members, they are not likely to be relevant for examinations with veterans who have already separated. The modules do not make this distinction, providing another example that practical application of the training content is not considered.

Military Structure and Culture

Knowledge of military structure and culture—and the application of this knowledge when providing care to service members or veterans—is essential for any provider working with individuals with a history of military service. Research has shown that health care providers have historically failed to recognize, interpret, and address how variations in patients’ health beliefs and behaviors may hinder effective communication and relationship building, and contribute to dissatisfaction, poor adherence, and worse health outcomes (Betancourt and Green, 2010; Zolnieriek and Dimatteo, 2009). Military cultural competence refers to a provider’s “attitudinal competence, cognitive competence, and behavioral competence in working with service members and veterans” (Atuel and Castro, 2018, p. 77). Attitudinal competence is a provider’s ability to acknowledge and confront one’s own attitudes and beliefs about the military population as a cultural group; cognitive competence is a provider’s understanding of military culture (including the organizational structure, cultural norms, and societal identities of service members and veterans); and behavioral competence refers to having the required skills to assess and treat service members and veterans (Atuel and Castro, 2018). Military cultural competence aids in the building of rapport with a veteran or service member and allows a provider to properly screen for appropriate exposures, experiences, and conditions (Atuel and Castro, 2018). Specific to MST and the conduct of C&P examinations, military cultural competence includes understanding aspects of the military that may affect reporting MST and the presentation of health sequelae among individuals with different backgrounds and experiences (Galovski et al., 2022; Hargrave et al., 2022). Military cultural competence also helps examiners to understand how systemic factors, such as institutional distrust or prior negative experiences with reporting, may influence a veteran’s willingness to disclose MST (Atuel and Castro, 2018). In addition, knowledge of military structure and culture helps them recognize how intersecting identities, such as race, gender, and sexual orientation, affect both vulnerability to MST and the physical and psychological impacts of the trauma.

Military cultural competence can be acquired through supplemental training. The VA Mission Act¹⁸ requires clinicians working within VA’s

¹⁸ John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Mission Act of 2018, Public Law 115-182, 115th Congress, 2nd Session.

contracted Community Care Network to complete an eight-hour course on military cultural competence. Although this training is highly recommended for VHA clinical staff, they are not required to complete the full eight-hour training. Clinical trainees in the VA system participate in military culture training as part of their fellowship and residency programs (VA, n.d.-a). As described in Chapter 2, MST differs from other forms of sexual trauma because military values, norms, and culture uniquely influence the risk of experiencing sexual trauma, the likelihood of disclosure, and the health effects of the trauma and their clinical presentation. It is important for examiners to understand how factors, such as feelings of institutional distrust or betrayal and prior negative experiences with reporting, may influence a veteran's willingness to disclose MST during an examination. Thus, knowledge of these factors is critical to conducting disability examinations for patients with a history of MST, understanding and assessing the effects of that trauma on the veteran's health and functioning, and assessing how a claimed condition may be related to MST.

Medical Opinions

Examiners provide critical documentation of the findings from the C&P examination in the form of clinical opinions about the effect of a claimed disability on a veteran's normal functioning. If requested, examiners also provide an opinion about whether the condition is related to MST and thus service-connected. (Note: While VA generally refers to this opinion as a "medical" opinion, given that some providers who may draft these opinions are not medical doctors [e.g., psychologists], it may be more appropriate to refer to these statements as "clinical opinions.") Examiners document these opinions of DBQs, which guide examiners through a clinical exam. VA also uses Medical Opinion DBQs, which require examiners to provide an opinion statement about the relationship between the present diagnosis and an in-service disease, injury, or event using legal language and a rationale supporting this statement (Majors and Hyberger, 2026). Neither VHA nor VBA MST training courses provide instruction on completing, developing, or drafting these opinions. The VHA general certification course on the medical opinion, which all examiners (including VBA-contracted and VHA examiners) take, includes training on the medical opinion and indicates, "There are specific rules about the medical opinions for MST, but that will be addressed in later trainings" (VA, 2022a). However, neither MST course includes information on drafting medical opinions specific to MST-related claims, and the committee identified no additional training on medical opinions for MST-related claims. Adjudicators use medical opinions as one source of evidence to determine whether a claimed disability is service-connected. Although the examiner is told to use the required legal

language in opinion statements, there is insufficient instruction in the training courses on what that language is or how to use it. This is of particular concern, because if service connection or impairment is not sufficiently described using legal language, an adjudicator may conclude inaccurately that there is no diagnosis or that the condition is not related to MST, and this can result in claims delays and denials.

The examiner's opinions about whether a claimed condition was incurred or aggravated during service and the level of impairment must be based on complete and accurate facts such as the veteran's prior medical history and exams, as well as "reasoned medical judgement."¹⁹ An opinion based on inaccurate facts is considered irrelevant and has no probative value (i.e., no impact on the claim).²⁰ The examiner's opinion must also include sufficient rationale for its conclusion. This rationale must be "factually accurate, fully articulated" and include "sound reasoning" for the conclusions made that contribute to the medical opinion.²¹ A conclusion provided without such rationale does not provide sufficient evidence for informed decisions by VA.²² However, the MST courses include no instruction on the key elements of a high-quality and sufficient rationale. Indeed, the 2022 VA Office of Inspector General (OIG) report on medical opinion requests quoted a claims processor who said, "No one has ever trained us what the medical opinion should actually say" (VA OIG, 2022b, p. 15).

In response to a request from the committee, VBA wrote, "A medical opinion shall provide a thoughtful conclusion based on medical research, all available evidence, including the entire claims folder, and supported by a logical, clearly stated rationale" (Majors and Hyberger, 2026). Optum Serve, one of the contracted vendors, further identified the following "essential components" of a medical opinion rationale:

- Integration of the veteran's medical records and service history, including relevant dates, diagnoses, and clinical findings;
- Explanation of biomechanical or pathophysiological mechanisms that support the claimed secondary or direct service connection;
- Citations from peer-reviewed medical literature and clinical guidelines that reinforce the medical rationale and provide evidence-based support; and
- A structured and coherent narrative that connects the evidence to the conclusion (Seymore and Carter-Visscher, 2025).

¹⁹ *Acevedo v. Shinseki*, 25 Vet. App. 286, 293 (2012).

²⁰ *Reonal v. Brown*, 5 Vet. App. 458, 460–61 (1993).

²¹ *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295, 304 (2008).

²² *Steff v. Nicholson*, 21 Vet. App. 120, 125 (2007).

Box 3-1 shows examples of exemplar medical opinions for physical and mental health conditions, which Optum Serve provided.

These elements are reasonable to include in a statement of clinical analysis about the relationship between a disability and MST. However, the current VA courses are insufficient to prepare examiners to draft medical opinions with these elements. Although the VBA training highlights the importance of identifying behavioral markers of MST for PTSD claims, it does not offer enough information or help in applying such knowledge to assure the examiner's ability to recognize, appreciate, and appropriately document such markers in the Medical Opinion DBQ. Similarly, the VHA training does not cover enough material to help examiners make connections between an MST experience and claimed conditions or symptoms. In addition, the trainings lack sufficient instruction on how to identify supporting evidence in the scientific literature, providing only one slide that directs examiners to review and cite peer-reviewed medical literature as needed to support the rationale for medical opinions. Clinicians may have exposure to research, but most are not trained to assess the strength and quality of epidemiologic research on the etiology of diseases. Relatedly, claims processors and adjudicators are unlikely to have the scientific expertise needed to assess the quality and accuracy of the literature cited in the medical opinions they review. This issue is relevant for all claims, but it is especially salient for MST-related claims where the literature on the health effects of MST is emerging and therefore changing rapidly. Providing a resource of vetted, high-quality sources developed with input from medical librarians may help examiners to identify appropriate evidence in the literature.

Ultimately, the lack of training on how to develop and draft a medical opinion of service connection for MST-related claims in the required legal language that is sufficient for VA claims raters to adjudicate claims may lead to ambiguity and the application of examiner and adjudicator discretion. This may result in differing opinions for different veterans who present with the same conditions and with similar MST experiences, depending on the literature identified by different clinicians (Webermann et al., 2026a). Further, the lack of VA guidance has likely contributed to the need for vendors to provide examiners with supplemental guidance on drafting medical opinions, both generally and specific to MST, as described earlier in this section (Dean, 2026; Mirza, 2026). Such efforts to improve the quality of medical opinions through increased standardization, training, and guidance are commendable. However, these courses may nonetheless result in differences between vendors, owing to different interpretations of ambiguous VA policies and statutory requirements. Moreover, these courses and tools are generally proprietary and thus not transparent to veterans or VA. Taken

BOX 3-1
Example Exemplar Medical Opinions of
Service Connection for MST

Exemplar Physical Health Opinion

Is the bladder condition at least as likely as not caused by the service connected MST and/or PTSD?

Opinion: It is at least as likely as not that the Veteran's current overactive bladder is proximately due to or the result of MST experienced during military service.

Rationale:

1. Clinical Evidence:
 - Veteran: Jane Doe, 42-year-old female, U.S. Army service from 2001–2006.
 - MST Documentation: Service records and VA mental health notes confirm that the Veteran experienced MST in 2003 while stationed overseas. She was diagnosed with PTSD in 2005 and has received ongoing mental health treatment since separation.
 - Bladder Symptoms: While no formal diagnosis of OAB was made during service, progress notes show that she presented to sick call three times in 2004 and 4 times in 2005 with complaints of suspected urinary tract infection. Each time a culture was obtained and found to be negative and she was sent home and told to drink cranberry juice. Post-service VA primary care notes from Dallas VAMC (2010, 2013, 2016) document intermittent complaints of urinary urgency, frequency, and nocturia.
 - Psychiatric Correlation: Mental health notes from 2022–2024 indicate persistent PTSD symptoms, including hyperarousal and anxiety, which have been temporally associated with worsening urinary symptoms.
2. Pathophysiology & Literature Support:
 - MST is a form of psychological trauma that can lead to long-term dysregulation of the autonomic nervous system, which plays a critical role in bladder control.
 - According to Psychology (2024), PTSD can lead to urinary incontinence and bladder dysfunction due to heightened stress responses, increased pelvic muscle tension, and altered neurohormonal signaling. [psychology.com]

- A study published in the American Journal of Psychotrauma (2025) found a significant correlation between PTSD severity and lower urinary tract symptoms (LUTS) in women with a history of sexual abuse. Expressive suppression—a common coping mechanism in trauma survivors—was strongly associated with both PTSD and LUTS severity. [ptonline.com]
- The International Continence Society (ICS) presented findings in 2020 showing a strong association between MST and voiding dysfunction, including OAB, in female veterans. [ics.org]

Conclusion: Given the Veteran’s documented MST, chronic PTSD, and progressive urinary symptoms consistent with OAB, along with strong supporting literature linking psychological trauma to bladder dysfunction, it is medically reasonable and supported by evidence to conclude that the Veteran’s overactive bladder is at least as likely as not proximately due to or the result of her service-connected MST.

Exemplar Mental Health Opinion

MST Medical Opinion Question #1: The examiner is asked to comment on whether the evidence of record corroborates the occurrence of the MST stressor event. Is the evidence of record at least as likely as not (50 percent or greater probability) consistent with the occurrence of the MST stressor event(s)? Please provide a rationale for the opinion and list any evidence used to arrive at your decision.

Rationale: The Veteran reported the MST event occurred around the summer of 2002. The examination request indicated that Tab A should be reviewed as potential marker evidence. Tab A is a Dental Health Questionnaire dated August 2003 that shows the then service member endorsed depression, anxiety, or nervousness, which was after the MST event. At enlistment in 2000, the claimant denied psychiatric symptoms to include depression and excessive worry. Therefore, the depression, anxiety, or nervousness noted in the 2003 STR is a behavior change compared to before the MST event. The evidence in Tab A showing endorsement of depression after the MST event in 2002 is consistent with the Veteran’s statements that she became depressed after the MST event. Based upon these considerations, the evidence in Tab A showing the claimant endorsed depression, anxiety, or nervousness in 2003 was a behavior change after the MST event and at least as likely as not (50 percent or greater probability) serves as marker evidence that is consistent with the MST stressor event and aftereffects described by the Veteran.

continued

BOX 3-1 Continued

MST Medical Opinion Question #2: IF YOUR EXAMINATION DETERMINES THE VETERAN HAS A CURRENT DIAGNOSIS OF PTSD, please provide an opinion as to whether the current PTSD diagnosis is at least as likely as not (50 percent or greater probability) caused by or a result of the MST stressor event(s). Please note that PTSD is the only mental health condition that can be service connected solely based on circumstantial marker evidence (38 CFR 3.304(f)(5)).

Rationale: The enlistment exam from April 2000 shows a normal psychiatric exam with no history of psychiatric symptoms endorsed. The Veteran indicated she was sexually assaulted around the summer of 2002, and she reported becoming depressed, anxious, and withdrawn after the MST event. As described above, there is marker evidence to support the occurrence of the MST event. On today's exam, the Veteran's symptoms met full DSM-5 criteria for PTSD, which was diagnosed directly related to the MST event described by the Veteran, which met DSM-5 Criterion A for a stressor event capable of supporting a PTSD diagnosis. Based upon these considerations, the current PTSD diagnosis is at least as likely as not (50 percent or greater probability) caused by or a result of the MST stressor event(s).

MST Medical Opinion Question #3: IF YOUR EXAMINATION DETERMINES THAT, IN ADDITION TO PTSD, THE VETERAN HAS ADDITIONAL MENTAL DISORDERS, please state whether the additional mental disorders are at least as likely as not (50 percent or greater probability) secondary to the PTSD and provide a rationale. For each mental disorder diagnosed, identify and clearly list which symptoms are attributed to each diagnosis. If one or more symptoms overlap and cannot be separated without speculation, please state so and provide a rationale (38 CFR 3.310).

Rationale: The Veteran was diagnosed with Major Depressive Disorder, moderate, recurrent episode in addition to PTSD. The Veteran reported feeling depressed after the MST event, and the Dental Health Questionnaire dated August 2003 shows the then service member endorsed depression, anxiety, or nervousness after the MST event. The Veteran reports her depression symptoms have continued over the years since experiencing the MST event, and VA treatment records show she screened positive for depression on the PHQ-9 in 2008, 2010, 2020, 2021, 2023, and 2025. She was formally diagnosed with Major Depressive Disorder in 2010, reporting that she had felt depressed since her military service, and she has had recurrent episodes since then. The Veteran's negative thoughts and depressed mood relate to her MST event are consistent with DSM-5 Criterion D, negative alterations in cognition and mood. For this Veteran, it appears her depression began as a

trauma-related symptom following the MST event and has since progressed to meet full DSM-5 criteria for a distinct Major Depressive Disorder, which is secondary to her primary diagnosis of PTSD. Finally, it is well established that depression is often comorbid with PTSD, and occurs in approximately 30-50% of individuals diagnosed with PTSD. While not fully understood, the relationship between PTSD and MDD is thought to be complex, involving bidirectional causality, common risk factors, and common vulnerabilities. Based upon these considerations, the Veteran's Major Depressive Disorder, moderate, recurrent episode is at least as likely as not (50 percent or greater probability) secondary to the PTSD.

The Veteran's depressed mood, sleep impairment, disturbances in motivation and mood, difficulty in establishing and maintaining effective work and social relationships, and suicidal ideation overlap both the PTSD and Major Depressive Disorder diagnoses as these are all common symptoms and functional impairments associated with both disorders and cannot be separated without resorting to speculation.

References:

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

Angelakis, S., & Nixon, R. D. V. (2015). The Comorbidity of PTSD and MDD: Implications for Clinical Practice and Future Research. *Behaviour Change*, 32(1), 1–25. doi:10.1017/bec.2014.26

MST Medical Opinion Question #4: IF YOUR EXAMINATION DETERMINES THE VETERAN DOES NOT HAVE PTSD BUT HAS A DIFFERENT MENTAL DISORDER(S), please review the claims folder for supporting in-service evidence of the MST stressor(s). (38 CFR 3.303) If there is in-service evidence supporting the Veteran's statement regarding the stressor, please provide an opinion as to whether the mental disorder(s) diagnosed on examination is at least as likely as not (50 percent or greater probability) caused by or a result of the MST stressor event(s). Please provide a rationale for the opinion and list the evidence used to arrive at your decision.

Rationale: N/A – The Veteran was diagnosed with PTSD.

SOURCE: Seymore and Carter-Visscher, 2025.

NOTE: CFR = Code of Federal Regulations; DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition; MDD = major depressive disorder; MST = military sexual trauma; OAB = overactive bladder; PHQ-9 = Patient Health Questionnaire-9; PTSD = posttraumatic stress disorder; VA = Department of Veterans Affairs; VAMC = Department of Veterans Affairs Medical Center.

together, these sources of potential differences arising from insufficient training may lead to inaccurate disability ratings and unfair decisions.

Modes and Format of Instruction

High-quality training includes instruction that employs a range of modalities, including interactive elements such as simulations or role play that allow trainees to apply knowledge and practice skills. Multi-modal approaches to training have been shown to improve learner understanding of the topic, retention of knowledge, and performance (Kane et al., 2024; Lucero et al., 2023; Reger et al., 2021). Specifically, a combination of didactic and interactive or simulated experiences has been shown to produce more optimal results in terms of skill acquisition and knowledge retention (Lucero et al., 2023; Reger et al., 2021). Reger and colleagues studied virtual standardized patients as part of a training scenario that allowed learners to practice communication and clinical skills in a low-risk environment with immediate feedback. This type of experiential learning yielded positive outcomes in enhancing diagnostic accuracy, clinical decision-making, and practitioner confidence (Reger et al., 2021). Simulation has been shown to increase patient safety, decrease errors, and improve clinical judgment, but it must be structured with clear objectives in set scenarios and clear methods of evaluation (Harder, 2010; Watts et al., 2021). When simulation or interactive components are included in training, studies have shown improvements in clinical approaches, use of evidence-based recommendations, and the ability to accurately assess the targeted disease (Lucero et al., 2023).

A high-quality MST training would be conducted via a web-based platform and include both didactic and interactive components. Didactic components establish foundational knowledge. Interactive components—such as simulation or work with a virtual standardized patient—are intended to allow the learner to apply the skills and knowledge obtained in the didactic components. Further, repetition of training via refresher or interval training sessions is needed to ensure that examiners have the latest evidence-based information and an opportunity to apply that knowledge and their skills in a low-risk environment before examining veterans with MST-related claims (Lucero et al., 2023; SAMHSA, 2023). Current requirements that VBA examiners complete MST training every five years and VHA examiners complete it one time are insufficient to ensure that the examiners maintain their competencies.

The current VA training courses for C&P examiners use limited modes of instruction, focusing on didactic approaches with little to no use of video or interactive approaches. Although slides in the training courses are generally clear and comprehensive, they tend to have dense content on each slide. Adding slides and breaking up the content would make each slide easier to

read and digest. Furthermore, the slides rely primarily on audio recorded over static slides. Especially for instruction on skills, incorporating video could help demonstrate how to practice or apply those skills. Lesson 3 in the VHA training module provides an appropriate and comprehensive introduction to trauma-informed care. For example, it outlines phrases that the examiner should avoid that could be construed as questioning the event and provides suggestions for how the exam should be conducted like sitting at the same level as the veterans, maintaining eye contact, using a calm tone, and allowing the veteran to take breaks from the exam as needed. Adding video could demonstrate not only the terminology but also the non-verbal communication that allows a patient to discuss these events (Lucero et al., 2023).

In addition to limited modes of instruction, the training courses lack several practical features that would more effectively support examiners in both learning and reviewing the material. In particular, the platform's navigational structure is limited. The table of contents returns users only to the beginning of each lesson, offering no mechanism for locating a specific section or video directly. Consequently, learners must remember the lesson in which the content appeared, navigate back to the start of that lesson, and progress until they find the relevant segment. In addition, the training courses do not provide copies of the slides for the lessons, which restricts examiners' ability to print or download the content. Making the materials easily accessible afterward would help examiners review key content and reference it during exams or while completing DBQs and medical opinions. Finally, the training environment does not provide a quick way for examiners to obtain clarification or ask questions about the material. Although email and phone support are available, the absence of a real-time option, such as a chat feature, limits timely access to assistance.

TRAINING ASSESSMENT AND CONTINUOUS QUALITY IMPROVEMENT

Acknowledging the progression of competence as a project of continuous learning, competencies can be acquired through educational coursework if learners demonstrate proficiency in applying specified competencies. To that end, assessment is a key feature of competence-based medical education, and best practices for assessing clinical competence may also apply to assessing the competence of C&P examiners. Assessment can serve formative and summative purposes. Formative assessment includes tests at the end of a lesson or course that can enhance the learning of the clinical practitioner by giving feedback on that person's acquisition of clinical knowledge and display of skills (Wass et al., 2001). Summative assessment assures that the clinicians' performance demonstrates competency, involves several key concepts to consider, and typically requires many different

tests for examination cases that are complex (Wass et al., 2001). These key assessment concepts include blueprinting (test content matches the objectives set by the curriculum), standard setting (the minimum competence to be achieved before certification), reliability (the reproducibility of test results), and validity (Wass et al., 2001).

Miller's Competency Pyramid (see Figure 3-1) is a framework that maps different types of assessments to different forms of competency, which is useful when designing assessment of performance competence. The model aims to enhance training for students, residents, and clinicians by progressing beyond simple factual tests of knowledge or essays, which demonstrate knowledge of application, to include the performance and action assessments of a learner's ability that "shows how" and "does" (Miller, 1990). Medical education seeks strategies that assess "shows how" before clinicians begin to practice independently (Boursicot et al., 2011). Among a variety of assessment methods is the use of unstandardized real patients in long and short cases, which can be observed or unobserved. Using an unobserved approach, the clinician presents the case (Wass et al., 2001). Medical schools frequently use a specific format of observed assessment, the objective structured clinical examination (OSCE), where clinicians rotate through a series of stations requiring application of clinical skills (Wass et al., 2001). The OSCE is described by some to be the gold standard of clinical competency and is frequently used in medical education (Al-Hashimi et al., 2023). Other tools involve patient perception questionnaires to assess aspects of clinician communication and perceived attitudes. Important to the medical examination process, patient perception of physician and nursing skills has identified the importance of communication, listening skills, and openness to questions. Patients judged good clinical judgment as important to nurse competency (Wyson and Driver, 2009). Standardized patients, rather than real patients, are being used more frequently. The American Medical Association Guide developed for disability examiners who conduct medical

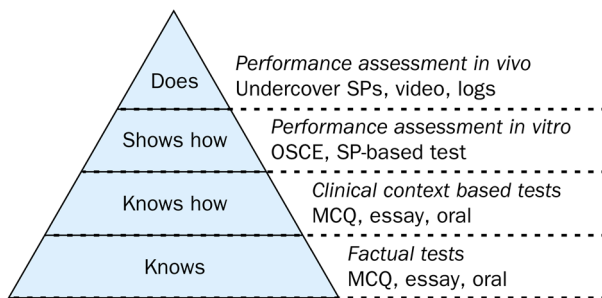


FIGURE 3-1 Miller's Competency Pyramid.

SOURCE: Wass et al., 2001. Reprinted with permission from *The Lancet*.

NOTE: MCQ = multiple choice question; OSCE = objective structured clinical examination; SP = simulated patient.

examinations for mental and behavioral disorders, also recommends a post-assessment satisfaction questionnaire as one mechanism of quality improvement (Els et al., 2022).

Initial Training Assessment

The sole assessment of C&P examiners currently is a written multiple-choice evaluation conducted after the initial MST training course is completed. Specifically, examiners must pass a written knowledge evaluation after completing each lesson with a score of 80 percent, as is required for all accredited courses (Eggers, 2025a; Statton, 2025b). Contract examiners have five attempts to pass a final assessment, after which the course assessment can be reset, or the examiner may complete the training again (Statton, 2025b). Although this score may provide a reasonable way to assess knowledge, this standard is insufficient to judge competency of providers, especially providers who do not specialize in diagnoses among veteran populations and survivors of sexual assault or in the influence of military culture on veterans' perception of their trauma experiences. Moreover, one-time training evaluations are inadequate for ensuring that examiners retain the information, and multiple-choice examinations do not ensure that examiners can apply the knowledge acquired when conducting a C&P exam. In the absence of continuing education and regular training, knowledge and skills may fade over time without reinforcement. The requirements to be retrained every five years (for contracted examiners) or just once (for VHA examiners) are insufficient to ensure that examiners maintain the standards of practice, especially as forms or procedures change and the emerging literature on the health effects of MST evolves.

In addition to initial training, consultation may provide significant value for VA disability examiners by improving their confidence, accuracy, efficiency, and job satisfaction. For new examiners, consultation accelerates professional development, while for seasoned staff, it offers opportunities for leadership and continued growth (Goldsmith et al., 2006; Pethrick et al., 2017). This results in higher-quality and more consistent evaluations for veterans. VHA has demonstrated that a multi-modal training approach with consultation was superior to one-dimensional dissemination approaches in achieving rapid, high-quality dissemination of evidence-based training for the treatment of PTSD (Karlin and Cross, 2014). This PTSD treatment approach also required demonstrated skill in applying military cultural competence and trauma-informed care (Karlin and Cross, 2014). Consultants were drawn from the ranks of experienced clinicians and available at a regional level, such that relatively few consultants were required to meet the training needs of thousands of VA clinicians across the nation (GAO, 2025). A similar approach could be developed in support of MST training.

Quality Assurance

For MST-related claims, as for all complex claims (TBI, Gulf War Illness), MDEO conducts special focused reviews because these claims are more likely to result in errors. VA procedures require these reviews every two years, but in 2025, the Government Accountability Office (GAO) found that these reviews were either overdue by nearly a year or not yet scheduled (GAO, 2025). For all claims, MDEO provides several forms of feedback to contractors about their performance (GAO, 2024, 2025). Feedback mechanisms for contractors include quality action plans, a quality checklist, special focused reviews for complex claims, technical assistance, vendor guidance memos, regular meetings, stakeholder feedback, and ad hoc assistance (GAO, 2024, 2025; VA OIG, 2022a). MDEO also uses financial incentives tied to performance. MDEO provides quarterly reports to the contracted vendors with the types of DBQs claims processors identified as incomplete or unclear and types of DBQs that are insufficient (GAO, 2025). Within 45 days of receiving this report, the contractor is required to provide MDEO with a quality action plan, which identifies the cause of errors and provides a corrective action plan (GAO, 2025). An MDEO analyst reviews the plan and summarizes findings. However, GAO found that MDEO had unclear and incomplete procedures for reviewing the plans and ensuring contractors completed the corrective actions (GAO, 2025). This finding echoes findings from an earlier VA OIG report, which found that the contracts with exam vendors did not require them to correct the errors MDEO identified during their quality reviews (VA OIG, 2022a). MDEO managers stated at the time that vendors did not need to perform corrective actions because VBA has typically decided the claims before the MDEO quality review (VA OIG, 2022a). However, failure to correct errors could result in inaccurate ratings and claims denials or lead to inefficiencies and waste by requiring appeals and reviews to address the errors.

MDEO uses a 13-question quality criteria checklist (see Box 3-2) to assess whether DBQs are completed accurately and completely, identify error trends, analyze effects of errors on claims, and identify corrective actions monthly (GAO, 2025; VA OIG, 2022a). MDEO also uses this checklist as one of five measures assessing contracted exam quality, customer satisfaction, exam volume, and timeliness, which serve as the basis for quarterly financial incentives to exam vendors. Contractors receive rewards if their average performance is above 97 percent and penalties below 92 percent (see Figure 3-2) (GAO, 2025). In the first quarter of fiscal year (FY) 2024, 10 of 13 contracts were above the reward threshold, and none were below the penalty threshold. This is a substantial improvement from the 2021 VA OIG report, which found that each of the three VBA-contracted vendors at the time had performance below the 92 percent

accuracy requirement for completed exam reports in 2017 through 2020, and also that VA was not using financial incentives owing to contractual wording and problems assessing timeliness (VA OIG, 2021). In response to this report, VBA executed new vendor contracts in 2021, which included both rewards and penalties, and imposed its first penalties in the third quarter of FY 2022 (GAO, 2025). GAO nonetheless found problems with the incentive payments in its more recent review. Specifically, MDEO contract officers use a manual method for calculating incentives payments, which they then apply to the contract's quarterly invoice (GAO, 2025). However, because MDEO does not have written procedures to validate these calculations, it incorrectly paid more than \$2 million in incentives in Q1 of FY 2024. Providing contractors with unearned financial rewards is unlikely to hold them accountable for their performance and quality as intended.

MDEO also collects direct feedback on exam quality from veterans and contractor officials, but it does not have a mechanism for examiners to provide feedback (GAO, 2025). GAO reported that MDEO relies on contractors to share feedback from examiners. However, contracted examiners said the vendors rarely elevate this feedback to MDEO. Examiners also reported that they would rather bring certain concerns directly to MDEO due to receiving conflicting or unhelpful guidance from contractors (GAO, 2025). Relatedly, examiners generally do not receive individual-level feedback needed to improve performance and quality. Regular feedback is primarily provided to contractor officials at the vendor level (Carter-Visscher and Seymore, 2025; Dean, 2026; Mirza, 2026; Skloss, 2025). Furthermore, all routine feedback that MDEO provides is summated across all examinations, and disaggregated performance on examinations related to MST is not routinely monitored or provided to contractors (Street, 2025). In response to questions about veteran satisfaction surveys, both VHA and VBA responded that satisfaction data cannot be disaggregated by type of disability claim or examination type (Statton, 2025c). Relatedly, MDEO responses to the committee's questions about selected descriptive and performance measures on MST-related claims were unreliable. For example, data on the number of examination reports per claim did not sum as expected (i.e., data within strata did not sum to the totals); data on the most frequent exams for MST-related claims included conditions not expected to be associated with MST, such as tinnitus; and MDEO did not provide data on internal pelvic exams, instead providing data on the number of gynecological examination reports (Statton, 2025a). These issues suggest that MDEO may have difficulty accurately disaggregating data from MST-related examinations, as compared with other examinations. Consequently, it would be important for MDEO to monitor performance

BOX 3-2
Contract Medical Disability Exam Checklist

Contract Exam Audit Criteria

	Question	Answer		
1	The results of this question are not provided to the contract vendors. This is an internal audit question only. Was the exam request adequate?	Yes	No	
2	Was the correct DBQ worksheet(s) completed for the condition(s) at issue?	Yes	No	
3	If required, does the report indicate a c-file (e-file) review was completed? <i>Note: If c-file review not required, mark n/a.</i>	Yes	No	N/A
4	For each condition at issue, was a definitive diagnosis provided? If not, was a sufficient explanation provided?	Yes	No	N/A
5	DBQ-Specific Does the DBQ report provide all required medical history for the condition(s) at issue?	Yes	No	
6	DBQ-Specific Does the DBQ report provide and sufficiently address clinical exam findings for the condition(s) at issue?	Yes	No	
7	DBQ-Specific Were the results of all required lab/diagnostic tests included in the report and the significance explained, or does the report indicate the tests are not medically indicated and why? <i>Note: If no testing required or requested, mark n/a.</i>	Yes	No	N/A

8	Does the DBQ report describe the impact of the condition(s) on the Veteran's functional status/ability to work? <i>Note: If there is no diagnosed condition due to normal exam findings, mark n/a.</i>	Yes	No	N/A
9	Excluding the diagnosis (es), were inconsistencies, contradictions and discrepancies resolved? <i>Note: If none existed, mark n/a.</i>	Yes	No	N/A
10	Excluding medical opinions, were all issues requested by the regional office in the remarks section of the exam request sufficiently addressed? <i>Note: If none requested, mark n/a.</i>	Yes	No	N/A
11	If requested, were all required elements of the medical opinion provided? <i>Note: If none requested, mark n/a.</i>	Yes	No	N/A
12	Does the report include the examiner's specialty and credentials? If so, do the credentials satisfy the authentication requirements?	Yes	No	
13	If applicable, does the DBQ report meet exam-specific contractual requirements? <i>Note: If no exam-specific contractual requirements, mark n/a.</i> This question is for informational purposes and will not be included in the quality score calculation.	Yes	No	N/A

NOTE: DBQ = Disability Benefits Questionnaire.
SOURCE: VA OIG, 2022a.

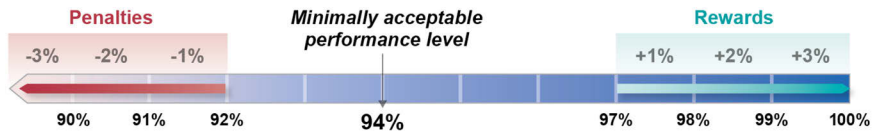


FIGURE 3-2 Medical Disability Examination Office fiscal year 2024 quality performance thresholds for financial incentives for contracted disability exams.

SOURCE: GAO, 2025.

on MST-related claims and examinations compared with non-MST claims and examinations.

In addition to MDEO's quality assurance activities, contracted vendors maintain internal processes to monitor the quality of C&P exams, medical opinions, and DBQs before submitting them to VBA and provide feedback to their examiners. Most vendors reported procedures including staff review of exam reports to confirm that all required elements are completed and that forms meet VBA standards (Carter-Visscher and Seymore, 2025; Dean, 2026; Mirza, 2026; Skloss, 2025). At Optum Serve, DBQs go through an automated Smart DBQ system to ensure all questions are answered and required follow-ups are completed; then clinical registered nurses review cases before they are sent to VBA (Carter-Visscher and Seymore, 2025). Leidos QTC Health Services and LSGS use structured checklists to ensure that all claimed conditions are evaluated, relevant evidence is reviewed, and clear rationales are provided for diagnoses or the absence of a diagnosis (Dean, 2026; Mirza, 2026). In addition, Leidos QTC Health Services has developed MST-specific procedures, including examiner training, workshops on identifying MST markers, and best-practice guidance. One of the vendors also provides individual-level feedback to examiners (Dean, 2026). At Leidos QTC Health Services, Optum Serve, and VES, quality assurance specialists work directly with examiners who have high rates of inaccurate or insufficient reports, drawing on both MDEO feedback and their own internal assessments to support improvement (Carter-Visscher and Seymore, 2025; Dean, 2026; Skloss, 2025). Optum Serve also assigns one-on-one peer tutors or mentors who closely review examiners' work and provide targeted feedback and support (Carter-Visscher and Seymore, 2025).

VHA DMA also has internal quality assurance processes to provide performance feedback to VHA examiners (Eggers, 2026). VHA uses a quality audit tool to assess the ratability of C&P disability examinations and conduct monthly audits, with results posted on the Veterans Support Service Centers website and reviewed quarterly with stakeholders (Eggers, 2026). Additionally, VHA medical centers perform peer chart reviews as part of examiners' Ongoing Professional Practice Evaluations, sharing feedback with examiners to address deficiencies and support continuous

improvement (Eggers, 2026). VHA DMA did not report receiving regular performance data from MDEO.

SUMMARY AND RECOMMENDATIONS

VA does not currently define any competencies necessary for providing C&P exams for MST-related claims. Rather, VA requires that C&P examiners are licensed and not barred from practice in any jurisdiction.²³ In addition, legal statutes define the scope of practice for different health professions based on clinical functions. However, licensure does not ensure competency or discipline to practice at the standard of care. Therefore, C&P examiners may not possess the competencies needed to perform C&P exams at the standard of care. Based on its review of the examiner's tasks in performing a C&P mental or physical health examination for an MST-related claim, VA general certification courses (including the MST course), best practices in medical education and providing clinical care to military and veterans, and its expertise, the committee recommends the following:

Recommendation 3-1: The Department of Veterans Affairs should ensure that all examiners, including trainees, who conduct compensation and pension examinations for claims related to military sexual trauma (MST) complete training and demonstrate proficiency in five core competencies prior to performing any MST-related examinations:

- a. MST and Health
- b. Trauma-Informed Approach
- c. Laws and Regulations Governing MST Claims
- d. Military Structure and Culture
- e. Medical Opinions

There is variation in what clinicians must demonstrate in the professional credentialing process for different disciplines. However, the committee did not identify any profession that requires proficiency in all the competencies needed to conduct MST-related C&P exams as a standard component of its education and training. In addition to professional standards, legal statutes define the scope of practice for different health professions based on clinical functions.²⁴ In general, state laws govern the scope of practice for clinicians in the community, while federal regulations permit VA to establish national standards of practice and direct VA health care professionals to follow the scope VA defines regardless of conflicting

²³ 38 CFR § 17.419, Health care professionals' practice in VA; VHA Directive 1900(5), VA National Standards of Practice (2023).

²⁴ Example statutes: California Business and Professions Code §2903.1; Texas Occupation Code §503.003; Florida Statute §491.003; New York Education Law §7701.

state laws.²⁵ Existing restrictions on providers who can perform specialized exams limit access for claims related to MST, because there are providers who may have the competency to perform these select examinations but are not allowed to do so under current policy (VA, 2026e). Such restrictions in the context of an underlying behavioral health workforce shortage would be expected to hinder timely access to C&P exams and the timely processing of MST-related claims. Consistent with the shift from a credential-based provider requirement to a competence-based one, any clinician who demonstrates the required core competencies would be qualified to conduct the exams within their legal and professional scope of practice. Therefore, the committee recommends the following:

Recommendation 3-2: The Department of Veterans Affairs should identify the broadest possible range of clinicians who can effectively perform compensation and pension examinations related to military sexual trauma within their professional credentials, level of training, and legal and professional scope of practice and expand the health disciplines permitted to do so.

In some cases, providers who are licensed and demonstrate core competencies may include trainees such as medical residents, and it is feasible under existing contractual language that trainees could perform examinations related to MST without having completed MST training. VA currently requires mental health exams but not medical (i.e., physical health) exams performed by residents to be conducted under close supervision and for both the trainee and the supervising clinician to co-sign the DBQ, where close supervision means “the supervising clinician meets with the Veteran, confers with the examining health care professional in providing the diagnosis and the final assessment, and co-signs the examination report” (VA, 2026e). Because MST-related exams are more sensitive than other C&P exams, ideally, a clinician of the same discipline as the trainee who has demonstrated core competencies to conduct C&P examinations for MST-related claims would provide direct rather than close supervision to provide greater oversight. Although the committee did not identify information indicating differences in exam quality between trainees and licensed, credentialed, and privileged examiners, this may reflect the lack of measures and a mechanism to document such differences.

²⁵ 38 CFR § 17.419, Health care professionals’ practice in VA; VHA Directive 1900(5), VA National Standards of Practice (2023); VHA Directive 1100.20(2), Credentialing of Health Care Providers (2021).

Recommendation 3-3: The Department of Veterans Affairs should require trainees to conduct compensation and pension examinations related to military sexual trauma, including physical and mental health examinations, under direct supervision and require both the trainee and the supervisor to co-sign all Disability Benefits Questionnaires.

Recommendation 3-4: The Department of Veterans Affairs should develop measures that allow it to monitor for differences in exam quality between trainees and licensed, credentialed, privileged, independent clinicians.

There is some content related to the five competencies in VA's existing general certification training courses for C&P examiners, including the MST course (Eggers, 2025a; Statton, 2025b). However, this information does not facilitate the development of clinical competency in these areas and is therefore likely insufficient for providers completing the training to apply these concepts in practice. The trainings are focused on conceptual knowledge and lack instruction on practical skills, including key skills to draft sufficient medical opinions on the connection between diagnosed disabilities and MST as the in-service event, as well as assessing functional impairment for conditions related to MST (VA OIG, 2022b). Lack of training and standardized processes results in variation in the quality of medical opinions related to differences in the claims processor's and examiner's knowledge about the health effects of MST. These training inadequacies may lead to incomplete and inaccurate assessments of impairments or service connection, harm to veterans such as retraumatization, inefficiency and delays due to insufficient claims development, and unfairness in the compensation process (SAMHSA, 2014; VA OIG, 2022b; Webermann et al., 2026a). In addition, the existing training uses limited modalities and lacks interactive modalities such as videos, virtual standardized patients, and simulations. These interactive modalities are current evidence-based best practices for graduate and continuing professional education and have been shown to improve learning, increase skill acquisition, boost knowledge retention, and improve performance (Kane et al., 2024; Lucero et al., 2023; Reger et al., 2021). Use of dense slides and limited modalities in the training courses can hinder engagement, knowledge retention, and skill acquisition.

The current assessment for both VHA and VBA-contracted examiners only uses a written multiple-choice format, does not assess skills, and is conducted solely at the end of the training module (Eggers, 2025a; Statton, 2025b). These qualities make the assessment insufficient to ensure that examiners demonstrate and maintain competencies needed to conduct C&P examinations for MST-related claims. The existing written-only assessment can assess foundational knowledge about each core competency. However, a

skills-based assessment is needed to provide the learner with an opportunity to demonstrate competence in skills and would complement the knowledge assessment as part of a multi-dimensional and multi-modal approach that provides multiple inferences about examiner proficiency for VA to triangulate to assess the learner's overall proficiency in the five core competencies (Ross et al., 2021). Skills-based assessment would incorporate multiple assessment modalities that could mirror those used in the training (e.g., video and simulations—whether paper cases, video cases, or standardized patients) and may include open-ended questions, such as a mock patient encounter using portions of DBQs (including Medical Opinion DBQs) in which the instructor determines a passing performance based on an assessment of key knowledge and skills demonstrated (e.g., application of military cultural competence, trauma-informed approach, use of required regulatory language) (Harder, 2010; Watts et al., 2021). The skills-based assessment also provides learners with the opportunity to demonstrate proficiency in the core competencies in a low-stakes setting where learners can make mistakes in a safe environment and from which they can practice and learn without risking harm to veterans or inaccurate disability determinations (Ross et al., 2021). Next steps in designing such assessments would include blueprinting, standard setting, and calibration. Blueprinting refers to the alignment of the content of the assessment with the goals of the training courses (i.e., proficiency in the five competencies) and involves elaborating on this alignment in granular detail. Standard setting is the definition of criteria to assess whether learners are prepared to perform trauma-informed C&P exams and to draft DBQs and medical opinions that are sufficient for VA to adjudicate a claim. Calibration is the evaluation of the reliability and validity of the assessment (Norcini et al., 2011; Wass et al., 2001).

Successful assessment development requires detailed knowledge of how key skills are applied and competencies are demonstrated in practice (e.g., how examiners perform trauma-informed exams or develop and draft sufficient DBQs and medical opinions), and is best done with input from key stakeholders, including veterans, VHA-employed and VBA-contracted C&P examiners, and VHA trainees/clinical residents (Norcini et al., 2011). The input of these stakeholders would support VA's understanding of the feasibility and acceptability of the MST training and assessment, including such considerations as provider receptivity and cost effectiveness to inform resource allocation. Stakeholder input could also help inform the calibration of the assessments by helping VA to measure the C&P examiner's baseline proficiency prior to implementing new MST training and to test the reliability and validity of the assessment tools.

Beyond the initial training assessment, requirements for examiners to complete MST training every five years for contract examiners and just once for VHA examiners are insufficient to ensure that they maintain

competence, particularly given the rapidly evolving evidence base on the health consequences of MST and changes to VA policies and procedures. While complete retraining and assessment is not needed annually for examiners to maintain competence, annual refresher courses would ensure that examiners have the latest evidence-based information on the health effects of MST, current information on VA policies and procedures, and a routine opportunity to apply that knowledge and their skills in a low-risk environment before examining veterans with MST-related claims. Annual MST refresher training for examiners would also bring their training requirements in line with those for claims processors. Therefore, to align the MST training with best practices in graduate and continuing professional education, better engage examiners in completing the training courses, and ensure proficiency in the five competencies, the committee recommends the following:

Recommendation 3-5: The Veterans Health Administration Office of Disability and Medical Assessment and Veterans Benefits Administration Medical Disability Examination Office should collaborate to modify the training goals of the military sexual trauma (MST) training course to reflect the five core competencies. In particular, they should collaborate to develop and provide training to both claims processors (including those involved in development and rating) and examiners on requesting, drafting, and reviewing medical opinions specific to MST-related claims.

Recommendation 3-6: The Department of Veterans Affairs should develop a new format for its training course on providing compensation and pension examinations related to military sexual trauma that uses a range of modalities including greater use of video, simulations, and virtual standardized patients.

Recommendation 3-7: The Department of Veterans Affairs should assess all examiners who conduct compensation and pension exams related to military sexual trauma after their initial training and annually thereafter. The initial training assessment should include a written knowledge assessment and a skills-based assessment that provides an opportunity for learners to demonstrate the five core competencies.

VA does not have a mechanism to monitor the performance of VHA and vendors for claims specific to MST. Additionally, MDEO has unclear and incomplete procedures for reviewing contractor quality improvement plans and ensuring contractors have completed requested corrective actions. MDEO sums all performance reporting and feedback across all examinations and/or claims, does not routinely monitor disaggregated performance

on examinations and/or claims related to MST, and does not routinely provide performance data specific to MST-related examinations and/or claims to contractors, VHA, or the public (GAO, 2015, 2024, 2025; VA OIG, 2021). The committee determined that data on multiple performance measures that MDEO provided in response to requests for information were not reliable, which raised concerns about MDEO's ability to accurately assess and monitor performance on MST-specific exams and claims. For example, it was unclear if DBQs marked as MST-related were for conditions incurred or aggravated by an MST experience or if they were related to another aspect of a veteran's military service (e.g., combat) but identified as related to MST because at least one claimed disability was related to MST (Statton, 2025a). In addition to concerns about separating MST-related claims and exams from other claims and exams, MDEO also does not conduct or require performance feedback for individual examiners (GAO, 2025). Furthermore, while MDEO's contracts with the contract exam vendors include vendor-level financial incentives and disincentives in the form of risk corridors to hold the vendors accountable for their overall performance related to contract exams, there are no such vendor-level measures for MST-related exams. The lack of these procedures and mechanisms increases the number of errors associated with MST-related examinations and imposes undue hardship on veterans with MST-related disabilities. To ensure full compliance and appropriate corrective action, the Deputy Secretary could, for example, review such annual reports to coordinate corrective actions between VHA and VBA. To ensure that specific examiners and contract examination vendors meet standards for performance and are held accountable for poor performance, the committee recommends the following:

Recommendation 3-8: The Veterans Health Administration (VHA) Office of Disability and Medical Assessment (DMA) and Veterans Benefits Administration Medical Disability Examination Office (MDEO) should produce annual reports on individual compensation and pension examiners that contribute to a high volume of insufficient or incomplete military sexual trauma (MST)-related claims. High volume should be defined as a proportion (e.g., top tenth percentile) of all VHA-specific or vendor-specific MST-related claims or a high proportion (e.g., substantially above average) of an individual provider's MST-related claims. Based on these annual reports, DMA and MDEO should require VHA or the vendor to develop corrective action plans for these examiners and maintain continuous monitoring of these examiners until the number of insufficient or incomplete MST-related examinations is within normative values.

Recommendation 3-9: The Veterans Benefits Administration Medical Disability Examination Office should develop data collection and processing mechanisms that allow for comprehensive analysis of data from examinations performed by Veterans Health Administration and contracted vendors including the following:

- a. Accurate disaggregation of performance on military sexual trauma (MST)-related claims, compensation and pension (C&P) examinations, Disability Benefits Questionnaires (DBQs), and medical opinions, as compared with other claims, C&P exams, DBQs, and medical opinions;
- b. Separate sampling and analysis of satisfaction surveys from veterans whose claims are related to MST; and
- c. Annual monitoring and reporting on performance on MST-related claims, exams, DBQs, and medical opinions to identify trends and improve examination quality.

Recommendation 3-10: For inclusion in any new contracts executed between the Veterans Benefits Administration Medical Disability Examination Office (MDEO) and the contract compensation and pension (C&P) examination vendors, MDEO should develop and implement a system of financial incentives and disincentives (such as risk corridors) based on annual performance on military sexual trauma (MST)-related claims and C&P exams (including corresponding Disability Benefits Questionnaires and medical opinions) and on satisfaction surveys from veterans whose claims are related to MST (as described in Recommendation 3-9).

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4

The Compensation and Pension Examination Process for Disability Compensation Claims Related to Military Sexual Trauma

The Department of Veterans Affairs (VA) awards compensation in the form of a tax-free monetary benefit to veterans who have a disease or injury incurred or exacerbated due to or during active military service that results in disability (CRS, 2024). Veterans with a service-connected disability can also be potentially eligible for other benefits such as health care and educational support. To qualify for disability compensation, VA must have evidence of the current disabling condition and a “nexus” or link between that disability and an in-service disease, injury, or event (VA, 2025k).¹ The Veterans Benefits Administration (VBA), which provides a variety of services and benefits to service members, veterans, and their families, administers the disability compensation program. To assess veterans’ eligibility, VBA often requests disability examinations, known as compensation and pension (C&P) exams. The Veterans Health Administration (VHA), which provides health care services to qualified veterans, provides some C&P exams, overseen by the Office of Disability and Medical Assessment (DMA), but nearly all are performed by VBA contractors, overseen by VBA’s Medical Disability Examination Office (MDEO) (GAO, 2025). Veterans can claim disability for conditions that result from military sexual trauma (MST). In fiscal year (FY) 2024, VA received 39,711 claims related to MST, of which nearly two-thirds (25,729) were granted and more than one-third were denied (Statton, 2025b). Among MST-related claims granted, the average

¹ 38 CFR § 3.303, Principles relating to service connection; 38 CFR § 3.304, Direct service connection; wartime and peacetime.

combined disability rating was 80 percent, with an average compensation rate of \$2,523.79 monthly (Statton, 2025b).

A major challenge associated with assessing and rating disabilities that result from MST is the incompatibility of MST claims with many components of the VA disability compensation process, which was originally established to provide compensation for combat-related injuries resulting in disability claims that are body system–based or medical/behavioral diagnoses that lead to functional impairments (IOM, 2007). Consequently, the modern VA clinical examination system is based on Disability Benefits Questionnaires (DBQs), and these questionnaires are primarily body system–based and condition-based (Hutchinson and Hyberger, 2025). By contrast, MST is not a diagnosis or disability; rather, VA considers it an event that can lead to service-connected mental and physical health conditions that qualify for VA disability benefits. This creates a level of complexity and uniqueness to MST-related claims that are processed within a disability system that was not originally designed for them. For example, in a small qualitative study VHA C&P examiners reported that MST-related posttraumatic stress disorder (PTSD) exams are more clinically and diagnostically complex compared with other PTSD exams (Webermann et al., 2026a). Although Congress and VA have made important progress in strengthening benefits and easing the disability claims process for survivors of MST (GAO, 2025),² this has required making MST claims work within a system that was not created for assessing the impairments associated with an experience that, as described in Chapter 2, can result in numerous and overlapping physical and mental health conditions (Galovski et al., 2022).

This chapter describes and assesses the C&P examinations in support of MST-related disability compensation claims. The committee reviews the process for physical health conditions (including five conditions specified in the committee’s Statement of Task—sexual dysfunction, pelvic pain, pelvic dysfunction, musculoskeletal disabilities, and cardiovascular conditions including stroke) and for mental health conditions related to MST. The scope of the committee’s charge is limited to the C&P examination portion of the claims process, but to provide context, the committee describes the full claims process—from filing a claim to receiving a decision—since many of the activities that occur before and after the examination influence the examination process and its outcomes.

Briefly, a veteran or a representative on that person’s behalf files a disability claim with VBA. The claimant then works with VBA representatives to gather evidence, such as medical and military records, to demonstrate that the claimed condition is due to or aggravated by the veteran’s service in

² MST Claims Coordination Act, Public Law 117-303, 117th Congress, 2nd Session and Dignity for MST Survivors Act, Public Law 117-300, 117th Congress, 2nd Session.

the military and that it causes impairment, or the extent to which it affects the veteran's overall health and limits that person's ability to function in daily life (VA, 2025d). VA refers to this information gathering as "claims development" (VA, 2026b). If the documentation is not sufficient for VBA to determine either that the claimed condition is related to MST or the level of impairment, VBA refers the claimant to either VHA or a contracted vendor to receive a C&P exam. Medical providers known as C&P examiners use DBQs tailored to specific conditions or body systems to guide the examination, diagnose or confirm the presence of the claimed condition, and assess the level of disability. If requested, the examiners also use the findings from the exam together with the documentation in the veteran's claims folder to draft a medical opinion to establish the "nexus" of the claimed disability and an event in service—that is, whether the claimed condition is related to MST as the in-service event and thus service-connected. The examiner submits the completed DBQ(s) to VBA, which reviews the full claims folder to determine if there is sufficient information to make a disability determination. If the folder is not sufficient, VBA may request additional information from the examiner or order another C&P exam. If there is sufficient information, VBA evaluates the claim; applies the VA Schedule for Rating Disabilities (VASRD), which is a system used to assign a disability rating; and notifies the veteran of the claim decision. If approved, veterans receive benefits; if denied or if veterans disagree with the decision, they may appeal through VBA and the Board of Veterans' Appeals. Figure 4-1 summarizes the disability determination process for MST-related claims, and the remainder of the chapter describes this process in more detail.

FILING AN MST-RELATED DISABILITY CLAIM

The first step for veterans seeking disability benefits is to file a claim with VA using VA Form 21-526EZ (VA, 2022b). Veterans can submit their claims in person at a VA regional office, online at VA.gov, or via mail, fax, or phone. A representative from a veterans service organization or a legal advocacy group can also file a claim on behalf of a veteran. The claim information portion of the form includes sections for the veteran to describe the current disabling condition or conditions; whether the condition is due to an environmental or occupational exposure (e.g., Agent Orange, radiation, burn pits), event, or injury; how the disability or disabilities relate to the in-service event/exposure/injury (e.g., injured left knee when brace on right knee failed); and the approximate date disability or disabilities began or worsened.

When VA receives a disability claim related to MST, the veteran is given the option to work with either a male or a female MST outreach coordinator at the VA regional office handling the case (VA OIG, 2021a,

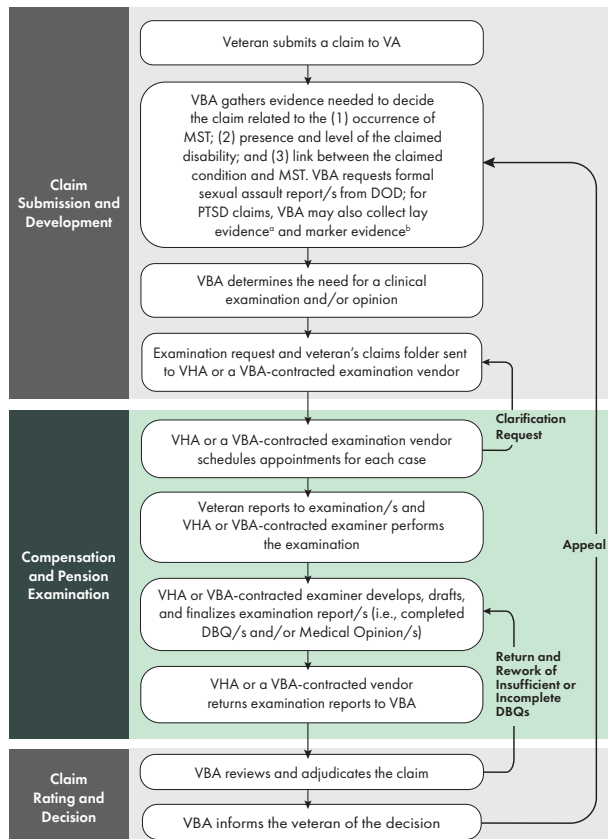


FIGURE 4-1 Summary of the Department of Veterans Affairs disability determination process for military sexual trauma-related claims that include compensation and pension examinations.

NOTES: To focus on the examination process, this diagram simplifies claims processes that do not require examinations and the appeals process, which are beyond the scope of the committee's Statement of Task. DBQ = Disability Benefits Questionnaire; DOD = Department of Defense; MST = military sexual trauma; PTSD = posttraumatic stress disorder; VA = Department of Veterans Affairs; VBA = Veterans Benefits Administration; VHA = Veterans Health Administration.

^a Lay evidence is evidence not requiring specialized education, licensing, or experience and is considered competent when it is provided by a person with knowledge of facts or circumstances and relates to matters that can be observed and described by a layperson.

^b Marker evidence refers to documentation in a veteran's record that is not an official report of the incident but supports the veteran's account. This can include behavioral changes such as requests for a change in duty assignment; shifts in performance or performance evaluations; disciplinary or legal problems; altered use of prescription or over-the-counter medications, drugs, or alcohol; and medical testing for pregnancy or sexually transmitted infections.

SOURCES: 38 CFR § 3.159(a)(2), Department of Veterans Affairs assistance in developing claims; 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime.

2021b). These specially trained coordinators serve as local points of contact for veterans filing MST-related claims (VA OIG, 2021a). The coordinator's first responsibility is to contact the veteran to determine whether the event was reported during military service and, if so, to obtain documentation of the report (VA, 2025p). Veterans can assist by providing any copies of reports they possess or specifying the military base where they filed the report. If an official report exists, the MST outreach coordinator submits it to a claims developer in VBA (VA OIG, 2021a, 2021b). Claims identified as related to MST are assigned to designated MST claims processors who have completed MST training and are assigned to a centralized MST claims processing site or other specialized site (see Chapter 3 for a summary of claims processor requirements). The claims developer is responsible for explaining benefit programs, interviewing claimants, identifying issues with claims, gathering necessary evidence, and generating award and notification letters for veterans in the VBA system (GAO, 2015).

CLAIMS DEVELOPMENT

VA's duty to assist requires VA to engage in reasonable efforts to assist veterans in gathering evidence, including medical, military, and other administrative records, and in obtaining a medical examination and opinion related to the claimed disability to support VA benefit claims.³ The duty to assist is important not only for supporting a claimant through the claims process but also for ensuring claims can be adjudicated, since federal regulations also require the VA disability ratings board to return claims with insufficient information for evaluation.⁴ For claims related to in-service personal trauma, including MST, the "Personal Trauma Development Checklist" (see Appendix D) guides VBA claims developers through claims development procedures as specified in the VA Adjudication Procedures Manual (VA, 2026a).

The claims developer is instructed to help the claimant collect the evidence needed to support the disability claim. Supporting evidence may include separation documents, service treatment records, and relevant medical documentation.⁵ The evidence is used to determine whether the condition is service-connected and to assess the level of disability. VA regulations define standards of evidence. Competent medical evidence is evidence provided by someone qualified through education, licensing, or experience to offer medical diagnoses, statements, or opinions.⁶ Lay evidence is evidence

³ 38 USC § 5103A(d), Duty to assist claimants.

⁴ 38 CFR § 4.2, Interpretation of examination reports.

⁵ 38 CFR § 3.304, Direct service connection; wartime and peacetime.

⁶ 38 CFR § 3.159(a)(1), Department of Veterans Affairs assistance in developing claims.

not requiring specialized education, licensing, or experience and is considered competent when it is provided by a person with knowledge of facts or circumstances and relates to matters that can be observed and described by a layperson.⁷

For MST-related claims, veterans must provide some evidence of the MST experience to establish MST as the qualifying in-service event. This requirement often involves multiple forms of evidence and repeated disclosures of their trauma, which can be retraumatizing for veterans, does not align with trauma-informed principles or approaches, makes veterans feel not believed, and contributes to feelings of institutional betrayal (Webermann et al., 2026b). As a participant in a small qualitative study of veterans' experiences filing MST-related disability claims stated, "They make you go through [your trauma] over and over and over and over and over" (Webermann et al., 2026b, p. 375).

For all claims related to MST except PTSD claims, federal statute requires sufficient evidence of an in-service disease, injury, or event to be eligible for disability compensation.⁸ Sufficient evidence of personal trauma including MST may include an original report or complaint regarding the MST experience filed with the Department of Defense Sexual Assault Prevention and Response Office, other in-service records (such as medical records) related to the trauma, or civilian documentation related to the trauma (e.g., civilian police or private medical records) (VA, 2025l). Of note, this contrasts with evidentiary requirements for disabilities related to combat, for which VA may rely on a veteran's lay testimony alone to establish service connection even if there is no official record of in-service diagnosis, injury, or disease aggravation.⁹ Thus, federal law requires a higher burden of proof to establish service connection for disabilities related to MST than for those related to combat.

For claims related to PTSD stemming from a personal trauma, which includes MST, VA regulations acknowledge that official military records may not always contain evidence of the traumatic event (also referred to as a "stressor") owing to reporting barriers.¹⁰ To ensure that the absence of formal documentation does not prevent veterans from receiving benefits, regulations allow veterans to use a broader range of evidence to corroborate the occurrence of the stressor.¹¹ Specifically, if the MST experience cannot be corroborated with sufficient evidence, VA regulations permit the use of behavioral changes following the trauma, which are known as markers

⁷ 38 CFR § 3.159(a)(2), Department of Veterans Affairs assistance in developing claims.

⁸ 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service.

⁹ 38 USC § 1154(b), Consideration to be accorded time, place, and circumstances of service.

¹⁰ 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime.

¹¹ *Ibid.*

(e.g., requests for changes in duty assignment; changes in performance or performance evaluations; disciplinary or legal challenges; changes in use of prescription or over-the-counter medications, drugs, or alcohol; tests for pregnancy or sexually transmitted infections), in combination with clinical review and interpretation of the marker evidence.¹² Notably, marker evidence need not reference MST to support its occurrence and may occur during or after military service (VA, 2025n). This contrasts with PTSD claims related to combat with the enemy, fear of hostile military or terrorist activity, or a prisoner-of-war experience. In these circumstances, federal statute allows VA to rely on a veteran's testimony to establish the claimed in-service stressor.¹³ Thus, again, these evidentiary requirements for PTSD claims also represent a higher evidentiary standard for MST claims compared with other claims.

Claimants may also complete VA Form 21-0781, "Attachment to the Statement in Support of Claimed Mental Health Disorder(s) Due to an In-Service Traumatic Event(s)," introduced in 2021 and updated in 2024. This form collects the veteran's lay testimony (or, self-reported experience) about the in-service trauma, including a brief description of the event and where and when it occurred, a checklist of behavioral markers, other documentation showing that the traumatic event occurred such as reports filed with the military or civilian police, and treatment information (see Appendix E). The form also has a section that is required for MST-related claims for VBA to communicate information about upcoming events planned during the claims process (such as C&P examinations or decision notification). Veterans have described this stressor statement as profoundly retraumatizing. A participant in a small qualitative study investigating the experiences of veterans filing MST-related disability claims described, "It was a big trigger. It was hard ... It's like going through this whole thing [the MST experience] all over again" (Webermann et al., 2026b, p. 376).

Once evidence is compiled, claims processors are instructed to review the claims folders, document evidence (including marker evidence) on the "Personal Trauma Incident/Marker Worksheet," and include the worksheet in the claims folder. As shown in Appendix F, the worksheet includes prompts for claims developers to summarize a traumatic incident and behavioral markers, as well as the supporting evidence. Unlike VA Form 21-0781, which veterans complete and includes a checklist of markers, the worksheet includes only examples and open-ended responses.

¹² 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime.

¹³ 38 USC § 1154(b), Consideration to be accorded time, place, and circumstances of service.

If the evidence of record identified during the claims development process is sufficient to decide a claim, the claims developer refers the claim to the claims rater for adjudication (described in more detail below). In such a scenario, C&P examinations are not necessary, and a process that does not require a C&P examination would minimize additional opportunities for retraumatization (VA, 2025f, 2025g).

EXAMINATION AND MEDICAL OPINION REQUEST

If VBA has sufficient evidence documenting the occurrence of an MST experience but insufficient medical evidence of the present diagnosis or level of impairment, claims processors request a C&P examination to obtain a diagnosis and assess level of disability.¹⁴ In most cases, this involves a clinical examination. However, for some physical health conditions (but not for mental health examinations), when the existing medical evidence is sufficient or can be supplemented by an interview with the veteran, C&P examiners can follow the Acceptable Clinical Evidence (ACE) process, in which the examiner reviews the evidence of record and, if additional information is needed, information obtained from an interview with the veteran (VA, 2025g, 2026d). As with the fully developed claims process, the ACE process, which excludes the requirement for a clinical examination, would limit opportunities for additional retraumatization.

Claims developers use the Examination Request Routing Assistant tool to determine whether a VHA clinician or a clinician from one of the four VBA-contracted vendors (Leidos QTC Health Services [LQTC], Loyal Source Government Services [LSGS], Optum Serve, Veterans Evaluation Services [VES]), known as C&P examiners, will perform the exam based on the availability and capacity of VHA providers in the veteran's location (VA OIG, 2021b). The relative share of exams performed by VHA in-house compared with those conducted by contracted examiners has shifted substantially as the number of disability compensation claims and corresponding C&P examinations has increased over time. In FY 2013, VHA performed most exams in-house, with contracted examiners conducting fewer than 20 percent of exams (CRS, 2022). By FY 2024, contracted examiners conducted the vast majority (93 percent) of C&P examinations (GAO, 2025).

As described in Chapter 1, the committee is charged with assessing whether any conditions linked to MST require referral for both mental and physical health examinations. In general, examiners are licensed medical professionals with expertise in the conditions they are assessing. This expertise includes recognizing the totality of symptoms associated with a

¹⁴ 38 CFR § 3.159(c)(4), Department of Veterans Affairs assistance in developing claims.

given condition, including both physical and mental health symptoms, as well as their impact on the individual holistically. Examiners therefore likely have sufficient clinical expertise to assess the full spectrum of impairment associated with a single condition without needing additional exams. In some cases, a physical health condition can contribute to the development of a mental health condition, or vice versa (Hanna et al., 2024; Scott et al., 2016). Four physical health DBQs—for amyotrophic lateral sclerosis, central nervous system and neuromuscular diseases, fibromyalgia, and initial and review traumatic brain injury (TBI)—ask about mental health conditions and direct the examiner to the mental disorder DBQ for completion by a qualified mental health examiner (VA, 2024a, 2024b, 2024d, 2024e, 2024g, 2025c). As described in Chapter 2, MST is associated with fibromyalgia and TBI (Cichowski et al., 2017; Häuser et al., 2011; Iverson et al., 2019; Iverson et al., 2020). Thus, a veteran claiming fibromyalgia or residuals of TBI associated with MST who also has mental health symptoms or conditions secondary to the fibromyalgia or TBI would be referred to both a physical and mental health examination. In rare cases, VA may ask veterans to undergo multiple examinations to assess a single condition. For example, there is no DBQ for chronic pain. Instead, physical pain (e.g., knee pain, back pain, pelvic pain, headaches) may be captured in a body-system DBQ, while emotional symptoms may be captured separately as secondary conditions (e.g., depression due to pain) in the mental disorders DBQ. For such a condition, separate physical and mental exams may be necessary for veterans to assess the full spectrum of impairment and thus for them to receive full and accurate rating and compensation for a single condition, but this may also increase burden and the potential for retraumatization for veterans.

If VA has some but insufficient evidence documenting the occurrence of an MST experience and there is competent evidence of a current diagnosed disability, a possible nexus between the current diagnosis and service, and the evidence is insufficient to determine whether a condition is service-connected, the claims processor must request a medical opinion DBQ to establish whether a claimed disability is related to MST as the qualifying in-service event based on clinical analysis and judgment (VA, 2025l, 2025m, 2025o). Typically, VA asks providers for medical opinions about the direct relationship between a claimed condition and an in-service disease/diagnosis, injury, or event (e.g., whether condition A is related to MST); an indirect (or, secondary) relationship between the claimed condition and an in-service disease/diagnosis, injury, or event (e.g., whether condition B stemmed from condition A, which is related to MST); or an aggravation opinion (e.g., whether MST worsened a preexisting condition), though there are other types of opinions as well. Claims processors can refer PTSD claims for examinations and medical opinions (VA, 2025m). Furthermore,

for all PTSD claims, marker evidence alone provides insufficient evidence of personal trauma; it requires clinical review and interpretation for VA to concede the traumatic event (VA, 2025o). Therefore, for PTSD claims related to MST based on marker evidence, claims processors must request a medical opinion to obtain this clinical review and interpretation to corroborate whether the MST experience occurred (VA, 2025o). Complex medical opinion requests, including those based on stressors involving MST, must be prepared/reviewed by both the claims rater and claims developer to help ensure the rater will have the information needed to adjudicate the claim (VA, 2025h).

In 2022, VA Office of Inspector General (OIG) reviewed medical opinion requests for disability claims and found that more than two-thirds of requests did not follow required procedures (VA OIG, 2022). Specifically, the review found that claims processors did not identify relevant evidence for the examiner or use required language in making the request (VA, 2026c; VA OIG, 2022). Additionally, in some cases, they did not request opinions when there was sufficient evidence to request one, while in other cases, they requested unnecessary opinions. VA OIG further concluded that these issues could result in inaccurate or insufficient medical opinions, incorrect claims determinations, claims delays, and other inefficiencies (VA OIG, 2022). For claims related to MST, unnecessary opinions expose veterans with MST histories to unnecessary opportunities for retraumatization.

All vendors reported having a specialized team that reviews the incoming examination requests for all claims for sufficiency and clarity (Dean, 2026; Mirza, 2026; Skloss, 2025). All vendors also reported receiving some ambiguous or incorrect examination requests. If incorrect or ambiguous requests are identified, the vendors will generally submit a clarification request to the requesting VA regional office (Dean, 2026; Mirza, 2026; Skloss, 2025). The vendor VES reported sending clarification requests for approximately 18 percent of all requests received (Skloss, 2025). The complexity of MST claims and processes relative to other claims (such as the differing evidentiary standards for PTSD and non-PTSD claims) can lead to unique issues for these examination requests. Although the share of clarification requests for MST claims compared with non-MST claims was not available, the complexity of MST claims increases the likelihood that VA claims processors do not follow procedures. For example, LQTC wrote,

MST request verbiage is standardized. Sometimes the VA sends in a PTSD contention marked as MST but forget to add the MST verbiage. LQTC then sends clarification requests to VA if this is a true MST case, and if yes, to add the MST verbiage. Sometimes MST medical opinion requests are received for mental conditions other than PTSD. LQTC then has to send a clarification request asking if there is also a claim for PTSD as

PTSD is the only Mental Health (MH) condition that can be corroborated by MST markers and if so, to please update [the examination scheduling request] to reflect PTSD contention. Sometimes the VA sends several MH (including PTSD) contentions in one request, all marked MST and repeats the MST medical opinion questions under each contention which results in multiples/duplicates. LQTC has to send it back to request that referral be corrected to show the MST medical opinions under PTSD only. (Dean, 2026, p. 3)

THE C&P EXAMINATION

The C&P exam typically includes a medical interview, a clinical examination, and a review of existing medical records. In response to a request for information from the committee, VA stated that between October 1, 2023, and June 3, 2025, nearly all (97.3 percent) MST-related disabilities granted (i.e., approved claims) had an examination; an analysis of the remaining 2.7 percent suggested that those also had examinations, which “were not reflected in the data because the claimed contention with the MST marker was not directly tied to the examination request” (Statton, 2025c). Thus, MST-related claims were nearly always if not always referred for C&P exams even though VBA policy and procedures do not always require an exam (Statton, 2025c). This suggests that there may be opportunities to clarify when exams are not required to minimize potential retraumatization. VBA did not provide information on examinations among denied claims.

Reviewing Evidence Related to the Claimed Disabling Conditions

For most claims involving physical health conditions, C&P examiners are encouraged to review the contents of the claims folder, which contains evidence related to the claimed disabling condition that the claims processor compiled. These claims folders vary in size depending on factors such as how long a claimant served in the military, how long and complex that person’s medical history is, and the frequency of that person’s engagement in health care (especially VHA health care). However, these records range from fewer than 100 pages to tens of thousands of pages per claim, with the average claim ranging from 2,000 to 4,000 pages (Dean, 2026; Skloss, 2025).

Examiners are required to review the claims folders for medical opinions, mental health examinations, and select physical health examinations (VA, 2025i). Claims developers are instructed to bookmark or annotate “relevant evidence” in the claims folders to help examiners and adjudicators distinguish potentially relevant records, yet VA acknowledges that vendors may not be able to view these bookmarks and annotations (VA,

2025j)). This lack of interoperability between VBA and vendor systems for sharing records results in loss of information about possibly relevant evidence in veterans' claims folders. Furthermore, the lack of functionality of VA's system to collate and organize files can result in the duplication of records, disorganized folders, and unnecessarily large folders for examiners to review in limited time.

To address the volume of records, vendors have established standardized systems, including dedicated teams who conduct manual reviews and proprietary technologies that use machine learning and artificial intelligence (AI) to conduct keyword searches, to comb through the records to identify potentially relevant evidence for the examiners to focus on (Dean, 2026; Skloss, 2025). However, these keyword searches may be limited, especially for older, hand-written records, and may therefore miss important claims information. Moreover, the rules governing how these proprietary technologies identify relevant information are not transparent to VA or claimants. While AI technologies may be warranted to manage the volume of records undergoing review and especially if different vendors use different AI tools, MDEO would need to develop transparent standards to address when these tools are used in record review or decision support, methods for validating their accuracy, approaches to ensuring their reliability across vendors, measures to ensure the privacy of veterans, and quality assurance processes for summaries and outputs to ensure their consistency and accuracy across vendors. As further evidence of the challenge of identifying information in veterans' records, in a written response to a request for information from the committee, LSGS also wrote that it provides its examiners with additional "instruction on how claims folders are organized in our health records system to enable them to locate or conduct a search for relevant records" (Mirza, 2026, p. 5).

Clinical Examination and Disability Assessment

Once VBA assigns the examination to a provider, the designated provider's office contacts the veteran to schedule the C&P exam. If assigned to VHA, the exam occurs at the veteran's nearest VHA medical center. If assigned to a vendor, the MDEO contract requires exams to be scheduled "as close to the veteran's home of record as feasible, but no farther than 50 miles for non-specialist exams and 100 miles for specialist exams" (VA OIG, 2023, p. i). Longer distances may be authorized if the veteran expressly approves farther travel and this approval is documented in the veteran's records (VA OIG, 2023). Such contract requirements address veteran concerns about excessive travel distances required to attend exams, which they have reported on satisfaction surveys (VA OIG, 2023). In a presentation to the committee, veterans' advocate Herman Breuer told the

story of one veteran's challenges accessing his examination, and its consequences, stating,

When we filed for disability, the veteran—now homeless, transient, and diagnosed with severe behavioral conditions—was assigned a C&P exam an hour and twenty minutes from his home. He lacked transportation, and the VA failed to notify him by mail of the appointment. As his advocate, I saw it in the system. I found the veteran and paid for an Uber to take him to the exam, since I couldn't switch it to telehealth within 72 hours. He called me 15 minutes before the appointment to say he was running 10 minutes late. I had no way to contact the examiner. He arrived 10 minutes late, the examiner canceled, and the veteran was denied disability. (Breuer, 2025)

At the same time, geographic requirements can also limit access to available examiners, especially specialists. Quantifying veterans' difficulties accessing examinations beyond such anecdotes has been a challenge because, as a 2023 VA OIG report found, MDEO was not monitoring travel requirements and thus could not assess the contractors' adherence to the requirements or identify areas for improvement (VA OIG, 2023). Vendors also reported allowing veterans to specify their preference for a man or woman examiner (Dean, 2026; Mirza, 2026; Skloss, 2025). This choice can be empowering and promote psychological safety and perceptions of collaboration and mutuality for veterans who have experienced MST.

MDEO contracts require contracted exams to be conducted “at the examiner's place of business or an appropriate place authorized by VA” (VA OIG, 2024, p. i). In addition, MDEO requires vendors to inspect all exam facilities to ensure compliance with Americans with Disabilities Act and Occupational Safety and Health Administration standards (VA OIG, 2024). In 2024, VA OIG conducted an independent review of facilities and determined that there were deficiencies in the accessibility, safety, and cleanliness at approximately 85 percent of the contract exam facilities it visited (VA OIG, 2024). Like its findings of MDEO's insufficient monitoring of mileage requirements, VA OIG determined that MDEO was unaware of the deficiencies because the office did not provide sufficient oversight to determine whether the vendor reports were accurate (VA OIG, 2024).

Beyond not meeting minimal regulatory standards for safe, clean, and accessible facilities, the physical environments where exams occur can be unwelcoming to veterans. In a presentation to the committee, Naomi Mathis, assistant national legislative director at Disabled American Veterans, recalled,

I went to a C&P exam at a storefront office where they literally had a pop-up sign that said they were seeing veterans. That's what is happening. Sometimes the examiner is working for [a VBA contractor], but they're

really a subcontractor, independent of [the contractor]. So yes, you'll see storefront examiner offices that one day were handling something else, and then suddenly they've got a sign saying they're seeing veterans today. (Mathis, 2025)

The need for positive physical environments is critical for veterans who have experienced MST, for whom a physically and psychologically safe environment is an important element of trauma-informed care (Machtlinger et al., 2015; SAMHSA, 2023). In contrast with the experience Mathis described above, safe physical environments promote spaces for privacy, confidentiality, and psychological safety and may include such elements as well-lit exteriors; low noise levels; warm, welcoming, and positive signage; and access to private areas for use in de-escalating situations or performing self-care (SAMHSA, 2023). These elements are not intended to be restricted to examination rooms but rather to apply broadly to facilities, encompassing exteriors, lobbies, waiting rooms, etc. VA does not have requirements to ensure that C&P exam facilities meet standards for trauma-informed spaces. Failure to provide safe and accessible examinations to veterans who have experienced MST may result in harm to veterans including retraumatization and even claims denials.

Disability Benefits Questionnaires

Once a veteran reports for a C&P exam, the examiner follows one or more DBQs tailored to the specific conditions or body systems for which the veteran is claiming benefits, by recording medical information relevant to establishing entitlement to disability compensation (Hutchinson and Hyberger, 2025). There are more than 70 DBQs that address a wide range of health conditions. Depending on which conditions and how many the veteran claims, an examiner may complete multiple DBQs during the exam. As described in Chapter 3, most examinations do not require a specialist (VA, 2026e). For instance, conditions related to the stomach and duodenum do not require evaluation by a gastroenterologist, since the exam does not demand highly specialized expertise. However, certain types of exams, including those for mental health, TBI, dentistry, and hearing, do require examiners with advanced training or licensure (VA, 2026f, 2026g, 2026h).

Since MST is an experience rather than a diagnosis, there is no specific DBQ for MST. Instead, the clinician uses the DBQ associated with each condition that the veteran says results from the MST experience. In FY 2022, FY 2023, and FY 2024, the most frequently completed DBQs for MST-related claims included those for medical opinion, PTSD (initial), hearing loss and tinnitus, headaches (including migraines), and various musculoskeletal conditions such as knee and lower leg, back (thoracolumbar

spine), and foot issues (Statton, 2025a).¹⁵ The lists of the top 10 completed DBQs were similar for VBA-contracted examiners and VHA examiners (Statton, 2025a).

There are notable differences between the most frequently completed DBQs and the most common diagnoses among veterans that screen positive for MST. VHA data show that patients who screen positive for MST are most likely to be diagnosed with PTSD, depressive disorders, neck and back pain, hypertension, anxiety disorders, sleep apnea, and diabetes (Eggers, 2026b). These differences raise concerns that veterans who experienced MST may not be receiving compensation for the full range of conditions associated with their trauma. The contrast between DBQs and diagnoses also underscores challenges tied to evidentiary requirements for non-PTSD conditions. Because PTSD claims related to MST can rely on lay evidence, many veterans may pursue compensation for PTSD while not filing claims for other related mental or physical conditions that require more strict documentation.

Because DBQs were not designed to account for the statutory requirements and uniqueness of establishing service connection for MST claims, they generally do not provide instruction or space to do so. Notably, the PTSD DBQ is the only DBQ that explicitly asks about MST, and it does not include sexual harassment as part of the definition or scope of MST (VA, 2024f). None include prompts to remind examiners of strategies to ensure a trauma-informed exam. None of the other DBQs include prompts, space, or questions to help the examiner make a connection between the veteran's claimed symptoms or conditions and the MST experience or to ensure the statutory requirements for MST claims are met. None of the DBQs include a defined place to note behavioral markers of MST identified during the examiner's review of the evidence in the claims file or during the exam or to report that the examiner reviewed lay evidence from the claim file, including the PTSD DBQ for which lay evidence and behavioral markers can be considered when establishing service connection. However, all the DBQs have questions that could better cue the examiner to make an evidence-based connection between a condition and MST, either by modifying the language in the question or adding a brief instructional note.

Some DBQs are missing major MST-related symptoms or conditions that are associated with the relevant body system or disorder. For example, the only form of sexual dysfunction listed on the Gynecologic DBQ is female sexual arousal disorder; the DBQ omits other types of sexual dysfunction such as sexual desire disorders, orgasm disorders, and sexual pain disorders which, as previously noted in Chapter 2, have been consistently

¹⁵ DBQ titles may vary when reported to VA, making it challenging to standardize the titles without compromising data integrity.

associated with MST (Pulverman et al., 2019a; Pulverman and Creech, 2021; Pulverman et al., 2019b; VA, 2025b). Relatedly, some DBQs are too narrow in scope and exclude other symptoms or conditions that may result from MST. For instance, the Gynecologic DBQ omits any opportunity to assess chronic pelvic pain outside the setting of endometriosis (VA, 2025b). Chronic pelvic pain is associated with a history of MST and may not be related to the veteran having endometriosis (Cichowski et al., 2017; Gibson et al., 2020; Shapiro et al., 2023). In addition, onset can be critical in linking the condition to the MST experience. However, only some DBQs include explicit instructions for an examiner to describe the onset of a condition or symptom, and only some include instructions to complete additional DBQs (or direct veterans to additional exams for specialized assessments) for secondary conditions or residuals. None of the DBQs allow for documentation of delayed onset. These omissions and inconsistencies could cause missed diagnoses that result in claims delays and denials.

Based on the clinical examination, the examiner is expected to document a veteran's symptoms and provide a medical opinion on the extent to which the claimed condition or symptoms impair the veteran's normal functioning. When drafting their clinical opinion, legal rulings have determined that examiners cannot require medical certainty and must give claimants the benefit of the doubt when evidence in support of or against claims is even.¹⁶

Internal Pelvic Examinations

As described in Chapter 1, the committee was tasked with examining the necessity of internal pelvic exams to diagnose certain conditions and identifying potential alternatives. Pelvic exams are not typically conducted as part of MST-related C&P exams (Eggers, 2025; Hutchinson and Hyberger, 2025). The sensitive nature of these exams can make them especially retraumatizing for veterans who have MST histories (Weitlauf et al., 2008; Weitlauf et al., 2010). The committee requested information on the frequency of internal pelvic exams from VBA but did not receive it. Instead, VBA provided the frequency of DBQs for gynecological conditions, which VA referred to as pelvic examinations (Statton, 2025a). In FY 2022, FY 2023, and FY 2024, the DBQ for gynecological conditions was completed in less than 10 percent of all MST-related claims (Statton, 2025a). However, this is approximately 10 times the frequency of Gynecologic DBQs compared with non-MST-related claims, among which these DBQs were conducted for less than one-half of 1 percent of claims.

¹⁶ *Wise v. Shinseki*, 26 Vet. App. 517, 531 (2014); 38 USC § 5107, Claimant responsibility; benefit of the doubt.

Pelvic exams conducted beyond the acute time frame of an incident of sexual violence are conducted to diagnose and manage a specific described complaint or condition. Since the C&P exam aims to determine disability and is not diagnostic or therapeutic in nature, a pelvic exam would likely be unnecessary as part of such an exam, especially in asymptomatic patients or in patients whose diagnosis is well established in the medical record. This is consistent with clinical guidelines that recommend against routine pelvic examinations among asymptomatic, nonpregnant adult women (Qaseem et al., 2014). Many conditions such as dyspareunia or sexual arousal disorders, including the gynecological conditions currently included in the VASRD,¹⁷ if not well described in the veteran's medical file, can be evaluated from history alone and would not require a pelvic exam (ACOG, 2018, 2020; Lamvu et al., 2021). Therefore, conducting a pelvic exam for C&P purposes provides no additional medical information beyond what would be available in the claimant's medical history. As Earl Hutchinson, assistant director for policy and program management, VBA MDEO, stated in the committee's first information-gathering meeting, "[VA] would almost never do a pelvic examination on a claimant for a claimed condition.... Most times that would be evaluated based on medical evidence already of record for a condition. Say, endometriosis or other things that may require some kind of pelvic exam, there's generally plenty of medical records, which you could use to evaluate a condition without the need for a pelvic exam" (Hutchinson and Hyberger, 2025).

For veterans making an MST-related disability claim with a pelvic component that has not been well elucidated in the medical record, conducting a pelvic exam may cause distress or retraumatization (Weitlauf et al., 2008; Weitlauf et al., 2010). In line with guidelines for clinical care, a trauma-informed approach to deciding whether to conduct a pelvic exam would carefully weigh the clinical necessity of the examination against the potential harms and would take into consideration the claimant's preferences as part of a shared decision-making model (ACOG, 2018). If an examiner who is appropriately credentialed to perform pelvic exams determines that a pelvic exam is needed to assess and document a claimed condition, such as in the rare situation when a new condition requires diagnosis during the C&P exam, applying trauma-informed principles when conducting the exam could minimize potential harm (ACOG, 2021). Some specific trauma-informed strategies include practicing clear communication to describe the exam to promote transparency and trustworthiness, allowing claimants to request a chaperone for peer support or safety, applying gender-sensitive and culturally responsive approaches, and using shared decision-making including verbal consent before starting the exam to empower and ensure

¹⁷ 38 CFR § 4.116, Schedule of ratings—gynecological conditions and disorders of the breast.

collaboration and mutuality with the claimant (Purkey et al., 2018; SAM-HSA, 2014, 2023; Soran, 2024). Best practices for trauma-informed care are described in more detail in Chapter 3.

Medical Opinion DBQ

As described previously, the examiner provides a medical opinion on service connection, if VA requests. The examiner documents this opinion on a Medical Opinion DBQ, which includes space for the examiner to record the evidence reviewed; the specific opinion VBA requested; sections for medical opinions of different types of service connection (direct, secondary, aggravation), specific exposures (Gulf War and toxic exposures), and a reconciliation opinion (used to guide adjudicators when existing medical evidence conflicts); and an open-ended remarks section (see Appendix G). Importantly, the examiner does not determine service connection or the disability rating; VA makes those decisions (VA OIG, 2021b). Similarly, examiners are not allowed to discuss adjudicatory issues such as whether the veteran appears credible or whether the stressor event occurred or was substantiated. Drafting a high-quality medical opinion for an MST-related claim varies depending on the complexity of the case and may take between 90 minutes and several hours (Skloss, 2025).

There are currently two processes for MST-related claims—one for PTSD claims that allows a lower evidentiary standard for establishing the occurrence of MST to allow use of behavioral markers and one for non-PTSD claims that has a higher evidentiary standard by requiring sufficient evidence.¹⁸ For non-PTSD claims related to MST needing sufficient evidence of MST, an examiner could only provide an opinion that the current condition is related to MST if there is a documented report of the MST or if there is an in-service diagnosis or injury, even if such evidence is not needed to diagnose the condition. For PTSD claims related to MST, the VBA medical opinion request asks examiners to corroborate the occurrence of MST and to provide an opinion of service connection (Eggers, 2026a; Seymore and Carter-Visscher, 2025). The differing evidentiary standards for PTSD claims and all other claims complicate the disability determination process for MST-related claims and create more opportunities for errors.

Although the lower evidentiary standard for PTSD claims removes the obstacle of needing evidence to corroborate MST experiences for veterans, medical opinions for PTSD nonetheless have their own limitations. Box 4-1 presents an example of a typical medical opinion request for PTSD related to MST, including standard medical opinion prompts, which VHA provided

¹⁸ 38 CFR § 3.304, Direct service connection; wartime and peacetime; 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service.

BOX 4-1
Example of a Typical Medical Opinion
Request for PTSD Related to MST

The Veteran is claiming service connection for Post-Traumatic Stress Disorder (PTSD) (also claimed as gambling disorder, depression and alcohol use disorder). Please examine the Veteran for a chronic disability related to his or her claimed condition and indicate the current level of severity.

If more than one mental disorder is diagnosed, please comment on their relationship to one another and, if possible, please state which symptoms are attributed to each disorder. PTSD is claimed due to the following stressor(s): Veteran is claiming sexual harassment conducted by superior.

The Veteran has claimed PTSD due to a specific stressful event. Confirmation is required to establish if a relationship exists between the claimed stressor and any mental health diagnosis.

Type of MEDICAL OPINION REQUESTED: Military Sexual Trauma (MST)

MST is a subset of personal trauma and refers to sexual harassment, sexual assault, or rape that occurs in a military setting.

This examination is being conducted to assist with determining whether the Veteran experienced an in-service personal assault stressor related to military sexual trauma (MST) that has resulted in a current PTSD diagnosis. Please review the claims file and state it was reviewed in your report. In your review, pay special attention to the Veteran's personal statement of the stressor, the tabbed supporting evidence, and any signs, events, or circumstances that may represent behavioral markers for the MST stressor. Your review is not limited to the evidence identified on this request form or tabbed in the claims folder.

EXAMINER: Evidence from sources other than the Veteran's service records may corroborate the Veteran's account of the stressor incident and may include evidence of behavioral changes. Behavioral changes occurring after service can also constitute markers, if they can reasonably be associated with a claimed in-service stressor.

1. The examiner is asked to comment on whether the evidence of record corroborates the occurrence of the MST stressor event. Is the evidence of record at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) consistent with the occurrence of the MST stressor event(s)? Please provide a rationale for the opinion and list any evidence used to arrive at your decision.

continued

BOX 4-1 Continued

2. IF YOUR EXAMINATION DETERMINES THE VETERAN HAS A CURRENT DIAGNOSIS OF PTSD, please provide an opinion as to whether the current PTSD diagnosis is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by or a result of the MST stressor event(s). Please note that PTSD is the only mental health condition that can be service connected solely based on circumstantial marker evidence (38 CFR 3.304(f)(5)).

3. IF YOUR EXAMINATION DETERMINES THAT, IN ADDITION TO PTSD, THE VETERAN HAS ADDITIONAL MENTAL DISORDERS, please state whether the additional mental disorders are at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) secondary to the PTSD and provide a rationale. For each mental disorder diagnosed, identify, and clearly list which symptoms are attributed to each diagnosis. If one or more symptoms overlap and cannot be separated without speculation, please state so, and provide a rationale (38 CFR 3.310).

4. IF YOUR EXAMINATION DETERMINES THE VETERAN DOES NOT HAVE PTSD BUT HAS A DIFFERENT MENTAL DISORDER(S), please review the claims folder for supporting in-service evidence of the MST stressor(s). (38 CFR 3.303) If there is in-service evidence supporting the Veteran's statement regarding the stressor, please provide an opinion as to whether the mental disorder(s) diagnosed on examination is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by or a result of the MST stressor event(s). Please provide a rationale for the opinion and list the evidence used to arrive at your decision.

Rationale must be provided in the appropriate section. If more than one mental disorder is diagnosed, please comment on their relationship to one another, and, if possible, please state which symptoms are attributed to each disorder.

Your review is not limited to the evidence identified on this request form, or tabbed in the claims folder. If an examination or additional testing is required, obtain them prior to rendering your opinion.

SOURCE: Eggers, 2026a.

to the committee in response to a request for information (Eggers, 2026a; Seymore and Carter-Visscher, 2025).¹⁹ Critically, by asking for a clinical opinion about whether the record of evidence corroborates the occurrence of MST, VBA effectively instructs the examiner to corroborate whether MST occurred. However, both the standard of care and best practices for forensic examinations and clinical care for conditions related to traumatic experiences focus on the presenting symptoms and do not require determining or corroborating whether a traumatic event or stressor occurred (ACEP, 2023; ACOG, 2021; APA, 2013; SAMHSA, 2014, 2024; Samuelson et al., 2024; WHO, 2013). Furthermore, documenting specific instances of MST can be challenging when MST may result from the cumulative effect of multiple incidents of varying levels of severity. For example, in a small qualitative study of veterans' experiences filing for disability compensation related to MST, a participant shared,

It's hard to prepare mentally where you're [being asked] like, "you need to get me these time frames about what exactly happened" and "you have to focus on one traumatic event." I wish there was more consideration of complex PTSD and how multiple events over years compile upon each other. (Webermann et al., 2026b, p. 376)

In addition, as described in Chapter 3, examiners do not have sufficient supplemental training from VA to inquire about MST in a trauma-sensitive manner. Therefore, examiners are unlikely to be prepared to conduct C&P examinations that provide the necessary clinical findings while reducing potential harms to veterans. Furthermore, as described in Chapter 3, because examiners lack training in key competencies needed to draft sufficient medical opinions, including identifying and interpreting behavioral markers and integrating clinical findings from the examination with the review of the veteran's medical history and supporting scientific evidence into a coherent, structured narrative, they are likely to apply substantial discretion in providing medical opinions (Webermann et al., 2026a). This ambiguity and discretion results in inconsistent decision-making and unwanted variation in the quality and sufficiency of medical opinions (VA OIG, 2022; Webermann et al., 2026a). A study of a small number of PTSD DBQs compared examination reports completed by VBA-contracted examiners to those completed by VHA examiners. Comparing the reports on three measures of quality, the authors concluded that contractor reports were statistically

¹⁹ The committee requested "copies of all versions of the Medical Opinion DBQ," which are not public, and VBA provided one Medical Opinion DBQ form. Based on information from VHA and contract exam vendors, VBA always includes four questions in medical opinion requests for PTSD related to MST, as shown in Box 4-1 (Eggers, 2026a; Seymore and Carter-Visscher, 2025).

inferior on the level of detail and synthesis of findings to VHA reports (Meisler and Gianoli, 2022). The types of deficiencies included no review of records, no relevant background report, and no mention of social and occupational functioning assessment (Meisler and Gianoli, 2022). However, when the authors compared the disability awards made based on these examination reports, they found that contractors had significantly higher disability ratings than VHA examiners (Meisler and Gianoli, 2022). This suggests that the deficient and insufficient medical opinions are associated with differential ratings outcomes arising from potential rating inaccuracies and may reflect unfairness in the disability compensation process.

Conditions Identified During a C&P Examination in Addition to the Claimed Condition(s)

VA only requests examinations and medical opinions for the conditions that a veteran self-identifies when filing a claim (Hutchinson and Hyberger, 2025). On the one hand, this respects veterans' perceptions of their own health issues. On the other hand, veterans lack medical expertise to diagnose conditions or link symptoms and conditions to diagnoses, injuries, or events from their military service. This may be especially true of physical health conditions associated with MST, such as residuals of PTSD like cardiovascular or gastrointestinal (GI) conditions, for which there is less awareness about their relationship to sexual trauma. In a presentation to the committee, Karen Seymore, a representative from the contracted examination vendor Optum Serve, stated,

Many MST survivors do not recognize the connection between their trauma and the physical symptoms they experience. They often associate residuals solely with visible injuries such as scars or disfigurement, while overlooking the more common yet invisible effects like GI issues, chronic pain, fatigue, [and] pelvic dysfunction. These symptoms are frequently underreported by veterans and under-documented by examiners, leading to gaps in the care and compensation. Compounding this issue is the expectation that veterans must self-identify and file claims for each of their specific residuals. This presents a significant barrier, as many are unaware that their physical and psychological symptoms are linked to their trauma. As a result, they may not pursue the full range of benefits they're entitled to, further contributing to the under-recognition and under-documentation of MST-related conditions. (Carter-Visscher and Seymore, 2025)

In other words, as described in Chapter 2, MST may result in multiple, overlapping, and co-occurring health effects, some of which veterans may not know are associated with MST, so this issue may be especially salient

for MST-related claims (Carter-Visscher and Seymore, 2025; Castro et al., 2015; Lofgreen et al., 2017). Precisely because the under-recognition of the health consequences of MST results in under-documentation and under-reporting, it is unclear when, how, and how often examiners identify service-connected conditions in addition to the claimed condition and are unable to document them (Carter-Visscher and Seymore, 2025). Optum Serve raised this as a “critical issue” (Carter-Visscher and Seymore, 2025); however, other vendors did not raise this issue as a primary concern for MST-related claims and exams. Nonetheless, to the extent that the existing process prohibits assessment of additional but unrequested diagnoses, DBQs, and medical opinions related to MST, assessing diagnoses identified during an examination would require multiple examinations and could result in claims processing delays and inaccurate ratings and compensation (Carter-Visscher and Seymore, 2025). If veterans are unaware of the broad range of health consequences of MST, VA’s system that relies on their initial reporting and self-identification of service-connected conditions would be expected to result in systematic under-reporting, under-diagnosis, under-documentation, and under-compensation of the full spectrum of impairment associated with MST.

Complicating this issue, VA has ambiguous and seemingly conflicting guidance about what examiners should do when they identify a potentially service-connected disability in addition to the claimed condition during an exam. In some circumstances, VA requires examiners to provide unrequested DBQs and opinions. Examiners are instructed to provide a DBQ or medical opinion when a requested DBQ requires one (VA, 2022a). For example, the initial and review PTSD DBQs direct examiners to the Eating Disorders DBQ if the veteran has symptoms of an eating disorder (VA, 2024c, 2024f). VA also instructs examiners to provide a medical opinion when the evidence of record (i.e., documents in the veteran’s claims folder and the clinical findings from the C&P examination) requires one (VA, 2022a). However, guidance for this scenario is unclear and inconsistent. The DMA Medical Opinion training course that all VHA and contracted examiners complete as part of their general certification training states, “As a result [of the ruling in the legal case *Clemons v. Shinseki*], when [the examiner] diagnose[s] a Veteran or Service member with a condition other than the condition they claim, [the examiner] must provide an opinion addressing the relationship between the diagnosed condition and service in addition to the requested opinion for the claimed condition” (VA, 2022a). *Clemons v. Shinseki* found that claims decisions cannot be limited to the conditions veterans self-identify when filing their claim, because veterans are not medical experts and their attempt to diagnose or label a specific condition to file a claim should not prevent VA from considering other

potential additional or alternate diagnoses.²⁰ The training also provides examples of claimed versus diagnosed conditions that would require an unrequested medical opinion (e.g., claimed PTSD but diagnosed depression, claimed foot condition but diagnosed peripheral neuropathy) (VA, 2022a). In contrast to these instructions in the training, multiple vendors stated that under MDEO policy examiners can only provide a medical opinion when requested by VBA (Carter-Visscher and Seymore, 2025; Dean, 2026; Mirza, 2026; Skloss, 2025). At the same time, multiple vendors also noted that VBA does not always request the correct examinations or the examinations for all diagnoses encompassed by a veteran's claim (Dean, 2026; Mirza, 2026; Skloss, 2025). To ensure VBA has sufficient clinical information to decide claims and avoid delays caused by additional examination requests or inadequate or insufficient reports that are returned for rework, vendors typically identify potential alternate or additional diagnoses that are not requested but could be encompassed by the claim during their initial review of the claims folder. The vendors then submit a clarification request to VBA to ensure that VBA requests all relevant diagnoses prior to any examination, rather than relying on a process that captures relevant diagnoses during a C&P exam (Dean, 2026; Mirza, 2026; Skloss, 2025).

REVIEWING THE CLAIM AND RATING THE MST-RELATED DISABILITY USING THE VASRD

Examiners submit the completed DBQs to VBA through the Compensation and Pension Record Interchange. Claims developers then review the full claim file, including the completed DBQ(s), to determine if there is complete and sufficient evidence for a decision. Because federal regulations require an examination report without sufficient information to be returned as inadequate,²¹ if additional information is needed to ensure the report is adequate for the rating board to evaluate the claim, the claims developer may request clarification or correction from examiners (known as the “Rework” process for contracted examiners), or even order another C&P exam (GAO, 2024).

Once submitted for rating, the claims rater reviews the evidence in the claims folder (e.g., military service and medical records, results of the C&P examination, lay evidence when permitted), evaluates the claim with respect to service connection and impairment, and applies the VASRD to assign a disability rating. The VASRD is a system codified in federal regulations that assigns a percentage rating from 0 to 100 percent per condition, reflecting the extent to which it affects the veteran's daily functioning (IOM, 2007).

²⁰ *Clemons v. Shinseki*, 23 Vet. App. 1 (2009).

²¹ 38 CFR § 4.2, Interpretation of examination reports.

The VASRD is organized into sections corresponding to different body systems and conditions (e.g., the musculoskeletal, respiratory, or cardiovascular systems; mental disorders; dental and oral conditions; infectious diseases, immune disorders, and nutritional deficiencies).²² Each section includes many codes, or four-digit code numbers assigned to medical diagnoses.²³ For example, the section of the VASRD on neurological conditions has approximately 115 VASRD codes.²⁴ Each VASRD code then maps to different disability rating levels, or percentages (e.g., TBI can be 100, 70, 40, 10, or 0 percent; PTSD can be 100, 70, 50, 30, 10, or 0 percent).²⁵ When a veteran has multiple disabling conditions, the individual ratings are combined using a combined rating table to ensure the total rating does not exceed 100 percent.²⁶ Most DBQs gather information on multiple/many diagnoses (e.g., for foot, plantar fasciitis, hammer toes, flat foot, etc.), each with its own VASRD code. In addition, a single VASRD can map to multiple DBQs. For example, degenerative arthritis appears in the back/spine, foot, knee, and lower leg sections of the VASRD.²⁷ Thus, with multiple conditions, as is common for MST-related claims, disability ratings become very complex.

Many sections of VASRD map closely to DBQs, but some sections are less well aligned. As an example of a condition that is well aligned, the criteria for PTSD listed in the VASRD closely mirror the questions asked in the two versions of the PTSD DBQ (initial and review) (VA, 2024f). The VASRD addresses mental disorders due to traumatic stress including PTSD in the General Rating Formula for Mental Disorders (VASRD code 9411).²⁸ Diagnoses made within this section are generally expected to conform to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (APA, 2013). Disability stemming from PTSD and other mental disorders considers symptom frequency, intensity, and persistence, along with the duration of remission periods and the veteran's ability to function during those periods. The criteria cited in the General Rating Formula for Mental Disorders map closely onto Section II.5 (Symptoms) of the initial PTSD DBQ (which is identical to the symptoms list in Section II.4 of the review PTSD DBQ) (VA, 2024f).^{29,30} Further, Section I.4 of the

²² 38 CFR Part 4, Schedule for rating disabilities.

²³ 38 CFR § 4.27, Use of diagnostic code numbers.

²⁴ 38 CFR § 4.124a, Schedule of ratings—Neurological conditions and convulsive disorders.

²⁵ 38 CFR § 4.130, Schedule of ratings—Mental disorders; 38 CFR § 4.124a, Schedule of ratings—Neurological conditions and convulsive disorders.

²⁶ 38 CFR § 4.25, Combined ratings table.

²⁷ 38 CFR § 4.71a, Schedule of ratings—Musculoskeletal system.

²⁸ 38 CFR § 4.130, Schedule of ratings—Mental disorders.

²⁹ 38 CFR § 4.126, Evaluation of disability from mental disorders.

³⁰ 38 CFR § 4.130, Schedule of ratings—Mental disorders.

initial PTSD DBQ (also found in Section I.4 of the review PTSD DBQ) lays out an anchored rating scale, which begins with “no mental disorder diagnosis” and then describes six levels of “Occupational and Social Impairment.” These map neatly onto the six levels of disability defined in the General Rating Formula for Mental Disorders. Similar alignment is observed for residuals of TBI (VASRD 8045) and multiple gynecologic conditions: VASRD codes 7610 (vulva or clitoris, disease or injury of [including vulvovaginitis]), 7611 (vagina, disease or injury of), 7612 (cervix, disease or injury of), 7614 (fallopian tube, disease, injury, or adhesions of [including pelvic inflammatory disease]), and 7615 (ovary, disease, injury, or adhesions of).³¹

In contrast to the close alignment observed between the DBQ and the VASRD for PTSD, the VASRD for endometriosis and the corresponding section of the Gynecologic DBQ are mismatched, and there are several ways in which impairments captured in the DBQ would not result in a disability rating for endometriosis (VA, 2025b).³² Section 13 of the Gynecologic DBQ, which addresses endometriosis, features a checklist of symptoms, including pelvic pain, heavy bleeding, irregular bleeding, lesions, bowel symptoms, anemia, and “other”; these last two symptoms (anemia and “other”) do not appear in the VASRD formula for endometriosis (VASRD code 7629), which only includes three symptoms: lesions, pelvic pain and heavy or irregular bleeding, and bowel or bladder symptoms. In addition, only the 50 percent rating formula of the VASRD includes lesions and bowel or bladder symptoms. Moreover, a 50 percent rating also requires that all three symptoms are present. If the veteran is experiencing lesions and/or bowel or bladder symptoms, but all three symptoms are not present, she would not receive a disability rating for endometriosis. Finally, the VASRD only addresses the veteran’s response to treatment for pelvic pain or heavy or irregular bleeding, and a rating is only awarded if either continuous treatment is required or these symptoms are not controlled by treatment. If pelvic pain or heavy or irregular bleeding due to endometriosis requires less than continuous treatment, the veteran would not receive a disability rating for endometriosis. Similarly, a veteran who experiences one or more of the other symptoms and requires continuous treatment or whose symptoms are not controlled by treatment would not be eligible for a disability rating.

In addition to misalignment between DBQs and the VASRD for certain conditions associated with MST, the VASRD lacks certain conditions (especially physical conditions) that current evidence has shown are commonly

³¹ 38 CFR § 4.124a, Schedule of ratings—Neurological conditions and convulsive disorders; 38 CFR § 4.116, Schedule of ratings—Gynecological conditions and disorders of the breast.

³² 38 CFR § 4.116, Schedule of ratings—Gynecological conditions and disorders of the breast.

linked to MST. For example, there is no section on chronic pelvic pain. Furthermore, the musculoskeletal section of the VASRD states that injury must be

[t]hrough and through or deep penetrating wound of short track from a single bullet, small shell or shrapnel fragment, without explosive effect of high velocity missile, residuals of debridement, or prolonged infection ... by small high velocity missile or large low-velocity missile, with debridement, prolonged infection, or sloughing of soft parts, and intermuscular scarring ... [or] due to high-velocity missile, or large or multiple low velocity missiles, or with shattering bone fracture or open comminuted fracture with extensive debridement, prolonged infection, or sloughing of soft parts, intermuscular binding and scarring.³³

Such language designed for injuries related to combat trauma does not encompass the types of injuries due to MST-related trauma, though injury from MST could be disabling. Omissions of conditions associated with MST result in inaccurate ratings and compensation.

CLAIMS DECISION AND APPEAL

The last step for veterans seeking disability benefits is for VBA to notify the veteran of the claims decision. In FY 2024, of the nearly 40,000 disability claims filed related to MST, nearly two-thirds were granted (Statton, 2025b). Among denied claims, the most common reasons for rejection were that the condition was not incurred or caused by service or that there was no diagnosis (Statton, 2025b). When making disability determinations, VA must apply the presumption of soundness, which requires VA to assume that a veteran was in good health at the start of service.³⁴ Furthermore, VA must provide clear evidence to dispute this presumption as a reason to deny disability claims. In other words, VA has the burden of identifying “clear and unmistakable” evidence (meaning evidence that cannot be “misinterpreted and misunderstood, i.e., it is undebatable”³⁵) that a veteran had a preexisting condition, indicating that the claimed disabling condition was not incurred during service, and that the condition did not worsen because of his or her service. This still applies if a health condition is noted but does not rise to the level of a disability at service entry.³⁶ In addition to placing the burden on VA to demonstrate that the veteran’s condition was

³³ 38 CFR § 4.56(d), Evaluation of muscle disabilities.

³⁴ 38 USC § 1111, Presumption of sound condition; 38 CFR § 3.304(b), Direct service connection; wartime and peacetime.

³⁵ *Horn v. Shinseki*, 25 Vet. App. 231, 234 (2012).

³⁶ *McKinney v. McDonald*, 28 Vet. App. 15 (2016).

not incurred or exacerbated during service, when adjudicating claims, VA must also apply the benefit of the doubt,³⁷ which requires VA adjudicators to award benefits to a veteran when the evidence in support of or against a claim is even. Applying these principles can be complex when a veteran has multiple conditions, especially mental health conditions, because some conditions are considered preexisting and not compensable. For example, VA regulation carves out personality disorders from being service-connected.³⁸ When a service member is discharged because a diagnosed personality disorder significantly impairs his or her ability to function in the military environment,³⁹ these discharges can block access to VA benefits and health care for other mental health conditions that may exist (Dao, 2012; Leroux, 2015).

The final rating directly influences the amount of monthly compensation a veteran receives and helps determine the range of VHA services and co-pays for which he or she is eligible (Drake and Burgess-Mundwiler, 2019). If approved, the veteran will receive benefits based on the assigned disability percentage according to the VASRD. Table 4-1 lists compensation rates for 2026, which range from \$180.42 per month for a veteran alone with a 10 percent disability rating to \$3,938.58 per month for a veteran alone with a 100 percent rating. Veterans with dependent family members such as spouses, children, and parents receive higher monthly benefits (VA, 2025a). As noted earlier, in FY 2024, the average disability rating for MST-related claims was 80 percent, with an average monthly compensation rate of \$2,523.79 (Statton, 2025b). If the veteran disagrees with the decision, that person may appeal through VBA and the Board of Veterans' Appeals (VA, 2025a).⁴⁰ The appeals process can be onerous and retraumatizing to veterans who have experienced MST, because they may require additional C&P examinations, requests for information, and testimony, which may require veterans to retell their stories and contribute to feelings of not being believed. The committee does not elaborate on these issues as they are beyond the scope of its charge.

SUMMARY

Assessing and rating MST-related disabilities can be challenging because MST is an experience, not a diagnosis, and the VA disability system and DBQs are designed for body system-based or condition-based claims;

³⁷ 38 USC § 5107, Claimant responsibility; benefit of the doubt.

³⁸ 38 CFR § 3.303, Principles relating to service connection.

³⁹ Department of Defense Instruction 1332.14, "Enlisted Administrative Separations" (2014).

⁴⁰ For more information on the history and development of the VASRD, please see the Institute of Medicine's report, *A 21st Century System for Evaluating Veterans for Disability Benefits* (IOM, 2007).

this creates complexity and unique challenges for processing MST-related claims. Key information needed for VA to adjudicate MST-related disability compensation claims comes in the form of clinical opinions based on a review of a veteran's records and findings from clinical examinations. If VA has sufficient evidence documenting the occurrence of an MST experience, claims processors request a clinical examination to obtain a diagnosis and assess the level of disability (VA, 2025e).⁴¹ In most cases, VA also requests a medical opinion about whether the claimed condition is related to MST and thus service-connected (Majors and Hyberger, 2026). The committee identified several critical issues related to the C&P examination process for MST-related claims, which may have adverse consequences for veterans by causing retraumatization and contributing to inefficiency and delays, inaccurate disability ratings, and inconsistent disability determinations and compensation.

When VA has some but insufficient evidence to decide a claim, claims developers request a clinical examination to obtain a diagnosis, assess the level of impairment, and, in most cases, request an opinion of service connection (VA, 2025e). Most conditions can be assessed in a single examination, sometimes with multiple DBQs. Occasionally, assessing the full spectrum of impairment requires multiple examinations, since some C&P exams like mental health exams are restricted to specialists (VA, 2026f, 2026g, 2026h). Some physical health conditions have mental health sequelae and vice versa. Four physical health DBQs specifically direct the examiner to the mental disorder DBQ for completion by a qualified mental health examiner. In rare cases such as chronic pain, separate physical and mental exams may be necessary to assess the full spectrum of impairment. In such cases, while multiple examinations help ensure that veterans receive full and accurate ratings and compensation for a single condition, this poses practical burdens and creates more opportunities for potential retraumatization.

VBA examination and medical opinion requests for claims related to MST are often ambiguous or incorrect, and this may lead to unnecessary examinations and claims processing delays. In particular, medical opinion requests can be unclear or not follow VA procedures (VA OIG, 2022). These incorrect or unclear requests result in inaccurate or insufficient medical opinions, incorrect claims determinations, and claims delays (VA OIG, 2022).

Once assigned a case, examiners are responsible for reviewing the claims folder containing a veteran's records for relevant evidence (including markers for PTSD claims) that has been previously bookmarked by a

⁴¹ 38 CFR § 3.159(c)(4), Department of Veterans Affairs assistance in developing claims; 38 USC § 5103A, Duty to assist claimants.

TABLE 4-1 Monthly Veterans Disability Compensation Rates for 2026

Dependent status	Monthly Payment in U.S. Dollars by Disability Rating									
	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Veteran alone	180.42	356.66	552.47	795.84	1,132.90	1,435.02	1,808.45	2,102.15	2,362.30	3,938.58
Veteran with spouse			17.47	882.84	1,241.90	1,566.02	1,961.45	2,277.15	2,559.30	4,158.17
Veteran with one child			596.47	853.84	1,205.90	1,523.02	1,910.45	2,219.15	2,494.30	4,085.43
Veteran with spouse and one child			666.47	947.84	1,322.90	1,663.02	2,074.45	2,406.15	2,704.30	4,318.99
Each additional child over age 18			32.00	43.00	54.00	65.00	76.00	87.00	98.00	109.11
Additional children over age 18 enrolled in school			105.00	140.00	176.00	211.00	246.00	281.00	317.00	352.45

SOURCE: VA, 2025a.

claims developer. Claims folders average 2,000 to 4,000 pages, and vendors often face challenges with incompatible systems and sometimes unusable tabs or bookmarks, which may cause examiners to miss relevant evidence (Dean, 2026; Skloss, 2025; VA, 2025i). Some vendors have developed proprietary technologies using keyword searches to identify potentially relevant information, but relying on vendors is not transparent and may result in inconsistent decision-making (Dean, 2026; Skloss, 2025). Implementing standards for these AI tools would increase fairness and consistency across vendors. These large and disorganized claims folders may lead to loss of information or examiners missing relevant information, which can lead to delays, denials, and inaccurate ratings.

A trauma-informed approach to C&P exams related to MST encompasses the physical environments where such exams occur. Safe physical environments promote spaces for privacy, confidentiality, and psychological safety (Machtinger et al., 2015; SAMHSA, 2014, 2024). For example, specific features may include well-lit exteriors, low noise levels, warm and welcoming signage, and access to private areas. These features apply to the facility including such areas as the exterior, lobbies, waiting rooms, and examination rooms. However, veterans report perceiving facilities to be cold and unwelcoming (Mathis, 2025). Moreover, basic deficiencies in the accessibility, safety, and cleanliness of contract examination facilities are common (VA OIG, 2024).

C&P examiners follow DBQs to guide clinical examinations and document clinical opinions about the veteran's level of impairment and, if requested, their opinion of service connection. Because MST is not a diagnosis but a qualifying in-service event, there is no specific DBQ for MST, and examiners must use the DBQ associated with each condition that the veteran claims is due to the MST experience. Relatedly, because DBQs were not designed to assess impairments associated with MST, they lack prompts or other protocols to identify MST markers or otherwise support examiners to link MST to disabling conditions. The committee was specifically tasked with assessing the "necessity of internal pelvic examinations to diagnose certain conditions, and potential alternatives to these examinations" (see the Statement of Task in Chapter 1). Pelvic exams are not frequent for MST-related claims but may be more common compared with other claims. However, most—if not all—gynecological conditions can be adequately evaluated for their presence and impairment from history and medical record review alone (ACOG, 2018; Qaseem et al., 2014). Therefore, compared with diagnostic or therapeutic health care encounters where internal pelvic exams can inform diagnosis or treatment, conducting pelvic examinations for C&P examinations would rarely benefit disability assessment.

Medical opinions of service connection represent a source of particular complexity and inconsistency. First, VA has two evidentiary standards for MST-related claims: all claims except PTSD require sufficient evidence such as service records (e.g., formal report of sexual assault or sexual harassment, in-service PTSD diagnosis), while PTSD claims permit lay and other evidence, including marker evidence, in recognition of the potential absence of service records documenting personal traumatic events including MST (VA, 2025I).⁴² This means that some of the evidence that examiners use to demonstrate service connection for PTSD related to MST cannot be used to establish service connection for other conditions related to MST.⁴³ Second, these opinions require examiners to provide medical opinions about whether evidence is consistent with an MST experience for PTSD claims and whether the claimed condition is related to MST for all claims (Majors and Hyberger, 2026). Because corroborating traumatic events is not standard clinical practice and VA does not provide sufficient training on how to do so, requiring examiners to do so likely leads examiners to ask veterans to retell their stories during an examination, which can trigger retraumatization. Third, VA has inconsistent policies and insufficient training for examiners on how to develop and draft the clinical opinions of service connection for MST-related claims, which may result in inconsistent decision-making and rating inaccuracies (VA OIG, 2022). Finally, both evidentiary standards for MST-related claims are higher than the standards applied to disabilities related to combat.

Examiners submit completed DBQs to VBA for review, claims adjudication, and assignment of a disability rating (IOM, 2007). Claims processors apply the VASRD to assign a percentage rating from 0 (i.e., no impairment) to 100 percent (i.e., total impairment) to the condition based on the veteran's symptoms and functional abilities, as documented in the DBQs (IOM, 2007). Lack of standardized terminology and descriptions of conditions and symptoms, limited guidance on how responses in the DBQs translate to criteria in the VASRD, poor alignment between the level of disability described in some DBQs and the corresponding sections of the VASRD, and the omission of common health conditions associated with MST in the VASRD may result in inaccurate or incomplete disability ratings for conditions related to MST.

Chapter 5 presents the committee's recommendations to address the many challenges in the C&P examination process for claims related to MST.

⁴² 38 CFR § 3.303, Principles relating to service connection; 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime.

⁴³ 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime.

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5

Improving the Compensation and Pension Examination Process for Disability Compensation Claims Related to Military Sexual Trauma

Veterans are eligible to receive disability compensation if they have a current health care condition (i.e., injury or illness) and a nexus or link between that condition and an in-service disease, injury, or event (VA, 2025d).¹ Military sexual trauma (MST) is not a disability, but the Department of Veterans Affairs (VA) considers it a qualifying in-service event and will provide disability benefits for conditions resulting from MST experiences. To receive MST-related disability compensation, VA must have evidence of a veteran's current diagnosis, the MST experience, and a relationship between the two. In many cases, key evidence about these eligibility criteria to inform VA claims decisions comes from a review of the veteran's records (including service records, medical records, and lay evidence from the veteran, friends and family, or civilian sources) and clinical findings or opinions based on disability examinations, known as compensation and pension (C&P) examinations. Clinicians performing these exams, known as C&P examiners, are primarily contracted by the Veterans Benefits Administration (VBA), though some are employed by the Veterans Health Administration (VHA). There has been a substantial shift from VHA-employed to contracted examiners, from contracted examiners performing nearly one in four exams in 2013 to more than 90 percent of exams in 2024 (CRS, 2022; GAO, 2025). This shift has resulted in a new workforce that lacks the traditional competencies and experiences of VHA in-house clinicians.

¹ 38 CFR § 3.303, Principles relating to service connection; 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service; 38 CFR § 3.304, Direct service connection; wartime and peacetime.

C&P examiners do not make determinations about whether a veteran experienced MST, but their clinical opinion is considered proof on the basis of which VA claims raters can make that determination.

In Chapter 4, the committee identified a range of challenges that veterans and examiners face in the C&P examination process related to MST—in particular, related to examination referrals and scheduling, the facilities where exams occur, the Disability Benefits Questionnaires (DBQs) that guide the clinical examinations, and the VA Schedule for Rating Disabilities (VASRD), which VA uses to assign ratings to disabilities. This chapter briefly summarizes these issues and presents recommended improvements. The committee's recommendations are limited to those relating to C&P examinations, as this is the scope of its charge. The committee acknowledges that there are opportunities for improvement throughout the claims process, including parts beyond the examination, as well as systemic issues that influence examinations, which the committee does not address as they are beyond the scope of its Statement of Task.

In evaluating all potential options for improvement, the committee considered their relative advantages and disadvantages, implementation challenges, and the extent to which each addressed problems with current protocols. In some cases, the committee considered multiple alternative options, which it also describes in this chapter. The committee also assessed how each potential option relates to the goals of a high-quality C&P exam. As outlined in Chapter 1, the committee's goals for the C&P examination process for claims related to MST are to ensure a high-quality process for the claimant that leads to reproducible outcomes, minimizes burden on veterans, and compensates claimants fairly. The committee defined a high-quality process as one that is evidence-based, trauma-informed, accessible (in physical proximity and time), accurate (i.e., enables the correct assessment of symptoms, impairments, and evidence or markers of MST), and transparent (meaning the process and decision-making should be clear for claimants, examiners, and VA). Six principles guide a trauma-informed approach: safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment, and cultural, historical, and gender issues (see Chapters 1 and 3). Reproducible outcomes mean that all claimants are treated the same, and any variation in the process is associated with the particular presentation of an individual claimant's case and not with the person who conducted the examination or where it was conducted. Minimizing burden on veterans includes minimizing administrative burdens as well as potential harms related to the claimant's trauma. Lastly, fair compensation refers to compensation commensurate with an accurately assessed level of service-connected disability, based on existing rules and regulations.

IMPROVING THE C&P EXAMINATION

MST is an experience associated with a broad range of frequently overlapping health consequences (Galovski et al., 2022). Conversely, VA's disability compensation system including the protocols and tools for C&P exams are designed as body system–based and single condition–based claims resulting from combat (VA OIG, 2021a). Applying MST to this system designed for combat-related injuries and illnesses creates fundamental incompatibilities, which makes C&P examinations for MST-related claims more complex than those conducted for other claims (VA OIG, 2021a). This complexity creates more room for inconsistencies, error, and lack of clarity, which contribute to delays, inaccurate disability ratings, inconsistent decision-making, and adverse experiences for veterans. The remainder of this section describes specific incompatibilities and presents recommended remedies.

Examination Referrals and Scheduling

As described in Chapter 1, the committee is tasked with assessing “[w]hether certain conditions linked to military sexual trauma require a referral for both a mental and physical health examination,” which the committee interpreted to mean whether there are conditions that require both a physical and mental health C&P exam to assess that single condition. In most cases, one examiner can fully assess a specific condition in a single examination, even if this requires completion of multiple DBQs. In some cases (e.g., fibromyalgia and traumatic brain injury [TBI]), physical conditions have mental health sequelae. In rare cases, and more commonly for conditions related to MST, multiple diagnoses co-occur with overlapping symptoms. For example, there is no chronic pain DBQ, and assessing physical symptoms (e.g., pelvic pain, headaches) would require separate assessment from the psychological symptoms (e.g., depressive symptoms). In such a case, assessing the totality of a veteran's impairment may require multiple examiners due to restrictions around certain specialist exams, like mental health exams. Requiring veterans to present for multiple examinations, potentially at different locations and times, can be practically and logistically challenging. Moreover, for veterans who have experienced MST, multiple examinations may expose them to more occasions when they are requested to retell their MST experiences, which can trigger retraumatization. To minimize these burdens on veterans and ensure accurate assessment and rating of the full spectrum of a veteran's impairment, the committee recommends the following:

Recommendation 5-1: When assessment of the full spectrum of impairments requires multiple, separate compensation and pension examinations, scheduling should be coordinated to reduce burden on the veteran, whenever possible. To facilitate this coordination, the Department of Veterans Affairs should consider scheduling examinations at a proximate location and time, using telehealth when feasible.

Examination Facilities

Ensuring a physically and psychologically safe environment is critical as part of a trauma-informed approach to C&P examinations for veterans who have experienced MST (Machtinger et al., 2015; SAMHSA, 2023). Best practices in trauma-informed care suggest features such as well-lit exteriors; low noise levels; warm, welcoming, and positive signage; and access to private areas (SAMHSA, 2023). These features and standards encompass not only examination rooms but the entire facility, including waiting rooms and other spaces. When clinically appropriate, such as when a physical examination is not required, allowing veterans the option of having a virtual C&P examination conducted remotely (from a safe space of their choosing) could lessen the potential for retraumatization while also increasing accessibility. Providing veterans with such an option is also consistent with the trauma-informed principles of collaboration, mutuality, and empowerment (SAMHSA, 2014). However, veterans have reported perceptions of unwelcoming and unsafe facilities (e.g., Mathis, 2025). In addition, prior VA Office of Inspector General (OIG) and Government Accountability Office reviews of the facilities contract examiners use for C&P examinations identified basic deficiencies in their accessibility, safety, and cleanliness (GAO, 2025; VA OIG, 2024a). Failure to provide safe and accessible examinations to veterans who have experienced MST may result in harm to veterans, including retraumatization and even claims denials. Therefore, to ensure a trauma-informed approach to C&P exams encompassing the environments where those exams occur, the committee recommends the following:

Recommendation 5-2: The Department of Veterans Affairs (VA) should define and set standards (e.g., well-lit exteriors, low noise levels, access to private areas) to ensure physical and psychological safety in environments where compensation and pension examinations related to military sexual trauma (MST) are conducted. For contracted exams, the Veterans Benefits Administration Medical Disability Examination Office should prioritize referring veterans whose claims are related to MST to examinations at facilities that meet these standards, produce annual reports on their adequacy, and articulate a process for evaluating and rectifying deficiencies identified in such facilities within a year

of receiving this report. As an accommodation for individuals with claims related to MST, VA should also inform claimants of the right to request a remote, virtual examination when clinically appropriate.

While these facility standards apply to all facilities, including both VHA facilities and those of contracted examiners, the committee acknowledges that VHA facilities are subject to standards and oversight beyond the scope of the committee's task. Therefore, the committee's recommendations focus on those used by contracted examiners for which the Medical Disability Examination Office has oversight authority and the ability to implement accountability mechanisms, such as through contracting and referrals. Furthermore, as noted at the beginning of the chapter, contracted examiners conduct most exams. The committee recommends prioritizing these facilities and not mandating them in recognition of the need to balance safety and accessibility (namely, timeliness and geographical proximity) when scheduling these exams.

Reviewing Evidence Related to the Claimed Disabling Conditions

Examiners are responsible for reviewing the claims folder containing a veteran's records for relevant evidence (including markers for posttraumatic stress disorder [PTSD] claims), as well as the possibly relevant evidence a claims developer bookmarks and annotates (VA, 2025b). Claims folders records average between 2,000 to 4,000 pages per claim, and vendors face challenges with incompatible systems and sometimes unusable bookmarks or annotations (Dean, 2026; Skloss, 2025; VA, 2025c). Some vendors have developed proprietary technologies using keyword searches to identify potentially relevant information, but because they often lack standards regarding when these tools are used, methods for validating their accuracy, approaches to ensuring data privacy and their reliability, and quality assurance processes, relying on vendors is not transparent and may result in inconsistent decision-making across vendors (Dean, 2026; Skloss, 2025). These large and disorganized claims folders may also lead to loss of information or examiners missing relevant information, which can lead to delays, denials, and inaccurate ratings. Due to conflicting comments across vendors, the committee was not able to determine the scope of this problem. Nonetheless, establishing standards such as minimum system requirements could mitigate these challenges. Therefore, to ensure timely and accurate claims processing, the committee recommends the following:

Recommendation 5-3: The Veterans Benefits Administration Medical Disability Examination Office (MDEO) should develop minimum standards for information systems of contract compensation and pension examination vendors (including interoperability requirements to view

Department of Veterans Affairs bookmarks and annotations) and incorporate these standards as requirements in any new contracts executed between MDEO and contract examination vendors.

C&P Examiners

A key challenge related to the quality of current C&P exams for MST-related claims is the entirely new contracted examiner workforce that lacks the traditional training and experience of working with veterans compared with VHA in-house clinicians. Specifically, when compared with contracted examiners, VHA-employed clinicians have more experience working with service members and veterans because they work exclusively with this population; those who completed their graduate medical education within VHA would also be expected to have more robust training in trauma-informed approaches and military cultural competence (VA, n.d.). Relatedly, VHA facilities may be more likely to meet standards for physically and psychologically safe environments because, as noted above, they must meet minimal standards and are subject to regular oversight by VA OIG. For these reasons, one potential option to ensure that C&P examiners are proficient in the competencies needed to perform MST-related examinations (see Chapter 3) would be to limit MST exams to VHA-employed C&P examiners and VHA facilities. However, such a proposal has significant disadvantages that are likely to outweigh the potential benefits. Namely, owing to the high demand for C&P exams for MST-related claims, coupled with the limited VHA workforce and facilities (which currently perform fewer than 10 percent of all C&P exams) (GAO, 2024), restricting MST-related exams to VHA clinicians and facilities would likely have significant adverse effects on veterans' access to these exams. VA also has requirements for timeliness and geographic distance when scheduling C&P exams that could not be feasibly balanced if all exams were restricted to VHA. Moreover, the committee expects that with adequate training in the competencies needed to perform MST-related exams and quality assurance measures, any appropriately credentialed clinician would be qualified to perform high-quality C&P exams for MST-related claims (see Chapter 3 for more information, including recommendations on examiner qualifications, training, and quality assurance). For these reasons, the committee determined that this option is not feasible.

Disability Benefits Questionnaires

C&P examiners follow body system-based DBQs to guide clinical examinations and document key findings. Lack of prompts to identify MST markers and otherwise link an MST experience to a condition in the

DBQs may result in inaccurate or incomplete DBQs, which can contribute to delays and denials of claims for conditions related to MST. Most DBQs do not adequately capture MST-related symptoms and conditions or provide examiners with instructions for linking these to the MST experience, leading to potential missed diagnoses or inaccurate opinions of service connection. The committee considered several alternative options for improving DBQs—such as changing all DBQs to include MST-relevant prompts and information, developing and implementing an MST-specific DBQ, and adapting the Personal Trauma Incident/Marker Worksheet for MST—which are described in the remainder of this section along with their relative advantages and disadvantages.

First, VA could edit all DBQs to include specific MST exam prompts to collect required information for MST claims. For example, new prompts or questions may include space to document whether the claim was related to an MST experience, provide instructions for MST claims, and document markers and other relevant evidence related to the veteran's MST experience. Importantly, although markers and other lay evidence may offer useful elements of a veteran's medical history to assess, for example, the onset and course of a condition, they currently can only be used in an opinion of service connection for PTSD.² Adding prompts and instructions would guide examiners to complete the specific requirements of an MST claim and would likely reduce MST claim errors related to missing marker and evidence information. As a result, these changes may assist examiners conducting any DBQ in developing their clinical opinion of service connection. However, there are several disadvantages to this approach. First, it would require edits to every DBQ. Second, this would mean changing all DBQs to accommodate one claim type, though MST claims are a minority of all disability claims and the most frequent service-connected condition for MST-related claims is PTSD (Majors and Hyberger, 2026). Additionally, these proposed modifications to the DBQ fall outside the scope of verifying disability and its related functional impact, which could result in MST being brought up inappropriately during non-MST claim exams. Lastly, for PTSD claims for which evidence of behavioral markers is permitted to substantiate the occurrence of experienced MST, the information that would be documented in the DBQ would overlap with information documented in two existing tools—the Personal Trauma Incident/Marker Worksheet that claims developers complete and VA Form 21-0781, “Attachment to the Statement in Support of Claimed Mental Health Disorder(s) Due to an In-Service Traumatic Event(s),” which claimants may use to document their lay testimony and provide marker evidence (see Appendixes F and E, respectively).

² 38 CFR § 3.304, Direct service connection; wartime and peacetime.

Another option to improve DBQs for MST-related claims would be for VA to develop a DBQ that is specific to MST claims, which would include evaluation of all potential physical and mental health challenges that result from MST in one DBQ. Like the proposed changes to the existing DBQs, this new MST-specific DBQ would include specific instructions and prompts for MST claims in particular. It would also include relevant medical opinions about function and whether the disability is related to MST (i.e., service-connected). An MST-specific DBQ would guide examiners through all the key markers of MST and ensure that relevant physical and mental health symptoms are clearly and thoroughly documented. In so doing, it would likely reduce MST claim errors related to missing marker and evidence information. Furthermore, the MST-specific DBQ could be designed with a trauma-informed approach, with specific considerations for trauma related to MST, and could reduce retraumatization by limiting the number of times a veteran must recount the MST experience. An MST DBQ could also include information from the scientific literature on links between MST and commonly associated health symptoms and conditions, which would reduce the burden of proof on veterans, minimize potential opportunities for retraumatization, and help the examiner develop an evidence-based opinion of service connection. Having one DBQ that captures all the health consequences of MST would also mean that a single MST-trained clinician could evaluate both physical and psychological symptoms without additional referrals or multiple C&P exams, thereby reducing administrative burden on the claimant. However, assessment of both the mental and physical health conditions associated with MST by a single clinician could be challenging, especially given current restrictions on the types of providers that can perform certain specialty exams, including mental health and TBI exams (VA, 2026a, 2026b, 2026c). Because of these restrictions, it is possible that an MST DBQ would require at least two or more examiners to conduct a single MST examination or a workforce capable of evaluating all possible outcomes related to MST. It is therefore also likely that an MST DBQ would require new specialized training for completion. Such potential workforce limits and specialized training to complete the MST DBQ could limit access to C&P exams for MST-related claims and delay MST claims processing.

Having a DBQ for MST-related claims has several other potential disadvantages. It might be challenging to have a DBQ that is inclusive of all possible outcomes related to MST; given VA's use of PDF format for all DBQs (e.g., compared with an online platform with branching logic), the questionnaire would likely be hundreds of pages long. An MST DBQ could also have second-order effects based on the existing requirements for completing certain specialized DBQs. For example, if a clinician completing an MST DBQ can evaluate residuals of TBI related to MST, it is unclear

whether the MST clinician would also be eligible to evaluate such residuals on TBI DBQs. Finally, using an MST-specific DBQ for an MST-specific examination would make the C&P process significantly different for a single type of claim, though such a change might be warranted since MST-related claims are unique relative to other types of claims.

A third option would be for VA to adapt the Personal Trauma Incident/Marker Worksheet (Appendix F) currently completed by VA claims processors and shared with examiners to create a new MST Experience/Marker Worksheet, which both claims developers and examiners would complete. The form would address MST-specific claim requirements not currently captured in the DBQs and would facilitate the examiner in determining whether the available evidence supports if MST occurred and whether the disability is related to that MST experience. The form would guide examiners through a trauma-informed examination process with MST-specific prompts to remind examiners of trauma-informed examination strategies and to ensure all required evidence and opinions are provided. This would reduce returned claims for missing information and claims denied due to insufficient evidence that the disability was caused by MST. Moreover, the form would improve efficiency since prompts would guide the examiner in completing required elements rather than relying on the examiner's ability to provide clear and sufficient documentation within the free-text narrative section of a DBQ form. Notably, this MST worksheet would not require changes to the DBQ to collect and evaluate evidence for MST. Rather, it would be completed along with the DBQ and medical opinion forms by the examiner, based on examination findings and records in the veteran's claims folder. This form is intended to be completed by examiners after reviewing the claims folder and completing the clinical examination, alongside the drafting of the medical opinion, and not with the claimant. This reduces potential retraumatization because it will, in many cases, guide the examiner through a rigorous documentation process without having to ask the patient to recall a traumatic event that has already been sufficiently described in existing records.

Development of the form would be best accomplished in collaboration with VHA and VBA subject matter experts, claims developers, examiners, claims adjudicators, VA MST coordinators, and VA policy leads in VA Central Office, among others. Nonetheless, specific proposed modifications to adapt the existing personal trauma worksheet for MST might include detailed instructions and reminders of requirements of an MST-related claim, a prompt to indicate what evidence was reviewed to develop opinions about function and service connection, and a checklist of potential markers encountered in the course of record review and the clinical examination. In addition, the form could include prompts with strategies for conducting trauma-informed examinations such as those related to clear

communication, seating arrangements, shared decision-making, and referrals to appropriate support services (SAMHSA, 2023; Soran, 2024). In contrast to the existing personal trauma worksheet which includes space for an open-ended response to document potential markers, the MST worksheet would use a checklist, as is currently included in the form veterans complete to provide evidence of their in-service trauma (VA Form 21-0781, see Appendix E). This could increase standardization and reduce ambiguity and error; the use of checklists has been shown to improve quality in other health care settings (Haynes et al., 2009; Treadwell et al., 2014). As described in Chapter 4, both claims processors and examiners report that identifying markers is complex, challenging, and ambiguous, leading to idiosyncratic responses and complicating claims determinations (VA OIG, 2021a, 2021b, 2022; Webermann et al., 2026). A checklist would standardize and guide both claims processors and examiners to identify marker and lay evidence, remind examiners of the marker evidence available to review, and guide them in documenting their findings to create a transparent record for claims raters and veterans. To that end, ensuring that veterans are aware of their right and clarifying the process to request copies of their examination documentation would promote trustworthiness and transparency in the claims process. Because MST is associated with a broad range of symptoms and conditions, including sub-clinical symptoms that may nonetheless affect function to a substantial degree, the form could also provide a prompt to document symptoms related to MST that are not a key focus of a particular DBQ (e.g., extreme social withdrawal, intense and unstable interpersonal relationships, substance use, dissociative episodes) but which are nonetheless relevant in assessing social and/or functional impairment. This provides opportunities for examiners to report on symptoms of impairment related to MST that are not captured in the DBQs. At the same time, the form maintains the body-system DBQ as it was intended—for identifying diagnoses and impairments. The development and implementation of a new MST worksheet also has some potential drawbacks. Importantly, it requires a new, additional form for examiners to complete, and there are no existing analogies of a VA disability-related form for this purpose. In addition, because some claimants will be required to have multiple examinations for a single claim (e.g., PTSD and major depression disorder, mental and physical impacts of fibromyalgia), the form may need to be completed more than once by different examiners, which would require adjudicators to review and synthesize information across multiple forms, thereby adding complexity to the process.

Each of these three alternatives or complements to the DBQs may help guide examiners through C&P examinations related to MST and help ensure a trauma-informed approach. This would minimize practical and emotional burdens on veterans, enhance collaboration and mutuality,

improve accuracy and trustworthiness in the process, and reduce inconsistency and delays. However, they also have important disadvantages related to their feasibility and implementation. Moreover, they do not address the drivers of inconsistencies and unfairness in the existing process, for which reason the committee does not prefer any of these strategies.

Medical Opinion DBQ

If requested, examiners provide a medical opinion of service connection about the link between a veteran's current symptoms or conditions and an in-service illness, injury, or event (VA, 2025f). For MST-related claims and conditions, this means providing an opinion about whether the claimed condition or conditions are related to MST. For PTSD claims, examiners are also typically asked to determine whether evidence is consistent with the occurrence of an MST experience (Eggers, 2026). These requests are likely to lead an examiner to ask veterans to retell their MST experiences during the examination process, which inhibits the psychological safety, collaboration, and empowerment of veterans. In addition, corroborating traumatic events is not standard clinical practice and VA does not provide supplemental training, which may leave examiners unprepared to do so. Furthermore, limited training, guidance, and an evolving evidence base on the health consequences of MST make developing and drafting MST nexus opinions difficult. Additional training and standardized guidance as well as VA-vetted scientific resources developed with VHA expertise could improve consistency and evidence-based decision-making.

VBA only requests exams for conditions that a veteran claims (VA, 2025h). However, in the course of their records review or during a clinical examination, examiners may identify potentially service-connected diagnoses in addition to those a veteran claims. This may be more common with MST-related claims because of the breadth and range of MST-related health consequences. The lack of clarity about whether and when to provide medical opinions for these additional conditions results in differing interpretations of rules by vendors and VHA, as well as different protocols to address the ambiguity. These differing interpretations and protocols result in inconsistent decision-making and lack of transparency in the MST claims process; requiring examiners to do so may lead to rating inaccuracies and under-compensating veterans for their service-connected disabilities (VA OIG, 2021a, 2021b, 2022; Webermann et al., 2026). Therefore, to ensure that examiners assess and provide information on the full spectrum of a veteran's impairment related to MST, examination reports are comprehensive and fully considerate of their clinical findings and opinions, and VA has timely information on a veteran's impairments required to accurately and efficiently rate and adjudicate an MST-related disability claim and thereby

increase transparency and trustworthiness in the examination process, the committee recommends the following:

Recommendation 5-4: The Veterans Benefits Administration Medical Disability Examination Office (MDEO) should clarify and provide consolidated guidance and training for examiners about when Disability Benefits Questionnaires (DBQs) or medical opinions for additional conditions diagnosed during the examination or identified based on a review of the veteran's records are required, permitted, or prohibited. In cases where such DBQs or medical opinions are required or permitted, MDEO should establish standardized processes for examiners to do the following:

- a. Clarify the examination and/or medical opinion request prior to any examination, and
- b. Submit unrequested DBQs and/or medical opinions for additional conditions identified.

Rating the MST-Related Disability

Claims raters use the VASRD, a system codified in federal regulations to assign a percentage rating from 0 to 100 percent to different levels of impairment for each condition (IOM, 2007).³ When a veteran has multiple co-occurring disabilities, the individual ratings for each condition are combined using a combined rating table to ensure the total rating does not exceed 100 percent.⁴ The VASRD does not include some conditions associated with MST, especially physical health conditions such as chronic pelvic pain and injuries. In addition, alignment between DBQs and the corresponding sections of the VASRD varies. For some conditions such as PTSD, TBI, and a range of gynecological conditions, clinical findings documented on the DBQs map neatly onto VASRD criteria for different levels of disability (VA, 2024a, 2024b, 2024c, 2025a). Others lack standardized terminology and descriptions of conditions and symptoms and provide limited guidance on how responses in the DBQs translate to criteria in the VASRD. Such poor alignment between the level of disability described in some DBQs and the corresponding sections of the VASRD for conditions related to MST may result in inaccurate or incomplete disability ratings, which creates inconsistencies in disability evaluations for veterans claiming disability for MST-related conditions. Therefore, the committee recommends the following:

³ 38 CFR Part 4, Schedule for Rating Disabilities.

⁴ 38 CFR § 4.25, Combined ratings table.

Recommendation 5-5: Within one year of this report and at least every five years thereafter, the Department of Veterans Affairs should review and revise Disability Benefits Questionnaires and the corresponding sections of its Schedule for Rating Disabilities to ensure that they capture health conditions, including both physical and mental health conditions, that emerging scientific evidence has shown are associated with military sexual trauma and for optimal alignment, especially regarding specific rating thresholds.

STANDARDS OF EVIDENCE IN SUPPORT OF MST-RELATED DISABILITY COMPENSATION CLAIMS

Currently, VA has two standards of evidence for MST-related disability compensation claims. For PTSD claims, VA allows lay evidence such as statements from friends and family and evidence of behavioral markers; for all other claims, VA regulations require sufficient evidence to substantiate an incident of MST as the in-service event.⁵ As the committee concluded in Chapter 4, the different standards for PTSD and non-PTSD claims add complexity to MST-related claims compared with other claims, resulting in inconsistent decision-making between PTSD and other MST claims, and may result in potentially inaccurate ratings for non-PTSD conditions related to MST compared with ratings for PTSD related to MST. The previous section described targeted improvements to the MST disability examination process. While each significantly ameliorates challenges of the status quo, none address the dual standards of evidence, the resulting process, and added complexity of MST-related claims and examinations. Applying a single evidentiary standard would reduce complexity in the process, promote consistency in decision-making, and potentially increase fairness and accuracy in ratings and compensation for disability compensation claims related to MST, especially between PTSD and non-PTSD MST claims. This section describes potential alternative evidentiary standards for MST that address the adverse consequences of the current standards.

Permitting Use of Lay Evidence and Behavioral Markers for All MST-Related Claims

One method to simplify the evidentiary standards for MST-related claims would be to apply the current standard for PTSD claims related to in-service personal assault (including MST) to non-PTSD claims and to allow the use of lay evidence and behavioral markers in addition to formal

⁵ 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service; 38 CFR § 3.304, Direct service connection; wartime and peacetime.

reports and other in-service documentation.⁶ Substantiating MST claims, whether through formal documentation or behavioral marker evidence, has been a major obstacle for veterans pursuing disability benefits for health conditions related to their MST experiences. Veterans pursuing disability benefits related to certain toxic exposures, combat exposure, prisoner-of-war (POW) experiences, and fear of hostile military or terrorist activity faced the same obstacle in documenting service connection prior to VA establishing policies which assumed the occurrence of one or more such exposures in the course of military service. As evidence of this obstacle, Table 5-1 shows that in fiscal year (FY) 2025, among more than 45,000 claims with at least one MST-related condition that VA granted service connection, PTSD was the most frequent service-connected condition, with more than 40,000 claims equaling 82 percent (Majors and Hyberger, 2026). The next nine conditions comprise fewer than 3 percent of all claims each. The relative paucity of service-connected claims for non-PTSD physical and mental health conditions associated with MST suggests that there are significant barriers to establishing service connection for those conditions relative to PTSD. Relatedly, according to data VA provided to the

TABLE 5-1 Ten Most Frequently Service-Connected Conditions for MST-Related Disability Claims, Fiscal Year 2025

Condition	Frequency n = 45,022 n (%)
Posttraumatic Stress Disorder	36,929 (82.0)
Female Sexual Arousal Disorder	1,091 (2.4)
Major Depressive Disorder	845 (1.9)
Chronic Adjustment Disorder	671 (1.5)
Migraine	470 (1.0)
Generalized Anxiety Disorder	372 (0.8)
Anxiety Disorder, Unspecified	355 (0.8)
Unspecified Neurosis	353 (0.8)
Penile Deformity (loss of erectile power)	346 (0.8)
Mood Disorder	262 (0.6)

NOTES: Numbers and percentages in column do not sum to the total or 100 percent owing to conditions outside the top 10 conditions. MST = military sexual trauma.
SOURCE: Majors and Hyberger, 2026.

⁶ 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service; 38 CFR § 3.304, Direct service connection; wartime and peacetime; 38 CFR § 3.303, Principles relating to service connection.

committee, the most common reason for claims denials is “Not incurred/caused by service” (see Table 5-2) (Statton, 2025). In FY 2024, this reason was provided for more than 60 percent of all MST claims denied. This suggests that providing corroborating evidence of the MST experience and the difficulty it creates in establishing a link between a claimed disability and an MST experience are serious limiting factors for veterans pursuing service connection. Similarly, a 2024 VA OIG report on VHA health care use and benefits among veterans who reported sexual assault during military service found that approximately one-third of veterans who formally reported sexual assaults to the Department of Defense (DOD) Sexual Assault Prevention and Response Office (SAPRO) during service had not received a service-connected disability (VA OIG, 2024b). This indicated to VA OIG that veterans who have experienced sexual assault may also experience barriers in benefits claims processing or applying for service-connected disability (VA OIG, 2024b).

As further evidence of the difficulty of receiving service connection for conditions associated with MST, studies have shown that PTSD claims related to MST were more likely to be denied compared with those related to combat or other trauma (ACLU, 2013; Webermann et al., 2024). Relatedly, a study of a nationally representative panel of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn veterans

TABLE 5-2 Ten Most Common Reasons for Rejection of MST-Related Claims

Reason for Rejection	Frequency n = 13,982 n (%)
Not incurred/caused by service	8,980 (64.2)
No diagnosis	8,367 (59.8)
Not secondary	1,662 (11.9)
Not aggravated by service	161 (1.2)
Constitutional/developmental abnormality	115 (0.8)
Not established by presumption	96 (0.7)
Not entitled to Chapter 17	39 (0.3)
Not in line of duty	22 (0.2)
Hearing normal for VA purposes	17 (0.1)
Substance abuse	9 (0.1)

NOTES: Numbers and percentages in column do not sum to the total because a claim can have multiple rejection reasons. MST = military sexual trauma; VA = Department of Veterans Affairs.

SOURCE: Statton, 2025.

found that men, whose PTSD claims were primarily related to combat (90 percent), were more likely to have their PTSD claims approved than women, whose PTSD claims were primarily related to MST (70 percent), and that differences in combat exposure explained this gender difference (Murdoch et al., 2025). This suggests that receiving service connection for combat is more likely than for other trauma exposures including MST. Among veterans whose claims were related to MST, analyses have found that men and Black claimants were more likely to have their claims denied (ACLU, 2013; Webermann et al., 2024). These patterns persisted between 2006 and 2022, despite changes in VA claims processing intended to improve the process for MST-related claims during the same period (ACLU, 2013; Webermann et al., 2024).

It is well documented that veterans and service members frequently do not report their experiences of MST. It is extremely difficult for victims to report any form of sexual trauma due to stigma and myths about sexual violence, including beliefs that sexual assault/harassment could not have occurred if there is no supporting evidence (Castro et al., 2015; Samuelson et al., 2024). In addition, survivors of sexual violence often may choose not to report their experiences to authorities due to the belief that nothing will be done (DOD, 2025). Aspects of military culture, which emphasizes hierarchy, authority, masculinity, and team cohesion, significantly add to the tendency not to report (Castro et al., 2015; Suris and Lind, 2008). Reporting a fellow team member can be seen as a form of team betrayal which, in turn, represents a threat to team cohesion, the lives of team members, and the success of the mission (Castro et al., 2015; Lofgreen et al., 2017; Suris and Lind, 2008). A service member's identity can be associated with specific challenges related to that person's identity during military service, which can also influence the likelihood of reporting MST (Biskupski-Mujanovic et al., 2025; Brown et al., 2021; Grau et al., 2022). For example, women may face prejudice and exclusion from male peers, which can discourage reporting of these experiences, particularly those that could lead to further isolation from their units (Bourke, 2022; Brown et al., 2021). Historical discrimination against racial and ethnic minorities can also foster institutional distrust, leading to lower rates of reporting among veterans who belong to these populations (Grau et al., 2022). Having not reported MST experiences contemporaneously, whether formally to authorities or informally to friends and family, especially when military culture and norms pressure service members not to report, currently impedes service members and veterans' access to VA disability benefits, particularly if they come to a decision later to pursue disability benefits for conditions stemming from their MST experience. Requiring formal documentation of MST experiences thus likely leads to claims denials for genuinely service-connected conditions owing to a standard of evidence for MST that most veterans

are unable to meet. Furthermore, this requirement has a negative emotional impact on veterans and may also discourage veterans from even applying for service-connected disability.

In recognition of the challenges of providing evidence of in-service personal assaults such as MST from the veteran's service records, VA regulations permit a lower evidentiary standard for PTSD claims, which also allows consideration of lay sources and evidence of behavioral markers (i.e., "sources other than the veteran's service records ... [such as] records from law enforcement authorities, rape crisis centers, mental health counseling centers, hospitals, or physicians; pregnancy tests or tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, or clergy").⁷ The rationale that veterans "may find it difficult to produce evidence to prove the occurrence of" incidents or experiences of personal assault, including MST, is equally applicable to PTSD and other conditions associated with MST.⁸ Applying this standard uniformly for all MST-related claims would therefore acknowledge that military records may not always contain records of the MST experience owing to the difficulty of reporting sexual assault generally and especially in the military environment for all MST-related claims. It would also acknowledge that evidence from sources other than military service records may provide credible supporting evidence of MST as the in-service event. Acknowledging these challenges for veterans who have experienced MST, particularly those rooted in military structure, culture, and history, would increase psychological safety, collaboration and mutuality, and empowerment in the claims and examination process. Applying this standard of evidence would also increase fairness among MST-claims by ensuring that the absence of such formal documentation does not impede veterans from receiving benefits for non-PTSD conditions related to MST, just as current regulations for PTSD stemming from an in-service personal assault including MST do.

Despite these relative advantages, allowing use of marker evidence still requires veterans to collect evidence to substantiate MST experiences, which can cause them emotional harm. Importantly, VA only considers behavioral markers sufficient evidence in combination with clinical interpretation, which VA obtains by requesting a medical opinion (VA, 2025g); C&P examiners provide this opinion by completing a Medical Opinion DBQ. As described in Chapter 4, the Medical Opinion DBQ asks examiners to provide opinions about whether the clinical findings are consistent with an MST experience occurring during the veteran's service and whether the PTSD diagnosis is due to or worsened by the MST experience,

⁷ 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime.

⁸ VA, "Post-Traumatic Stress Disorder Claims Based on Personal Assault," Federal Register 65, no. 200 (October 16, 2000): 61132-61133.

and to provide a rationale supporting these opinions based on the claimant's records, findings from the clinical examination, and scientific evidence (Majors and Hyberger, 2026; Seymore and Carter-Visscher, 2025). By requiring examiners to provide opinions used to corroborate whether incidents of MST occurred and whether the current PTSD disability is due to MST (and thus service-connected), VA is implicitly asking examiners to question veterans' stories, which makes veterans feel like they are not believed, and requires asking veterans to relate (and, consequently, relive) their traumatic experiences. In testimony to the Senate Committee on Veterans' Affairs in 2024, mental health therapist Alissa Engel testified that a client of hers said,

The whole process basically retraumatizes people. It would have helped if I didn't have to talk to so many people about it. I had to talk to some guy who made me feel like crap, didn't seem remotely interested in what I was saying, and just kept asking me if I was thinking of dying. If I would have said yes, he would have committed me, but because I said "no" he wrote that I was "sometimes sad and depressed." Even this time, I've seen you for years, but I'm still going to have to go see some stranger who's going to meet me once and somehow make a determination on me. If they could streamline the process, so people who are already in care didn't have to retell and basically beg some stranger to believe them; that would be great. I'm just really tired of constantly living in fear that I have to relive these moments, and hope I'm believed. (U.S. Congress, 2024, p. 3)

Similarly, in testimony to the House of Representatives Committee on Veterans' Affairs Subcommittee on Disability Assistance and on Memorial Affairs and Subcommittee on Health in 2021, Kristina Keenan, representing the Veterans of Foreign Wars of the United States, said, "A veteran's account of an MST incident alone is typically insufficient for a VA claim, leaving veterans feeling that their stories are not believed" (U.S. Congress, 2021). Although examiners are instructed not to question veterans' experiences of sexual trauma in the military during C&P examinations, the requirements to provide a clinical opinion about the occurrence of MST for PTSD claims and to provide evidence of MST to establish service connection run counter to this instruction. This contradiction can lead to retraumatization and seriously impedes the disability claims process.

Also as described in Chapter 4, the process for substantiating evidence of MST contrasts with VA's evidentiary standards for other military exposures where the scientific information needed to establish service connection is incomplete, does not exist, or is impossible to obtain such as toxic exposures and exposure to combat trauma or fear of hostile military or terrorist activity. In these cases, VA has established presumptions of exposure that do not require any evidence and instead presume exposure if a known military exposure is consistent with the veteran's service history.

Such presumptions are consistent with VA's principle of the benefit of the doubt, simplify claims development and research, and reduce the potential for inconsistent decision-making by claims processors and examiners, thus facilitating consistent, timely, and fair processing of disability claims related to these presumptive exposures.⁹

Applying the evidentiary standard for PTSD related to personal trauma for all MST-related claims has several benefits, primarily associated with applying a single standard for all MST-related claims. Since PTSD claims are the most common type of MST-related claim, extending the evidentiary standard for these claims to other MST-related claims could simplify and standardize the process for all MST-related claims. This would reduce burden and complexity for claims developers, examiners, and claims raters, which may lead to more consistent and more timely outcomes. It would also reduce burden for veterans, who currently must navigate two different processes, and improve fairness in claims determinations by creating one standard of evidence for MST claims. At the same time, this process still has several important disadvantages. Notably, it requires claims processors and examiners to identify behavioral markers and relies on their discretion in identifying and interpreting them, which evidence has shown makes the PTSD-related MST process more complex, as compared with other claims (VA OIG, 2021a, 2021b; Webermann et al., 2026). This complexity is compounded by the perceived clinical and diagnostic complexity of PTSD claims related to MST compared with other PTSD claims (Webermann et al., 2026) and, as described in Chapter 3, by the lack of training on needed skills, including understanding legal and regulatory frameworks, practicing trauma-informed care, identifying and interpreting markers, and drafting sufficient medical opinions. This ambiguity and reliance on personal discretion at multiple levels results in inconsistent decision-making, lacks transparency, and causes potential inaccuracy and unfairness in disability ratings. Moreover, it also still requires examiners to provide medical opinions about service connection, including potentially requiring them to corroborate whether MST occurred, which could harm veterans by retraumatizing them, making them feel disbelieved, and requiring them to retell their story. Therefore, while applying the same evidentiary standard for non-PTSD MST-related claims as for PTSD claims related to in-service personal assaults such as MST would significantly improve the MST disability determination process as applied under current evidentiary standards, it fails to address significant inconsistencies between the standards for evaluating disabilities related to MST experiences (physical, mental, and otherwise) and the standards used to assess disabilities related to traumatic experiences from other aspects of military service such as combat.

⁹ 38 CFR § 3.102, Reasonable doubt.

Eliminating the Requirement to Corroborate MST as the Qualifying In-Service Event

To address the key shortcomings of requiring any evidence, whether through formal reports or informal documentation of behavioral markers, to substantiate incidents of MST and thus establish service connection, the committee considered reducing VA's requirement to corroborate the occurrence of MST during service. Under this approach, VA would not require the entire evidence of record to establish service connection for disabilities related to MST. Instead, VA would rely on veterans' lay testimony of their MST experiences to establish MST as the in-service event if three conditions are met. First, the MST experience is consistent with the circumstances and conditions of the veteran's service; second, a VA clinician or a clinician contracted by VA confirms that the claimed MST experience is adequate to support the claimed disability (i.e., the veteran's symptoms are related to the MST); and third, there is no clear and convincing evidence to the contrary in the veteran's record.

U.S. Code grants the Secretary of Veterans Affairs the authority to issue regulations about the level of evidence needed to establish entitlement to benefits.¹⁰ In regulations about service connection of disabilities, U.S. Code also requires the Secretary to give "due consideration ... to the places, types, and circumstances of such veteran's service as shown by such veteran's service record, the official history of each organization in which such veteran served, such veteran's medical records, and all pertinent medical and lay evidence."¹¹ VA has interpreted this statute to mean that it must consider the entire evidence of record, which may include but not be limited to the veteran's lay testimony.¹² By contrast, federal statute directs VA to accept lay or other evidence of service as sufficient proof of service connection for conditions related to combat.¹³ Accordingly, for combat-related disabilities, VA regulations permit "lay or other evidence ... as sufficient proof of service connection if the evidence is consistent with the circumstances, conditions or hardships of such service even though there is no official record of such incurrence or aggravation."¹⁴ Thus, the standards of evidence for establishing service connection for MST are higher than for combat.

Congress and VA have also relaxed the standards of evidence of service connection for other service-related traumatic exposures such as fear of

¹⁰ 38 USC § 501(a)(1), Rules and regulations.

¹¹ 38 USC § 1154(a), Consideration to be accorded time, place, and circumstances of service.

¹² VA, "Post-Traumatic Stress Disorder Claims Based on Personal Assault," Federal Register 65, no. 200 (October 16, 2000): 61132-61133.

¹³ 38 USC § 1154(b), Consideration to be accorded time, place, and circumstances of service.

¹⁴ 38 CFR § 3.304(d), Direct service connection; wartime and peacetime.

hostile military or terrorist activity or POW experiences.¹⁵ Presumptions for these exposures are established based on when and where a particular exposure was known to have occurred. Consequently, VA needs only to establish that the veteran served in the known location and at times of a known exposure. Just as serving in a combat zone increases risk of certain adverse exposures, military service at any place or time elevates the risk of exposure to sexual trauma. As detailed in Chapter 2, it is well documented that MST is a persistent and pervasive problem, with approximately 15 percent to more than 70 percent of veterans reporting MST experiences, depending on the methods of assessment. In the words of one participant in a qualitative study examining how women veterans cope with experiences of combat and MST,

One of the problems over in Iraq for female soldiers is that there is a lot of sexual harassment and rape is huge. And it does not matter if you're 18 or 58 ... They have to be worried about the guy that's next to them, you know, that's supposed to be protecting and taking care of them and a lot of times he becomes like public enemy number one for them. (Mattocks et al., 2012, p. 540)

Some evidence supports an elevated prevalence of sexual assault and sexual harassment in the military compared with the general population. One study directly compared sexual assaults between military and non-military women and found that the lifetime prevalence of rape among Air Force women (28 percent) was more than twice as high as the prevalence in a national sample (13 percent), and nearly half of the military sample had been the victims of rape, molestation, or attempted sexual assault (Bosstock and Daley, 2007). More recent estimates require comparisons across different surveys conducted using different methods in military and non-military samples separately. Results from the 2023 Workplace and Gender Relations Survey of Military Members showed that 6.8 percent of women and 1.3 percent of men in the military reported experiencing unwanted sexual contact, defined as penetrative sexual assault, non-penetrative sexual assault, and attempted penetrative sexual assault (Samuelson et al., 2024). In comparison, results of the Centers for Disease Control and Prevention's 2023/2024 National Intimate Partner and Sexual Violence Survey, which provides state- and national-level estimates of sexual violence, showed that 5.5 percent of women and 2.1 percent of men nationally experienced contact sexual violence (including attempted rape, sexual coercion, and unwanted sexual contact) (CDC, 2025). The Bureau of Justice Statistics,

¹⁵ 38 CFR § 3.304(f), Direct service connection; wartime and peacetime; Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022, Public Law 117-168, 117th Congress, 2nd Session.

National Crime Victimization Survey, which estimates nonfatal criminal victimizations including those both reported and not reported to police, found that in 2023 there were 1.7 rapes or sexual assaults (i.e., rape, attempted rape, or other type of sexual attack) per 1,000 persons age 12 or older (0.17 percent) (Tapp and Coen, 2024). Directly comparing the prevalence of sexual violence across these surveys is challenging due to differences in the samples, measurement of sexual violence, and contextual features of military and civilian environments that influence disclosure (Castro et al., 2015; Lofgreen et al., 2017; Suris and Lind, 2008). However, these findings are generally consistent with an elevated risk of sexual victimization in the military as compared with the general population.

As described in Chapter 2, MST is distinct from other forms of sexual trauma owing to the context and culture of the military, which emphasizes values that may increase the risk of sexual trauma, discourage reporting, and contribute to unique health sequelae (Castro et al., 2015; Galovski et al., 2022; Lofgreen et al., 2017; Suris and Lind, 2008). As stated in DOD’s 2025 Annual Report on Sexual Assault in the Military, “When incidents of sexual assault occur, they undermine [military] ethos and erode unity within our military” (DOD, 2025). This violation of core military value, which under normal circumstances cements respect for and reliance on fellow military members in performance of their duties, makes MST “unique compared to [sexual harassment and assault within] civilian contexts” (Herriott et al., 2024). Thus, MST is not only a personal trauma, as VA’s disability compensation currently treats it, but it is inherently a service-related trauma. Eliminating the requirement to corroborate MST with evidence acknowledges the inherent increased risk of exposure to sexual harassment and/or sexual assault from serving in the military at any time or any place, just as serving in combat increases risk of other exposures related to service in the military. Given this precedent, a general description of the MST experience (including both formal reports and lay evidence) would be sufficient for VA to establish that the MST experience is consistent with the circumstances and conditions of a veteran’s service. Formal reports would include military service and medical records; lay evidence would include such evidence as civilian police reports, private medical records, buddy statements, marker evidence (i.e., evidence of behavioral changes such as changes in duty assignment, performance, or performance evaluations; disciplinary or legal problems; substance use; and medical testing for pregnancy or sexually transmitted infections following an MST experience), and the veteran’s lay testimony about the experience (i.e., that person’s self-reported statement, such as is currently documented on VA Form 21-0781 “Attachment to the Statement in Support of Claimed Mental Health Disorder(s) Due to an In-Service Traumatic Event(s)”; see Appendix E).

Relying on clinical opinions provided by a VA clinician or a VA-contracted clinician to help VBA determine whether a current condition (diagnosis and symptoms) is related to MST and thus service-connected aligns VBA's disability compensation process with the standard of care and VA's own policy for diagnosing and treating patients who have experienced service-related trauma, especially sexual trauma. VHA's MST Program Directive, which establishes VHA's authority and policy for "MST counseling, care, and services," does not require that service members or veterans provide documentary evidence to support their experiences of MST to be eligible to receive free treatment for conditions related to MST.^{16,17} The committee identified no evidence that VHA's policy has been abused or results in fraud. To the contrary, the 2024 VA OIG report on VA health care use and benefits (including disability compensation) among veterans who reported sexual assault during service found that the share of veterans who did not formally report sexual assault experiences to SAPRO but used VHA health care was smaller than the share of veterans who formally reported sexual assault to SAPRO (32.4 percent vs. 53 percent, respectively) (VA OIG, 2024b). The VA OIG report also found that approximately half of veterans who reported sexual assault to SAPRO did not use VHA health care, which is a lower share than would be expected given the known deleterious effects of sexual assault on health. Contrary to fraud concerns, VA OIG recommended increased outreach about available VA health care resources (VA OIG, 2024b).

Reducing the requirement to corroborate MST experiences with evidence also aligns the disability compensation process with other clinical and policy guidelines reflecting best practices for clinical care and forensic examinations related to sexual trauma, which are guided by a trauma-informed approach; such guidelines include the Department of Justice's *A National Protocol for Sexual Assault Medical Forensic Examinations*, World Health Organization (WHO) guidelines for responding to intimate partner violence and sexual violence against women, American College of Obstetricians and Gynecologists clinical guidelines for sexual assault, and American College of Emergency Physicians consensus recommendations on the *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient* (ACEP, 2023; ACOG, 2019; DOJ, 2024; WHO, 2013). None of these guidelines require the corroboration of incidents of sexual trauma to diagnose and treat health conditions related to experiences of sexual trauma. Clinicians following these guidelines can determine whether presenting conditions are related to sexual trauma without needing to substantiate the occurrence of that trauma. Therefore, clinicians can provide

¹⁶ VHA Directive 1115(1), Military Sexual Trauma (MST) Program (2018).

¹⁷ 38 USC § 1720D, Counseling and treatment for sexual trauma.

clinical opinions about whether conditions are related to MST without needing to substantiate MST. In addition to aligning VA's MST disability compensation process with these guidelines focused on clinical care related to sexual trauma, eliminating the requirement to corroborate MST with evidence also aligns the VA policy and process with other guidelines related to care for individuals who have experienced trauma more generally, including VA/DOD's clinical practice guidelines for the treatment of trauma-related health conditions; *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) diagnostic criteria for trauma and stress-related disorders; and general principles of trauma-informed care (APA, 2013; SAMHSA, 2024). As with sexual trauma more specifically, clinicians following best practices can diagnose and treat conditions related to trauma exposures without interrogating the circumstances of the trauma. Aligning VA's standards of evidence for service connection for MST-related claims with such best practices would eliminate the need for providers to perform such interrogation and to make arbitrary (and often inconsistent) decisions in the process of corroborating the traumatic stressor based on insufficient evidence.

This proposed change restricts clinical opinions of service connection to VA or VA-contracted clinicians as VA does for PTSD stemming from other service-related trauma. As described in Chapter 3, VA provides special training related to MST to VA and contract C&P examiners to provide these opinions using the legally required language that claims raters need to adjudicate the claims (VA, 2022). Although the committee identified a range of shortcomings and potential improvements to VA's current MST training, implementing the committee's recommended improvements and limiting the provision of clinical opinions about whether disabilities are related to MST to VA or VA-contracted clinicians nonetheless ensures a minimum level of competence to provide such opinions gained from those mandatory trainings. In addition, VBA also regularly reviews the quality of these examinations and mandates certain quality assurance requirements in contracts with examination vendors. In so doing, VA can ensure a minimum level of quality for VA and contract examinations and examination reports, including the clinical opinions.

Eliminating the requirement to provide evidence of MST has several additional advantages. As described earlier in this section, doing so aligns the disability compensation process for MST with Congress's and VBA's prior use of presumption for combat and other trauma exposures for disability compensation. This would acknowledge that service records may be unavailable for MST experiences as they are for combat exposures. Additionally, given that PTSD is the most common DBQ employed for MST, it is inconsistent to require the kind of documentation currently required for the occurrence of MST when it is not required for other service-related

trauma exposures. This change thus promotes fairness in the disability compensation system. Second, eliminating the requirement to provide evidence of MST would also address the requirement to document a single incident of MST when MST may result from the cumulative effect of sexual harassment and a series of incidents of assault at various levels of severity. It would furthermore better align the treatment of sexual harassment as a stress exposure with the DSM-5 criteria for PTSD diagnoses (APA, 2013). For the purposes of diagnosis and treatment of PTSD, DSM-5 Criterion A (also known as the “stressor criterion”) requires that the person was exposed “to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: [including] ... Experiencing repeated or extreme exposure to aversive details of the event(s)” (APA, 2013). This criterion supports the idea that those who experience repeated episodes of sexual harassment, molestation, or assault are, in themselves, accepted by the DSM-5 as satisfying the stressor criterion for diagnosing PTSD. Further, repeated exposure to core elements of stressful events (e.g., ongoing, close working and living arrangements with perpetrators) would also qualify as traumatic stressors meeting the DSM-5 criterion.

The committee acknowledges that reducing the requirement to corroborate MST involves a potential trade-off between increased sensitivity (i.e., ensuring that veterans with true experiences of MST and have related disability receive service-connection and associated disability benefits) and decreased specificity (i.e., the potential risk of fraud associated with unfounded reports of MST). While the financial compensation and other benefits available to veterans with service-connected disabilities can create an incentive for veterans to malingering or commit fraud, the committee did not identify evidence of systemic, widespread, or otherwise notable fraud specific to disability compensation related to MST. With respect to MST reporting more generally, evidence of unfounded reports of sexual assaults in the military is low, with fewer than 1 percent of formal reports annually classified as either false (i.e., where evidence supports that the crime did not occur or the accused did not commit the crime) or baseless (i.e., allegations inappropriately reported as sexual assault) (DOD, 2025). This rate is lower when compared with estimates of unfounded reports of sexual assault in civilian settings, which range from 2 to 10 percent (Lisak et al., 2010; Spohn et al., 2014). As the committee described earlier in the chapter, not only did it identify no evidence of fraud associated with VHA’s policy and experience providing health care to service members and veterans who have experienced MST, for which VA requires only a veteran’s self-report, but a VA OIG analysis found that fewer veterans who had formally reported sexual assault in service received service-connected disability and associated benefits (including health care and disability compensation) than would be expected given the known adverse health effects of experiencing MST (VA

OIG, 2021b). Thus, rather than fraud, VA OIG found evidence that veterans with MST histories underuse VA benefits.

Eliminating the need for veterans to provide documentary proof of their MST experience does not mean that their lay testimony alone would be sufficient to receive service-connected disability benefits. VA would still require evidence of a current diagnosis or symptoms and would scrutinize the link between the reported MST and the related disability based on the clinical opinion of VHA-employed or VBA-contracted examiners with specialized training, just as VA regulations require to establish service connection for PTSD associated with fear of hostile military or terrorist activity.¹⁸ The committee was not tasked with evaluating fraud in the disability compensation program. However, it identified no evidence of systemic or widespread fraud related to the changed evidentiary standards for PTSD related to fear of hostile military or terrorist activity in the evidence examined. In consideration of these factors taken together, the committee expects the risk of fraud from reducing the requirement to corroborate MST for disability compensation to be similarly low. Furthermore, any considerations of fraud would be balanced against the potential advantages of relaxing this requirement to include minimizing retraumatization and practical challenges of requiring veterans to disclose their trauma repeatedly and in multiple ways, simplifying claims development, improving the timely claims processing, improving accuracy in disability ratings, and improving consistency and fairness in compensating veterans for disabilities related to MST, especially as compared with veterans with disabilities related to other traumatic military exposures.

Summary

VA currently has two standards of evidence for MST-related claims—one for PTSD and another for all other claims (VA, 2025e).¹⁹ These standards result in different processes for C&P examinations related to MST, which adds complexity to MST-related claims compared with other claims and results in inconsistent decision-making and potentially inaccurate ratings and compensation for non-PTSD conditions compared with PTSD (Webermann et al., 2026). Applying a single standard for service connection for all MST-related claims would simplify the process and increase accuracy and consistency in claims rating and compensation. Congress and VA could allow the use of lay evidence and behavioral markers for non-PTSD claims

¹⁸ 38 CFR § 3.304, Direct service connection; wartime and peacetime.

¹⁹ 38 USC § 1154(b), Consideration to be accorded time, place, and circumstances of service; 38 CFR § 3.304(f)(5), Direct service connection; wartime and peacetime; 38 CFR § 3.303, Principles relating to service connection.

as is done for PTSD claims. This would significantly improve the MST disability determination process but nonetheless fails to address significant inconsistencies between the standards for disability evaluations related to MST experiences and those for other traumatic experiences during military service. Therefore, to reduce burden on and potential harms to veterans, simplify the claims development and research procedures, improve the timely processing of disability claims related to MST, improve rating accuracy, and ensure fairness in compensating veterans for disabilities related to MST, the committee recommends the following:

Recommendation 5-6: The Department of Veterans Affairs should use a single evidentiary standard and process for assessing military sexual trauma-related claims.

Recommendation 5-7: Congress should enact legislation directing the Secretary of Veterans Affairs to accept evidence from laypersons or other sources as sufficient proof of service connection of any condition claimed to have been incurred or aggravated by experiencing military sexual trauma (MST), regardless of whether there is an official service record of the MST experience or an associated condition. The Secretary should amend adjudication regulations to eliminate the requirement for corroborating a veteran's lay testimony of MST as an in-service event with evidence and allow service connection to be established if the following apply:

- a. A Department of Veterans Affairs (VA) provider or a provider with whom VA has contracted confirms that MST is adequate to support the diagnosis of a claimed disability (i.e., the veteran's diagnosis and symptoms are related to the MST experience),
- b. The MST experience is consistent with the circumstances and conditions of the veteran's service, and
- c. There is no clear and convincing evidence to the contrary in the veteran's record.

CONCLUDING REMARKS

Key challenges associated with MST-related C&P examinations include ambiguous or incorrect examination and opinion requests that may lead to unnecessary examinations and claims processing delays; physically and psychologically unsafe examination facilities; large and disorganized claims folders that may lead to loss of information or examiners missing relevant information; lack of prompts or other protocols to identify MST markers (or, indicators of the effect of MST on the veteran, often in the form of behavioral changes), foster trauma-informed examinations, or support

examiners in linking MST to disabling conditions on the DBQs that guide the clinical examinations; inconsistent policies and insufficient training for examiners on how to develop and draft the clinical opinions of service connection for MST-related claims; lack of standardization and poor alignment between DBQs and the VASRD; and omitted conditions associated with MST in the VASRD. This chapter recommends improvements VA can implement to address these problems and ensure a trauma-informed approach to the clinical examinations for veterans who have experienced MST. However, these targeted improvements do not address the dual evidentiary standards for PTSD and other claims related to MST, the resulting dual claims and examination processes, and the consequent complexity.

Currently, veterans are eligible to receive disability compensation related to MST if there is evidence of the claimed current disability, an experience of MST, and a link between the disability and MST (i.e., service connection; VA, 2026d).²⁰ Evidentiary requirements to prove that veterans meet these criteria have been a major barrier to substantiating MST-related disability claims. Military service at any place or time elevates the risk of exposure to sexual trauma (Klingensmith et al., 2014; Nichter et al., 2022; Suris and Lind, 2008; Wilson, 2018). MST is thus not only a personal trauma but a uniquely service-related trauma (Kimerling et al., 2010). At the same time, elements of the military context pressure service members not to disclose MST experiences (Andresen and Blais, 2019; Lofgreen et al., 2017; Mengeling et al., 2014). Thus, having not reported MST experiences contemporaneously, whether formally to authorities or informally to friends and family, can currently impede service members' or veterans' access to VA disability benefits if they come to a decision later to pursue disability benefits for conditions stemming from their MST experience.

Congress and VA set forth exceptions to VA's evidentiary requirements in other situations when there is a low likelihood of evidence corroborating a known exposure, such as combat-related trauma, other in-service trauma exposures (i.e., fear of hostile military or terrorist activity, POW experiences), and toxic exposures (see, e.g., 38 USC § 1154(b) and 38 CFR § 3.304). Thus, VA's evidentiary standards are higher for MST than other in-service events and experiences. This report recommends that Congress and VA reduce the burden of proof for establishing the occurrence of MST as an in-service event. The recommendation recognizes that service in the military is associated with an increased risk of MST as a traumatic exposure, just as VA recognizes that veterans who have served in combat or in a combat zone are at higher risk of traumatic exposure. To that end, it speaks to a principle that when military service is found to be associated with specific

²⁰ 38 CFR § 3.303, Principles relating to service connection.

traumatic experiences, as MST is, it is reasonable to assume that such traumatic events are as likely to have occurred as not. This is particularly true when evidence has shown that reporting or disclosing MST is stigmatic and, in some cases, actively discouraged.

Under the committee's recommendation for VA to no longer require proof of MST, veterans still must show a current disability and demonstrate its service connection. Relying on clinical opinions provided by a VA clinician or a VA-contracted clinician to establish whether a current condition is related to MST aligns VBA's disability compensation process with the standard of care for diagnosing and treating patients who have experienced trauma, particularly sexual trauma. These standards include VHA policy to provide care for service members and veterans who have experienced MST;²¹ the Department of Justice's guidance for health care and law enforcement professionals for performing sexual assault medical forensic examinations, and clinical guidelines for the care of individuals who have experienced sexual assault from WHO and medical specialty societies (DOJ, 2024; ENAU, n.d.; WHO, 2013). These standards do not require proof of sexual trauma to provide clinical care or perform forensic examinations. It also aligns the process with VBA's prior use of presumption for other trauma exposures for disability compensation (i.e., for PTSD stemming from combat exposure, fear of hostile military or terrorist activity, and POW experiences).²² Furthermore, eliminating the requirement to provide evidence of MST addresses the requirement to document incidents of MST when MST may result from the cumulative effect of sexual harassment or a series of assaults of varying levels of severity. This better aligns VBA's treatment of sexual harassment as a stress exposure with DSM-5 criteria for PTSD diagnoses (APA, 2013). In the longer term, VA may consider the feasibility of establishing a process to identify presumptions of service connection for conditions that the scientific literature has shown to be strongly associated with or caused by MST, similar to the process used for toxic exposures (NASEM, 2023). Evidence on the wide-ranging health effects of MST is rapidly evolving. This evidence encompasses direct associations between MST and certain health outcomes, as well as distal and indirect health effects. For example, in some cases, direct evidence on the association between MST and health outcomes such as cardiovascular disease is sparse. However, evidence has shown robust associations between MST and certain psychological sequelae (e.g., PTSD) and between those mental health conditions and secondary physical health effects (Edmondson et al., 2013; Jacquet-Smailovic et al., 2022; Sumner et al., 2023). Such evidence

²¹ VHA Directive 1115(1), Military Sexual Trauma (MST) Program (2018).

²² 38 CFR § 3.304(f), Direct service connection; wartime and peacetime; 38 USC § 1154(b), Consideration to be accorded time, place, and circumstances of service.

suggests a link between MST and physical health conditions mediated by (or, secondary to) psychological conditions. In such cases, examiners and veterans themselves may not be aware that these distal or indirect physical health effects are related to MST. Although the committee recommended refresher training to ensure C&P examiners have current knowledge about the health consequences of MST, because examiners only assess conditions a veteran claims and because the direct evidence on MST and these exposures is limited, this training does not address the fundamental difficulty of a disability compensation process that relies on veteran self-identification of claimed disabilities. Therefore, as is done for other military exposures, establishing presumptive conditions could streamline and improve timely claims processing, improve consistent decision-making, and increase accuracy in disability ratings and compensation by reducing reliance on claims processor and examiner decision-making based on insufficient evidence.

Finally, the committee's charge and thus its recommendations are limited to the C&P examinations and, insofar as they shape the conduct and outcomes of these clinical exams, elements of the disability determination process beyond these exams. However, as described in Chapter 1, the committee found it necessary to review the entire claims process to understand the context in which C&P examinations occur. As part of this review, the committee identified and described in this report several systemic issues with the disability compensation process and areas beyond the examination (such as in the claims development, rating, and appeals processes) that adversely affect veterans who have experienced MST; given the focus of this assessment, the challenges identified beyond the examination process are not comprehensive. Nonetheless, to the extent that these challenges remain unaddressed, the disability compensation process may continue to retraumatize veterans who have experienced MST, inaccurately and inconsistently rate their disabilities, and contribute to an overall experience that is not trauma-informed. Improving the experience of veterans who have experienced MST would require a comprehensive assessment of and improvements to the entire claims process, encompassing claims development, adjudication, and appeals, in addition to the examination process.

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Appendix A

Public Law 117-289

AN ACT

To direct the Secretary of Veterans Affairs to seek to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine for a review of examinations, furnished by the Secretary, to individuals who submit claims to the Secretary for compensation under chapter 11 of title 38, United States Code, for mental and physical conditions linked to military sexual trauma.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. INDEPENDENT REVIEW OF ASSESSMENTS BY THE SECRETARY OF VETERANS AFFAIRS OF MENTAL AND PHYSICAL CONDITIONS LINKED TO MILITARY SEXUAL TRAUMA FOR PURPOSES OF AWARDING DISABILITY COMPENSATION.

(a) **AGREEMENT.**—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall seek to enter into an agreement with the National Academies of Sciences, Engineering, and Medicine (in this Act referred to as the “National Academies”) to perform the services covered by this section.

(b) **COMPREHENSIVE REVIEW.**—Under an agreement between the Secretary and the National Academies under this section, the National Academies

shall conduct a comprehensive review of examinations, furnished by the Secretary to individuals who submit claims to the Secretary for compensation under chapter 11 of title 38, United States Code, for mental and physical conditions linked to military sexual trauma (in this Act referred to as “MST”), for the purpose of assessing the impairments of such individuals arising from MST. The review carried out pursuant to paragraph (1) shall include the following elements:

(1) A determination of the adequacy of tools and protocols used by the Secretary to provide examinations described in this subsection, including—

- (A) the Disability Benefits Questionnaires;
- (B) the Department’s schedule of rating disabilities;
- (C) consideration of whether certain conditions linked to MST should require referral for both a mental health examination and a physical health examination; and
- (D) the necessity of internal pelvic examinations to diagnose certain conditions linked to MST, and whether alternatives to such examinations could be considered if a veteran objects to or cannot complete such examination.

(2) A determination of what credentials and training are necessary for a health care specialist or provider to perform such examinations related to physical conditions linked to MST, for men and for women, including—

- (A) sexual dysfunction;
- (B) pelvic pain;
- (C) pelvic dysfunction;
- (D) musculoskeletal disabilities; and
- (E) cardiovascular conditions (including stroke).

(3) A determination of what credentials and training are necessary for a health care specialist or provider to perform such examinations related to mental health conditions linked to MST, for men and for women.

(4) An assessment of the quality of MST training for individuals who perform such examinations, including recommendations for improvements to such training.

(c) REPORTS

(1) **REPORT OF THE NATIONAL ACADEMIES.**—Not later than 540 days after the date on which the Secretary enters into an agreement under subsection (a), the National Academies shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report on the comprehensive review conducted under subsection (b). Such report shall include the following elements:

- (A) The findings of the National Academies under subsection (b).
 - (B) Recommendations of the National Academies regarding legislative or administrative action to improve of the adjudication of claims described in subsection (b).
- (2) **REPORT OF THE SECRETARY.**—Not later than 90 days after submission of the report under paragraph (1), the Secretary shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the plans of the Secretary to carry out any action based on the findings and recommendations of the National Academies.

Appendix B

Biographical Sketches of Committee Members and Staff

COMMITTEE MEMBERS

Hortensia Amaro, Ph.D. (*Chair*), serves as a distinguished university professor and senior scholar at the Wertheim College of Medicine and Stempel College of Public Health and Social Work at Florida International University. Previously, she held positions as dean's professor of social work and public health and assistant vice provost at University of Southern California; distinguished professor and director of the Institute on Urban Health at the Bouvé College of Health Sciences at Northeastern University; and professor of public health at the School of Public Health at Boston University. Her primary areas of research include treatment of substance use disorders, co-occurring mental health and posttraumatic stress disorder (PTSD), gender-based violence, human immunodeficiency virus (HIV) prevention in women, and health inequities in diverse underserved populations. Her major contribution has been the translation of research to practice as demonstrated by her development and implementation of prevention and treatment of community-based programs, including residential and outpatient treatment programs for underserved populations. Amaro has received numerous awards from national, state, and community organizations for her contributions to science and practice. She has served on numerous advisory committees for National Institutes of Health, Centers for Disease Control and Prevention (CDC), Department of Health and Human Services, Health Resources and Services Administration (HRSA), and Substance Abuse and Mental Health Services Administration, among others. Her professional service includes associate editor of the *American*

Journal of Public Health, Psychology of Women Quarterly, and *American Psychologist*, and vice chair of the board of the Boston Public Health Commission. She also currently serves as an elected member of the American Psychological Association's Board on Publications and Communications and as president of the Academy of Science, Engineering and Medicine of Florida. Among her accomplishments are election to the National Academy of Medicine; two honorary degrees, the Carl Taube Lifetime Achievement Award and the Sedgwick Award Medal for Distinguished Service in Public Health (American Public Health Association); Professors Who Inspire Elizabeth Hurlock Beckman Award; Ernest R. Hilgard Lifetime Achievement Award, Division 1 (American Psychological Association), Humanitarian of the Year Award (Massachusetts School of Professional Psychology); Betty Ford Lectureship Award (Addiction Medicine Education, Research and Services Association); and distinguished visiting professor, Ben Gurion University, Israel. Amaro completed her doctoral studies at the University of California, Los Angeles, with specialization in developmental, social, and educational psychology in 1982. Her doctoral dissertation investigated the role of culture, religion, and gender roles in Mexican American women's attitudes toward abortion and related reproductive health issues. Amaro has previously served on 12 National Academies of Sciences, Engineering, and Medicine consensus committees, including one as committee chair and one as vice chair.

Sara Kintzle, Ph.D., is a research professor at the University of Southern California Suzanne Dworak-Peck School of Social Work. Kintzle's expertise lies in understanding the life experiences of individuals who have served or are currently serving in the U.S. Armed Forces. Her research broadly focuses on providing insight into topics such as the risks and protective factors related to successful military transition; challenges to psychological and physical health; risks for suicide, sexual harassment, stalking, and sexual assault; the experience of National Guard and Reserve service members; the experience of women in the military and post-transition; and securing post-service employment. Kintzle has extensive experience in the dissemination and translation of scientific findings for program and policy recommendations. Kintzle joined the University of Southern California in 2013 after graduating from the University of Georgia's doctoral social work program. She also earned a master's degree and a bachelor's degree in social work, as well as a Bachelor of Arts in Psychology, from the University of Iowa. Kintzle's work at the University of Southern California includes a demonstrated record of obtaining external funding, having led research studies as principal investigator (PI) or Co-PI on grants totaling over \$12 million. In 2024, she met with congressional and Department of Defense (DOD) staff on how the results from the Southern California Veterans Study might impact policy. In 2021, she presented to President Biden's

DOD Independent Review Commission on Sexual Assault in the Military and represented the United States as an expert on a North Atlantic Treaty Organization panel addressing sexual violence in the military in 2017.

Heather Krull, Ph.D., is a senior economist at RAND. Her research spans military recruiting, retention, and health policy topics. She led several studies related to the joint DOD/Department of Veterans Affairs (VA) disability evaluation system. Other work includes assessments of how traumatic brain injury and mental health are treated in the military health system, options for maintaining clinical proficiency for future deployments among military providers, and readiness patterns among those who transfer from the active component to the reserve component. She led an assessment of the current and projected health care needs of patients served by VA, a requirement of the Veterans Access, Choice, and Accountability Act of 2014. She served as a member of the National Academies of Sciences, Engineering, and Medicine Committee on VA Examinations for Traumatic Brain Injury in 2018. Krull earned her B.A. in economics and mathematics from St. Norbert College and her Ph.D. in economics from the University of North Carolina-Chapel Hill.

Harold Kudler, M.D., is a medical associate professor at Duke University School of Medicine. He received his M.D. from Downstate Medical Center and trained in psychiatry at Yale University. From 2000 through 2005, he co-chaired VA's Special Committee on Posttraumatic Stress Disorder, which reports to Congress. He has served on the International Society for Traumatic Stress Studies Board of Directors, co-led development of joint VA/DOD Guidelines for the Management of Posttraumatic Stress, and advised *Sesame Street's* Talk, Listen, Connect series for military families. From 2006 to 2014, he co-led the North Carolina Governor's Focus on Service Members, Veterans, and Their Families and, in 2012, was appointed to the North Carolina Institute of Medicine. From 2004 to 2014, Kudler was associate director of VA's Mid-Atlantic Mental Illness Research, Education, and Clinical Center on deployment mental health. In 2014, he joined VA Central Office in Washington, DC, where he served as chief consultant for Mental Health Services and as acting assistant deputy under secretary for Patient Care Services from 2017 until his retirement from VA in 2018. In 2018, Kudler returned to North Carolina, where he continues his efforts on behalf of service members, veterans, and their families. Regarding the National Academies of Sciences, Engineering, and Medicine, he was an invited speaker in its comprehensive review of VA's PTSD efforts and represented VA Central Office in a series of meetings called to consider development of a new National Academies section on mental health. After retirement from VA, he served on an ad hoc National Academies committee that reported on VA Whole Health.

Mary Jo Larson, Ph.D., is a senior scientist II at the Heller School for Social Policy and Management at Brandeis University. She previously was the director of health services research at the New England Research Institutes in Watertown, MA. Larson designs and conducts health services research studies that identify the unmet behavioral health care needs and service utilization patterns of U.S. populations. Her most recent research has focused on various issues confronted by military members and veterans, including effectiveness of pain management strategies (opioid and non-pharmaceutical therapies); deployment-related mental and substance use problems; military traumatic brain injury; missed opportunities to identify behavioral health problems; and strategies to improve specialty behavioral health services. Larson holds a Ph.D. in social policy from Brandeis University and an M.P.A. from Harvard University's Kennedy School of Government, where she was honored as a Lucius N. Littauer Fellow. She served on the 2013 Institute of Medicine (IOM) Committee on Assessment of Resiliency and Prevention Programs for Mental and Behavioral Health in Service Members and Their Families and the 2011 IOM Committee on Prevention, Diagnosis, Treatment, and Management of Substance Abuse in the Armed Forces.

Susan McCutcheon, Ed.D., M.S.N., retired in 2021 after a 38-year career at VA. She most recently served as the national mental health director of family services, women's mental health, and military sexual trauma (MST) for the Office of Mental Health Services and Suicide Prevention. McCutcheon had national oversight for three distinct and significant mental health programs: family mental health services for veterans, mental health services for women veterans, and mental health services for veterans who had experienced MST. She was responsible for developing clinical policies, providing national guidance, preparing testimony, and defining the vision of mental health programming in her area of responsibility. She developed training to support the provision of evidence-based practice family therapies, provided continuing education for the facility-based MST coordinators, and created an annual women's mental health mini-residency, which was also attended by health care providers from DOD. Prior to assuming her responsibility in VA Central Office in 2004, McCutcheon was the director for community mental health at the Louis Stokes Cleveland VA Medical Center in Ohio. Most of her career has been in the field of mental health, with a major emphasis on trauma, women's issues, serious mental illness, and families. McCutcheon has received graduate degrees in psychiatric/mental health nursing, industrial/organizational psychology, and educational administration. She was also selected as a Robert Wood Johnson Executive Nurse Fellow and completed a three-year fellowship. The National Disabled American Veterans presented McCutcheon with their 2019 Special Recognition Award. This award recognized her many years as a policy maker

and program manager of veterans' programs, particularly with regard to addressing the needs of women veterans but also in the area of MST.

Marie-Christine Nizzi, Ph.D., is a licensed clinical neuropsychologist and the chief executive officer of Precision Psychologie PLLC. She holds appointments as a psychologist in the Department of Psychiatry at Mass General Brigham and Harvard Medical School. She is the head of research and program development of the Amputee Center of Excellence as supported by the Manton Foundation at Spaulding Rehabilitation Hospital. Her research focuses on developing new patient-reported outcome measures to inform treatments and better support the quality of life, sense of self, and resilience of patients with a history of trauma and limb loss. She was named 2018 Harvard Horizons Scholar for her work with U.S. veterans and recipients of a face transplant. For her leadership as past president of Harvard Alumni for Mental Health and appointed director on the Harvard Alumni Association Board of Directors, she received the Harvard Outstanding Community Impact Award in 2023. An international specialist, Nizzi completed two Ph.D.s: one from Harvard University and one from Paris I Pantheon-Sorbonne. She received her Cognitive Processing Therapy certification from VA Boston, where she served in the National Center for PTSD-Clinical Team.

Logan C. Peterson, M.D., FACOG, is the vice chair of education, director of clinical clerkships, and an assistant professor in the Department of Gynecologic Surgery and Obstetrics at the Uniformed Services University. He is board-certified by the American Board of Obstetrics and Gynecology and is a fellow of the American College of Obstetricians and Gynecologists. Peterson earned his medical degree from the Saint Louis University School of Medicine before completing his internship and residency at Madigan Army Medical Center. His career includes service as an attending physician at Walter Reed National Military Medical Center, where he also directed the Sexual Assault Medical Forensic Exam program. Following his military service, he joined the faculty of the F. Edward Hébert School of Medicine. In addition to his educational responsibilities, he maintains an active clinical presence at both Walter Reed and the United States Naval Academy.

Carolyn M. Porta, Ph.D., M.P.H., is an associate vice president and professor of nursing at the University of Minnesota and an adjunct professor in the Divisions of Epidemiology and Environmental Health Sciences in the School of Public Health at the University of Minnesota. Her research focuses on building evidence for patient-centered, trauma-informed care for those who have experienced violence and interventions to mitigate burn-out of health care workers. Her extensive leadership in large-scale global workforce development projects has strengthened multidisciplinary training

and workflow among diverse human, animal, and ecohealth students, professionals, leaders, and teams around the globe. She is the PI of the HRSA Sexual Assault Nurse Examiner-Advanced Nursing Education program and co-PI for the National Institute for Occupational Safety and Health Midwest Center for Occupational Health and Safety, leading the environmental and occupational health nursing program. She has received sustained funding for research and workforce development projects from federal and foundation entities, exceeding \$120 million (nearly \$10 million as PI), and has disseminated this work in more than 125 peer-reviewed publications. Porta has been a forensic nurse since 1996 and for the past 17 years has been a forensic nurse examiner at Regions Hospital, a Level 1 trauma center in St. Paul, seeing patients who have experienced intimate partner/domestic violence and/or sexual violence. Porta is an inducted fellow of the American Academy of Nursing (AAN) and the National Academies of Practice; she has served on AAN expert panels and policy statement writing groups. She has been recognized for her excellent patient care, being inducted into the University of Minnesota Academies for Excellence, and for her research and leadership with awards from the International Association of Forensic Nurses and the Academy of Forensic Nursing. She holds a Ph.D., an M.P.H. (maternal/child health), two M.S. degrees (public health nursing, environmental/occupational health), and a B.S. in nursing. She is a board-certified sexual assault nurse examiner and has advanced training in forensic experiential interview techniques. She has served as a discussant for a National Academies of Sciences, Engineering, and Medicine consensus study addressing burnout experienced by women in science, technology, engineering, and mathematics fields; this is her first National Academies consensus study committee service.

David N. Smith, M.D., is a clinical assistant professor of medicine at Yale University School of Medicine, a clinical trial site senior PI, and a board-certified practicing noninvasive cardiologist. He completed his undergraduate degree at the University of Connecticut, his medical degree at University of Medicine and Dentistry of New Jersey (Rutgers)–Robert Wood Johnson Medical School, and then his internal medicine residency, postdoctoral National Institutes of Health vascular biology fellowship, and clinical cardiology training at Yale University. Smith completed the Diversity in Clinical Trials certification from the National Medical Fellowships and has recently been an instructor for the Alliance for Representative Clinical Trials of the National Minority Quality Forum. He is a national speaker in biotechnology, the pharmaceutical industry, and continuing education. Smith is a fellow of the American College of Physicians and the American College of Cardiology.

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE STAFF

Leslie Y. Kwan, Ph.D., M.P.H., is a senior program officer for the Health Care and Public Health Program Area in the Center for Health, People, and Places at the National Academies of Sciences, Engineering, and Medicine. She has supported a range of consensus studies on public health and health care issues, including on military exposures and health, raising the minimum age for tobacco products, the health consequences of e-cigarettes, accounting for social risk factors in Medicare value-based payment programs, and health care scheduling and access. She worked in the international program at the Commonwealth Fund, a health care foundation, where she supported the Harkness Fellowships in Health Care Policy and Practice and the fund's annual international survey. Earlier, she taught English as a foreign language in Aulnay-sous-Bois, France, as a Fulbright Scholar. She holds a Ph.D. in public administration and public policy (health policy) from the George Washington University and an M.P.H. in sociomedical sciences from Columbia University's Mailman School of Public Health.

Crystal J. Bell, M.P.P., M.S., was a program officer on the Board of Health Care Services in the Health and Medicine Division at the National Academies of Sciences, Engineering, and Medicine. She joined the National Academies as an associate program officer in 2021. She directed several National Academies projects addressing topics such as telehealth, care for people with Alzheimer's disease and related dementias, and essential health care services for women experiencing intimate partner violence. Prior to joining the National Academies, she was a program manager for the Chadwick Institute for Metropolitan Development at DePaul University while completing her graduate studies in public policy. In that role she coauthored several papers that incorporated findings from her original research to highlight the effects of the COVID-19 pandemic on the transportation sector and the resulting impacts on industry and people. While in graduate school at DePaul, Bell also joined USAID's Power Africa office as a virtual student federal service intern. In that role she conducted significant research into energy projects in sub-Saharan Africa to support partnership development. Bell was a health care professional for 20 years before entering the policy field. As a certified athletic trainer, she cared for patients in a variety of settings, including orthopedic and pediatric pulmonology specialty practices, outpatient physical therapy, as well as youth, intercollegiate, and professional athletics. She received an M.P.P. from DePaul University, where she was also inducted into the Pi Alpha Alpha honors society. She received an M.S. in sports health care from A.T. Still University–Arizona School of Health Sciences and a B.A. in athletic training from North Central College.

Jennifer Zhu, M.S., was an associate program officer for the Board on Health Care Services in the Health and Medicine Division at the National Academies of Sciences, Engineering, and Medicine. Zhu earned her master's and bachelor's degrees in biomedical engineering, with a variety of projects in tissue engineering, reproductive sciences, immunology, and nanoparticles. She previously worked in oncology research at the National Cancer Institute, where she first became interested in public health. She worked on the National Cancer Policy Forum, where she took part in multiple activities, including helping drive the three-part webinar series on the Impact of the Dobbs Decision on Cancer Care.

Anna Adler, M.P.H., is a research associate for the Health Care and Public Health Program Area in the Center for Health, People, and Places at the National Academies of Sciences, Engineering, and Medicine. She started at the National Academies in 2023 as the senior program assistant for the National Cancer Policy Forum. She graduated with her Bachelor of Science in Public Health in May 2023 and master's in public health in July 2024 from the George Washington University. Before joining the National Academies, she worked as a research assistant on a project contracted by the CDC Data Modernization Initiative and as an intern with the National Center for Health Research.

Aja Drain was a research associate for the Health Care and Public Health Program Area in the Center for Health, People, and Places at the National Academies of Sciences, Engineering, and Medicine. At the National Academies, Drain worked on several projects, including a consensus study on Strategies to Better Align Investments in Innovations for Therapeutic Development with Disease Burden and Unmet Needs. Prior to her position at the National Academies, Drain was an award-winning reporter for WAMU/DCist.com and freelanced for National Public Radio and Science Friday covering public health and science issues. Before journalism, Drain conducted research and worked in academic, non-profit, and industrial organizations throughout her undergraduate career. She has experience in infectious diseases at Washington University School of Medicine, microbiology at Accelerate Diagnostics, HIV/AIDS care at Vivent Health, cancer research at University of Arizona, and diversifying the cancer care workforce at City of Hope. She obtained her B.A. in anthropology (global health and the environment) with a minor in biology from Washington University in St. Louis.

Abian Hailu is a senior program assistant for the Health Care and Public Health Program Area in the Center for Health, People, and Places at the National Academies of Sciences, Engineering, and Medicine. At the

National Academies, Hailu has worked on two completed consensus studies: Principles and Framework to Guide the Development of Protocols and Standard Operating Procedures for Face and Hand Transplants, and Meaningful Outcome Measures in Adult Hearing Health Care. He also regularly supports the Roundtable on Quality Care for People with Serious Illness and various other projects. Prior to joining the National Academies, he worked as an intern for two maternal health organizations focusing on policy research and reproductive justice. Hailu obtained a B.S. in health sciences with a minor in psychology from Virginia Commonwealth University.

Eliza Souser was a senior program assistant at the National Academies of Sciences, Engineering, and Medicine. Her work at the National Academies included working with the Committee on Sustaining Essential Health Care Services Related to Intimate Partner Violence During Public Health Emergencies and the Committee on Strategies to Better Align Investments in Innovations for Therapeutic Development with Disease Burden and Unmet Needs. Before working with the National Academies, she had experience working with child development and learning. She completed her B.A. in history from George Mason University with a focus on oral history, minoring in legal studies with a specialization in constitutional law.

Sharyl J. Nass, Ph.D., serves as the senior program director for the Health Care and Public Health Program Area at the National Academies of Sciences, Engineering, and Medicine, which provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine. The Health Care and Public Health Program Area addresses the delivery of primary and specialty health care across the life course, including care quality and patient safety, workforce, training, and financing and public health services, including prevention, surveillance, epidemiology, and population health improvement. For more than 25 years, Nass has worked on a broad range of health and science policy topics that includes cancer research and care, the quality and safety of health care and clinical trials, developing topics for precision medicine, and strategies to support clinician well-being. She has a Ph.D. from Georgetown University, postdoctoral training at the Johns Hopkins University School of Medicine, and a research fellowship at the Max Planck Institute in Germany. She also holds a B.S. and an M.S. from the University of Wisconsin–Madison. She has been the recipient of the Cecil Medal for Excellence in Health Policy Research, a Distinguished Service Award from the National Academies, the IOM staff team achievement award (as team leader), and Health and Medicine Division Mentor Award.

Appendix C

Public Meeting Agendas

FIRST INFORMATION-GATHERING MEETING

JANUARY 29, 2025

Virtual

1:30–1:35 PM	Introductory comments Hortensia Amaro, Committee Chair
1:35–2:35 PM	Insight from Department of Veterans Affairs James Eggers, Acting Deputy Chief Officer, Veterans Health Administration, Office of Disability and Medical Assessment Earl Hutchinson, Assistant Director, Policy and Program Management, Medical Disability Examination Office Stephanie Hyberger, Clinical Program Management Officer, Medical Disability Examination Office
2:35–3:10 PM	Committee questions
3:10–3:15 PM	Closing comments Hortensia Amaro, Committee Chair

SECOND INFORMATION-GATHERING MEETING

MARCH 18, 2025

Virtual

SESSION 1

- 10:00–10:05 AM **Introductory comments**
Hortensia Amaro, Committee Chair
- 10:05–11:30 AM **Insight from veterans’ service organizations on VA’s military sexual trauma (MST) disability exams**
Naomi Mathis, Assistant National Legislative Director, Disabled American Veterans
Jennifer McGuire, National Service Officer II, Benefits, Wounded Warrior Project
Cindy Noel, Assistant Director, Field Operations, Veterans of Foreign Wars
Julie Howell, Associate Legislative Director for Government Relations, Paralyzed Veterans of America
- 11:30–12:00 PM **Committee questions**
- 12:00–12:05 PM **Closing remarks**
Hortensia Amaro, Committee Chair

SESSION 2

- 1:00–1:10 PM **Introductory comments**
Hortensia Amaro, Committee Chair
- 1:10–2:10 PM **Insight from veteran’s legal and local advocates**
Christine Clemens, National Organization of Veterans’ Advocates Board President, Partner at Chisholm Chisholm & Kilpatrick
Herman “Herm” K. Breuer, Senior Advisor, Ward Circle Strategies
- 2:10–2:45 PM **Committee questions**
- 2:45–2:50 PM **Closing comments**
Hortensia Amaro, Committee Chair

THIRD INFORMATION-GATHERING MEETING

MAY 8, 2025

Virtual

- | | |
|----------------|---|
| 11:25–11:30 AM | Opening remarks
Hortensia Amaro, Committee Chair |
| 11:30–12:15 PM | Presentations from Veterans Benefits Administration staff
Abigail Werner, Policy Liaison, Compensation Service
Courtney Pederzani, Senior Mental Health Officer,
Medical Disability Examination Office
Konane Stradling, Training Chief, Medical Disability
Examination Office |
| 12:15–1:00 PM | Presentations from Veterans Health Administration staff
Henry E. Bridges, Senior Medical Officer, Veterans
Health Administration, Office of Disability Medical
Assessment
Stacey Pollack, Senior Consultant, Veterans Health
Administration, Office of Mental Health
Amy E. Street, National Director, Military Sexual
Trauma, Veterans Health Administration, Office of
Mental Health |
| 1:00–1:30 PM | Committee questions and discussion |
| 1:30–1:35 PM | Closing remarks
Hortensia Amaro, Committee Chair |

FOURTH INFORMATION-GATHERING MEETING

JUNE 25, 2025

Virtual

- | | |
|----------------|--|
| 12:30–12:35 PM | Welcome and opening remarks
Hortensia Amaro, Committee Chair |
|----------------|--|

- 12:35–1:05 PM **MST-related compensation and pension exams—
Perspectives of contractor examiners**
Karen P. Seymore, Senior Medical Director, Veteran
Services, Optum Serve
Robin Carter-Visscher, Deputy Medical Director and
Mental Health Lead, Veteran Services, Optum Serve
- 1:05–1:35 PM **Committee questions and discussion**
- 1:35–1:40 PM **Chair’s closing statement**
Hortensia Amaro, Committee Chair

Appendix D

Personal Trauma Development Checklist and Instructional Guide

Veterans Benefits Administration (VBA) claims processors are instructed to follow this checklist and the accompanying guide when developing claims related to personal trauma (including military sexual trauma). VBA provided these documents to the committee in response to a request for information (Majors, 2026a, 2026b).

Personal Trauma Development Checklist

Directions: Complete this checklist after reviewing the Personal Trauma Development Checklist Instructional Guide, which provides additional guidance and resources.

Verify that a complete claim application has been received.

Mark the appropriate box. Check:

- “Yes” if/when the action is/was taken
- “No” if the action was not taken and you will take that action prior to moving the claim forward
- “N/A” if the action does not apply

Reference this checklist during each step of the claim process. It must be completed and uploaded into the eFolder before requesting an examination or advancing the claim for a complex medical opinion review or as Ready for Decision (RFD).

Section A: Claim Details			
Verify the appropriate special issue indicator is associated with the contention(s)			
Benefit Claim ID:	Claimant's Name:		
Section B: Personal Traumatic Event(s) Information	Yes	No	N/A
B1: Is sufficient traumatic event information available to verify the event or support behavioral changes (markers) (Consider all evidence: military records, written statements, VAMC records, private treatment records, and lay evidence, etc.)	☐	☐	☐
B1a: If yes , tab the evidence and <i>either</i> • request an examination if the traumatic event is established by sufficient documentary evidence, <i>or</i> • route for a complex medical opinion review if the traumatic event cannot be established without reliance on marker evidence. (Please note, a referral for a complex medical opinion review is only needed when the stressor cannot be corroborated except by relying on marker evidence. No complex medical opinion is necessary if the stressor can be established by documented evidence in service records or alternative evidence.) If no , initiate/complete subsequent development as warranted. For example, VBMS Letter: PTSD – Need stressor details/ med evid personal trauma incdnt may be needed.			
B2: Does the claimant specify or does the evidence show a relevant record in the custody of either a federal or private entity regarding the traumatic event? (e.g., military police, civilian police, etc.) If yes , develop to the records custodian following applicable Federal or non-Federal development procedures. If no , continue to next step.	☐	☐	☐
B3: Was a buddy or witness identified who may be able to provide a			

Personal Trauma Development Checklist

statement (e.g., did the claimant indicate they told a friend, family member, or that a fellow Service member witnessed the event)? If yes , use VBMS Letter Paragraph: Submit buddy statement(s) and add enclosure: VA Form 21-10210. If no , continue to the next step.	☐	☐	☐
Section C: Development for DoD Reports, Defense Sexual Assault Incident Database (DSAID) Inquiry, or Others	Yes	No	N/A
C1: Were the results of the DSAID inquiry positive ? If yes , document the results of the inquiry following the guidance in the DSAID SOP. Additional development for traumatic event information is not required. Refer to Section B. If no , Follow the guidance in the DSAID SOP and go to the next step.	☐	☐	☐
C2: Did the claimant indicate the traumatic event was not reported and was the DSAID data search result negative? If yes , then no additional DoD report development is required. If no , continue to the next step.	☐	☐	☐
C3: Did the claimant indicate they completed a restricted MST report, or is it not clear whether a restricted or unrestricted report was filed? If yes , use VBMS Letter: MST- Restricted Report . If no , continue to the next step.	☐	☐	☐
C4: Did the claimant indicate an unrestricted report was filed? If yes , use VBMS Letter: MST- Unrestricted Report If no , continue to the next step.	☐	☐	☐
C5: Is development to the Sexual Assault Prevention and Response Office (SAPRO) required, because DSAID was negative ? https://www.safehelpline.org/ . If yes , develop to the SAPRO at the base where the incident was reported. Use VBMS Letter: Initial 3rd Party Letter – PTSD obtain Investigative Reports (if restricted, VA Form 21-4142/VA Form 21-4142a signed by the claimant is required). If no , continue to the next step.	☐	☐	☐
Section D: Development for Federal Records	Yes	No	N/A
D1: Are all Service Treatment Records (STRs) of record for all periods of service or are all development actions complete and final notification letter (FNL) issued, if applicable?	☐	☐	☐
D2: Does the claimant's statement or other evidence suggest mental health treatment, and/or in-patient hospitalization?	☐	☐	☐
D2a: If yes , were complete records submitted or found within STRs?	☐	☐	☐
D2b: If no , was proper development followed to obtain Clinical Records or notification completed to claimant and custodian of record (e.g., Military Treatment Facility (MTF) or National Personnel Records Center (NPRC), which may be found in Joint Legacy Viewer (JLV))?	☐	☐	☐

Personal Trauma Development Checklist

D3: Are Service Personnel Records of record for all periods of service or are all development actions complete and FNL issued, if applicable?	☐	☐	☐
D4: If records were requested in Defense Personnel Records Information Retrieval System (DPRIS), was an appropriate screenshot of the request uploaded to the claims file?	☐	☐	☐
D5: Were relevant VA Medical Center Records obtained and uploaded to the claims file, regardless of whether the claimant identified them?	☐	☐	☐
D6: Were VA Vet Center Records identified by the claimant? If yes , send appropriate subsequent development letter to the claimant. Use VBMS Subsequent Development Letter: 21-4142/21-4142a If no , continue to next step.	☐	☐	☐
D7: Did the claimant return a complete VA Form 21-4142/VA Form 21-4142a? If yes , continue to the next step. If no , continue to Section E.	☐	☐	☐
D8: Were VA Vet Center records requested from the named/identified facility? If yes , continue to next step If no , send a third-party letter to the custodian. Use VBMS Letter: Initial Federal 3rd Party Letter – PTSD request copy of Vet Center records . Note : PMR contractor will not develop for Vet Center records.	☐	☐	☐
Section E: Development for Non-Federal Records	Yes	No	N/A
E1: Were private treatment records identified on the application or on accompanying correspondence? If yes , use VBMS Letter: 21-4142/21-4142a If no , continue to the next step.	☐	☐	☐
E2: Have all attempts to obtain private treatment records been completed? Note : If the PMR vendor cannot process the request, claims processors must make reasonable attempts to obtain the record.	☐	☐	☐
Section F: Important Information	Yes	No	N/A
F1: Was the required information specific to military sexual trauma (MST) provided to the claimant? If yes , you are confirming that the <i>MST-Important Information</i> was included in the custom 5103 notice or development letter, as appropriate. If no , include the <i>MST-Important Information</i> in the custom 5103 notice or development letter, as appropriate. Note : Send when developing to the claimant for information regarding a claim based on MST. See Required Information in MST Claims Development Letters.	☐	☐	☐

Personal Trauma Development Checklist

Section G: Other Traumatic Event Development	Yes	No	N/A
G1 If a non-personal traumatic event(s) was identified, has the appropriate development been completed?	☐	☐	☐
Notes (if applicable):			
By signing this document, you are certifying that you reviewed the claim and have used this document to determine the next appropriate action or that all appropriate actions have been taken.			
Employee Signature:			

Personal Trauma Development Checklist
Instructional Guide

Directions for use: When entitlement has not been previously established for initial or supplemental claims, and a complete application for benefits based on personal trauma has been received, the Personal Trauma Development Checklist must be completed and uploaded into the claims file before requesting an examination, or advancing the claim to the rating activity for a complex medical opinion review or as Ready for Decision (RFD).

It should be completed and uploaded at least one time at any of the following points in the claims process:

Prior to...	Claims Processor is Responsible When...
requesting an examination if a complex medical opinion review is not required	requesting an examination
requesting a complex medical opinion review	referring the claim for a complex medical opinion review
updating status of the claim to RFD	updating the claim status to RFD
requesting a complex medical opinion if the checklist has not been previously completed	requesting the complex medical opinion
rendering a decision for the benefit sought if the checklist has not been previously completed	rendering the decision on the claim

Section A: Claim Details

Verify that the claimant's name and benefit claim ID are updated on each development checklist you complete. The development checklist should not be recycled: a new checklist should be completed for each claimant. Revise a prior development checklist if it is incomplete or if new, relevant, or additional evidence has been received or additional markers have been identified.

Section B: Personal Traumatic Event(s) Information

Verify that a complete application for benefits is received, and sufficient traumatic event information is provided. For events involving personal trauma, VA must have some information about the type of personal trauma experienced (e.g., assault, battery, robbery, mugging, stalking, harassment, military sexual trauma (MST)) and a general timeframe. Timeframe need not be limited to a 60-day window as Military Records Research Center (MRRC) development would generally not be appropriate.

Resources:

M21 -1 VIII.iv.1.B - Assigning Claim Attributes to Claims Based on Personal Trauma	Claims processors must assign the appropriate special issue indicator based on the traumatic event to facilitate tracking and proper claim routing
M21-1 VIII.iv.1.B - Procedure for Reviewing for Credible Evidence of a Personal Trauma Stressor	Make all required efforts to obtain personal trauma evidence. Consider all available evidence. Overdevelopment for details about the traumatic event may trigger or retraumatize the Veteran. A review of the eFolder must be completed to review for evidence of an in-service traumatic event prior to development (e.g., a written statement that provides the same information as VA Form 21-0781). No more than one attempt should be made per M21-1 VIII.iv.1.A VBMS Paragraphs for Stressor Development.
M21-1 II.iii.1.C - Notification Requirements for an Incomplete Application Based on Experiencing MST	An allegation of MST experience during service without an associated claim for a specific disability is not substantially complete.

Follow Up Stressor Details	Details of the stressor could be in private medical records (PMRs), CAPRI, STRs, etc. Do not use a letter that references information not applicable to MST claims processing. For example, the Military Records Research Center (MRRC) is only relevant in limited cases, such as when the Veteran states the perpetrator was court-martialed. M21-1 VIII.iv.1.B - Personal Trauma or MST Stressors and MRRC. Use trauma-informed language in development letters.
Section C: Development for DoD Reports, Defense Sexual Assault Incident Database (DSAID) Inquiry, or Others	
The Department of Defense (DoD) Sexual Assault Prevention and Response Office (SAPRO) and VBA have a data-sharing agreement for certain reports. Results from the DSAID Lookup Tool direct further development needs.	
Resources:	
DSAID Lookup Tool SOP	Instructs claims processors on how to request access, refer cases for lookup, and how to document the results.
M21-1 VIII.iv.1.B - DoD's Reporting Procedures Following MST Events	DoD offers two reporting options for MST: restricted and unrestricted. Restricted reporting allows a service member to file a report confidentially without initiating the investigative process.
M21-1 VIII.iv.1.B - Subsequent Development Letter for a Restricted MST Report	In certain situations, development to the claimant for a copy of this report is required.
M21-1 VIII.iv.1.B - Developing to DoD in Claims Based on MST	In certain situations, development to DoD may be required.
Section D: Development for Federal Records	
38 C.F.R. § 3.159 outlines VA's duty to assist in claims development, including notifying claimants of necessary information and VA's efforts to obtain it. If development is unsuccessful, a final notification letter (FNL) must be sent to the Veteran.	
Resources:	
M21-1 III.ii.2.A - General Information on Service Records	M21-1 III.ii.1.A - Requesting OPTRs from an MTF
M21-1 III.ii.2.B - Procedures for Obtaining Service Treatment Records (STRs)	M21-1 III.ii.1.A - Obtaining VA Medical Records
M21-1 III.i.2.C - Notification Requirements of Inability to Obtain Federal Records	M21-1 III.ii.1.A - Obtaining Records from a Vet Center
M21-1 III.ii.2.E - Service Record Address Codes and Addresses for Military Records Centers and Other Agencies	M21-1 VIII.iv.1.E - Alternative Sources of Evidence of In-Service Personal Trauma
M21-1 III.ii.2.C - Clinical Records and Personnel Records	
Section E: Development for Non-Federal Records	
38 C.F.R. § 3.159 provides VA's duty to notify claimants of the necessary information and evidence needed to support the claim, which includes assisting claimants in obtaining evidence.	
Resources:	
M21-1 III.i.2.C - VA's Duty to Obtain Relevant Non-Federal or Private Records	When a claimant adequately identifies relevant records, VA has a duty to request those records and, if necessary, request the appropriate release forms from the claimant.

M21-1 VIII.iv.1.E - Alternative Sources of Evidence of In-Service Personal Trauma	Alternative sources of evidence can be non-Federal records or Federal records and depends on the records custodian as to whether Federal or non-Federal development applies. Examples of non-Federal records include, but are not limited to, civilian police records.
M21-1 III.i.2.C - Assisting in Obtaining Third-Party Records	When a claimant identifies records pertaining to another individual that are relevant to the claim, VA has a duty to assist in making reasonable attempts in requesting these records.
M21-1 III.i.2.A - Requests for Buddy Statements	If the claimant identifies someone who knows about their disabilities or traumatic event, notify the claimant they can provide a buddy statement.
Section F: Important Information	
38 C.F.R. § 3.159 outlines VA's duty to assist in claims development to include notifying the claimant of the necessary information and VA's efforts to obtain it.	
Resources:	
M21-1 VIII.iv.1.B - Required Information in MST Claims Development Letters	When creating a letter to obtain information from the Veteran regarding a claim based on MST, the initial or subsequent development letter must contain this information.
Section G: Other Traumatic Event Development	
M21-1 II.iii.1.A - Considering Unclaimed Theories of SC	There are multiple theories, or ways, of establishing entitlement to service-connected compensation. A claim for service connection encompasses all potential theories of SC, whether claimed or unclaimed. Development must be completed for all unclaimed theories when directed by the rating activity.
Employee Signature	
By signing this section, the employee affirms they have completed the sections within the personal trauma development checklist with accuracy and have taken all appropriate action(s) on the claim.	

REFERENCES

- Majors, B. 2026a. Veterans Benefits Administration response to November 2025 request for information–Personal trauma development checklist, February 2, 2026.
- Majors, B. 2026b. Veterans Benefits Administration response to November 2025 request for information–Personal trauma development checklist guide, February 2, 2026.

Appendix E

VA Form 21-0781

Veterans have the option to complete VA Form 21-0781 to provide their lay statement about experiences of in-service trauma and their current claimed mental health disability for claims for a mental health disorder related to an in-service combat, personal, or other traumatic event. This form is published by the Department of Veterans Affairs. See <https://www.vba.va.gov/pubs/forms/VBA-21-0781-ARE.PDF> (accessed November 10, 2025).



**ATTACHMENT TO THE STATEMENT IN SUPPORT OF CLAIMED MENTAL HEALTH DISORDER(S)
DUE TO AN IN-SERVICE TRAUMATIC EVENT(S)**

When To Use This Form:

Use this form, VA Form 21-0781, *Statement in Support of Claimed Mental Health Disorder(s) Due to an In-Service Traumatic Event(s)*, to provide a statement in support of a claimed mental health disorder(s) (e.g., post-traumatic stress disorder (PTSD), depression, anxiety, bipolar disorder, etc.) due to an **in-service** traumatic event(s) to include:

- **Combat traumatic event(s)** (e.g., engaged in combat with the enemy, experienced fear of hostile military or terrorist activity, served in an imminent danger area, served as a drone aircraft crew member, etc.)
- **Personal traumatic event(s)** (e.g., sexual assault or sexual harassment, also known as military sexual trauma (MST), physical assault, robbery, stalking, domestic intimate partner abuse, or harassment, etc.)
- **Other traumatic event(s)** (e.g., involvement in car accident or natural disaster, worked on burn ward or graves registration, witnessed the death, injury, or threat to the physical integrity of another person not caused by the enemy, or an experience that involved friendly fire that occurred on a gunnery range during a training mission, etc.)

Note: This form is optional and not required. However, completing this form could assist with your claim. VA can use the information you provide to review your military records and other sources of information for evidence to support your claim.

What Form Is Required:

Whether or not you complete this form, you **must** submit one of the following based on the type of claim sought. VA forms are available at www.va.gov/vaforms.

If you are filing a **new claim** or a claim for **increased disability** compensation ...

please complete and submit VA Form 21-526EZ, *Application for Disability Compensation and Related Compensation Benefits*.

If you **disagree with a prior decision or an evaluation** (a claim after an initial claim for the same or similar benefit was previously decided) **and have new and relevant evidence** ...

please complete and submit VA Form 20-0995, *Decision Review Request: Supplemental Claim*.

Evidence That Can Be Used to Support Your Claim:

VA will obtain or attempt to obtain evidence that supports your claim:

- If your claim is for mental health disorder(s) related to combat, personal traumatic event(s), or other traumatic event(s), service treatment records and/or personnel records can be used to support the occurrence of the traumatic event(s).
- If your claim is for PTSD related to a personal traumatic event(s), alternative sources of evidence or changes in your behavior such as a change in work performance, substance abuse, economic or social behavioral changes, etc. can also be used to support the occurrence of the traumatic event(s).

NOTE: VA will obtain and/or request your service treatment records, personnel records and any other Federal records you identify.

Lay testimony can be used:

- If you have any individual(s)/witness(es) who know about the personal traumatic event(s) or would have a knowledge of a behavioral change(s) you experienced after the personal traumatic event(s), and wants to provide a statement on your behalf, use VA Form 21-10210, *Lay/Witness Statement*, and attach it or send it to the address provided in this attachment. If your individual(s)/witness(es) is a veteran, they may be requested to provide their DD Form 214, *Certificate of Uniformed Service*, or other evidence of service.

If you know of evidence not in your possession and want VA to try to get it for you:

- Complete and sign VA Form 21-4142, *Authorization to Disclose Information to the Department of Veterans Affairs (VA)*, and
- Complete and sign VA Form 21-4142a, *General Release for Medical Provider Information to the Department of Veterans Affairs (VA)*, identifying any private medical records you wish VA to request for you.

If the holder of the evidence declines to give it to VA, asks for a fee to provide it, or otherwise cannot get the evidence, VA will notify you and provide you with an opportunity to submit the information or evidence. **Note:** It is your responsibility to make sure we receive all requested records that are not in the possession of a Federal department or agency.

If You Need Assistance:

You may wish to contact an accredited Veterans Service Officer (VSO) to assist you with your application. For a list of accredited veterans service organizations go to https://www.va.gov/ogc/recognizedvsos.asp. Should you need further assistance with the application process, you may also contact your State Department(s) of Veterans Affairs at https://www.va.gov/statedva.htm.
If you have any questions concerning your claim, you may call 1-800-698-2411. If your claim is related to MST, you may also visit the following website to locate the Veterans Benefits Administration (VBA) MST Outreach Coordinator for your area: https://www.benefits.va.gov/benefits/mstcoordinators.asp.
For information on Veterans Health Administration (VHA) health care service, visit www.va.gov/health-care/about-va-health-benefits. To learn more about VHA health care services available related to MST, visit www.mentalhealth.va.gov/mst or contact a VHA MST Coordinator. A list is available at www.mentalhealth.va.gov/msthome/vha-mst-coordinators.asp or you can contact your local VA medical facility and ask to speak to the MST Coordinator.
If you or someone you know is in crisis, call the Veterans Crisis Line at 988 and then press 1, visit https://www.veteranscrisisline.net/ to chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year. Support for deaf and hard of hearing individuals is available.

General Information:

Want to apply electronically? You can apply online at www.va.gov. If you sign in or create an account, we can prefill parts of your application and save your work in progress. You can also upload all your supporting documents with your claim, then track claim status online. Get started at https://www.va.gov/disability/how-to-file-claim/.
If You Are Mailing Your Completed Form, Send To: Department of Veterans Affairs Evidence Intake Center P.O. Box 4444 Janesville, WI 53547-4444

[illegible]

SECTION II: TRAUMATIC EVENT(S) INFORMATION (Continued)		
4.		
5.		
6.		
SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S)		
IMPORTANT: This information will help us identify records or sources of evidence that may support your claim. If you are unable to include this information, VA will still review and consider all the evidence available to support your claim. If additional space is needed, use Section V: "Remarks".		
Note: VA understands that in-service traumatic event(s) may not have been reported or documented. In these situations, other information, such as behavioral changes and/or sources of evidence, may be used to support the in-service traumatic event(s).		
10. INDICATE ANY BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) (Note: Behavioral changes can include but are not limited to the examples listed in Items 10A through 10C. If your traumatic event(s) is combat only, you may skip to Item 11.)		
A. BEHAVIORAL CHANGES EXPERIENCED FOLLOWING THE TRAUMATIC EVENT(S) (Check any box that applies)		B. ADDITIONAL INFORMATION ABOUT THE BEHAVIORAL CHANGES (If applicable) (e.g., approximate time change occurred, documentation, or record)
☐	INCREASED/DECREASED VISITS TO A HEALTHCARE PROFESSIONAL, COUNSELOR, OR TREATMENT FACILITY	
☐	REQUEST FOR A CHANGE IN OCCUPATIONAL SERIES OR DUTY ASSIGNMENT	
☐	INCREASED/DECREASED USE OF LEAVE	
☐	CHANGES IN PERFORMANCE OR PERFORMANCE EVALUATIONS	
☐	EPISODES OF DEPRESSION, PANIC ATTACKS, OR ANXIETY	
☐	INCREASED/DECREASED USE OF PRESCRIPTION MEDICATIONS	
☐	INCREASED/DECREASED USE OF OVER-THE-COUNTER MEDICATIONS	
☐	INCREASED/DECREASED USE OF ALCOHOL OR DRUGS	
☐	DISCIPLINARY OR LEGAL DIFFICULTIES	
☐	CHANGES IN EATING HABITS, SUCH AS OVEREATING OR UNDEREATING, OR SIGNIFICANT CHANGES IN WEIGHT	

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S) (Continued)													
☐	PREGNANCY TESTS AROUND THE TIME OF THE TRAUMATIC EVENT(S)												
☐	TESTS FOR SEXUALLY TRANSMITTED INFECTIONS												
☐	ECONOMIC OR SOCIAL BEHAVIORAL CHANGES												
☐	CHANGES IN OR BREAKUP OF A SIGNIFICANT RELATIONSHIP												
C. AS NEEDED, LIST ANY ADDITIONAL BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) THAT WERE NOT LISTED IN ITEM 10A.													
11. WAS AN OFFICIAL REPORT FILED? (Note: When reporting a sexual assault during military service, the Department of Defense offers two different reporting options, restricted or unrestricted. Knowing the report type will help VA take the necessary steps to obtain a copy of the report. If you are unsure which report was filed, VA may send you a follow up letter with additional information. Submitting a restricted or unrestricted report was not an option prior to 2005.) ☐ YES (If "Yes," check the appropriate box below indicating which type of report was filed) ☐ NO (If "No," skip to Item 12) ☐ RESTRICTED ☐ UNRESTRICTED ☐ NEITHER ☐ POLICE REPORT (Provide location, if known) ☐ OTHER (e.g., After Action Report (AAR), incident report, formal complaint, Judge Advocate General (JAG), Criminal Investigative Division (CID), Naval Criminal Investigative Service (NCIS), etc.)													
12. POSSIBLE SOURCES OF EVIDENCE FOLLOWING THE TRAUMATIC EVENT(S) (Check all that apply) (Note: The following sources of evidence may provide additional information for your claim. This list is not all inclusive. If you have any individual(s)/witness(es) who know(s) about the in-service traumatic event(s) or would have knowledge of a behavioral change you experienced after the personal traumatic event(s), and wants to provide a statement on your behalf, use VA Form 21-10210, Lay/Witness Statement. If your individual(s)/witness(es) is a veteran, they may be requested to provide their DD Form 214, or other evidence of service.) <table border="0"><tr><td>☐ A RAPE CRISIS CENTER OR CENTER FOR DOMESTIC ABUSE</td><td>☐ A CHAPLAIN OR CLERGY</td></tr><tr><td>☐ A COUNSELING FACILITY OR HEALTH CLINIC</td><td>☐ FELLOW SERVICE MEMBER(S)</td></tr><tr><td>☐ FAMILY MEMBERS OR ROOMMATES</td><td>☐ PERSONAL DIARIES OR JOURNALS</td></tr><tr><td>☐ A FACULTY MEMBER</td><td>☐ NONE</td></tr><tr><td>☐ CIVILIAN POLICE REPORTS</td><td>☐ OTHER (Specify below):</td></tr><tr><td>☐ MEDICAL REPORTS FROM CIVILIAN PHYSICIANS OR CAREGIVERS WHO TREATED YOU IMMEDIATELY FOLLOWING THE INCIDENT OR SOMETIME LATER</td><td></td></tr></table>		☐ A RAPE CRISIS CENTER OR CENTER FOR DOMESTIC ABUSE	☐ A CHAPLAIN OR CLERGY	☐ A COUNSELING FACILITY OR HEALTH CLINIC	☐ FELLOW SERVICE MEMBER(S)	☐ FAMILY MEMBERS OR ROOMMATES	☐ PERSONAL DIARIES OR JOURNALS	☐ A FACULTY MEMBER	☐ NONE	☐ CIVILIAN POLICE REPORTS	☐ OTHER (Specify below):	☐ MEDICAL REPORTS FROM CIVILIAN PHYSICIANS OR CAREGIVERS WHO TREATED YOU IMMEDIATELY FOLLOWING THE INCIDENT OR SOMETIME LATER	
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☐ FAMILY MEMBERS OR ROOMMATES	☐ PERSONAL DIARIES OR JOURNALS												
☐ A FACULTY MEMBER	☐ NONE												
☐ CIVILIAN POLICE REPORTS	☐ OTHER (Specify below):												
☐ MEDICAL REPORTS FROM CIVILIAN PHYSICIANS OR CAREGIVERS WHO TREATED YOU IMMEDIATELY FOLLOWING THE INCIDENT OR SOMETIME LATER													
SECTION IV: TREATMENT INFORMATION													
13A. HAVE YOU RECEIVED TREATMENT RELATED TO THE IMPACT OF THE TRAUMATIC EVENT(S) LISTED IN ITEM 9A? ☐ YES (If "Yes," complete Items 13B through 13E) ☐ NO (If "No," skip to Item 14)													
13B. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply) <table border="0"><tr><td>☐ PRIVATE HEALTHCARE PROVIDER (including non-Federal records)</td><td>☐ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)</td></tr><tr><td>☐ VA VET CENTER</td><td>☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)</td></tr><tr><td>☐ COMMUNITY CARE (Paid for by VA)</td><td></td></tr></table>		☐ PRIVATE HEALTHCARE PROVIDER (including non-Federal records)	☐ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)	☐ VA VET CENTER	☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)	☐ COMMUNITY CARE (Paid for by VA)							
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☐ VA VET CENTER	☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)												
☐ COMMUNITY CARE (Paid for by VA)													
Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your private provider (excluding community care (paid for by VA)) or VA Vet Center health records, VA requires your consent by completing VA Form 21-4142, and VA Form 21-4142a. VA forms are available at www.va.gov/vaforms													

PAGE 6

SECTION VIII: WITNESSES TO SIGNATURE (Note: Only use this section if the veteran/service member signed Item 16A with an "X")	
17A. SIGNATURE OF WITNESS	17B. PRINTED NAME AND ADDRESS OF WITNESS
18A. SIGNATURE OF WITNESS	18B. PRINTED NAME AND ADDRESS OF WITNESS
SECTION IX: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE (Note: Only required if Item 16A is blank)	
NOTE: An alternate signer signature will not be accepted unless a valid VA Form 21-0972, <i>Alternate Signer Certification</i>, is of record or attached to this request. I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; OR, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; OR, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; OR, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; AND, that the claimant is under the age of 18; OR, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; OR, is physically unable to sign this form. I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.	
19A. ALTERNATE SIGNER'S SIGNATURE	19B. DATE SIGNED (MM/DD/YYYY) - -
SECTION X: POWER OF ATTORNEY (POA) SIGNATURE (Note: Only required if Item 16A is blank)	
I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge. Note: A POA's signature will not be accepted unless at the time of submission of this claim a valid VA Form 21-22, <i>Appointment of Veterans Service Organization as Claimant's Representative</i>, or VA Form 21-22a, <i>Appointment of Individual as Claimant's Representative</i>, indicating the appropriate POA is of record with VA.	
20A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE	20B. DATE SIGNED (MM/DD/YYYY) - -
20C. ACCREDITATION NUMBER	20D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known) - -
PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Completion and submission of this form is voluntary. However, the requested information is important to assist VA in thoroughly researching your military record and other sources to obtain supporting evidence of traumatic event(s) in service. The responses you submit are considered confidential (38 U.S.C. 5701). RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control Number. The OMB control number for this project is 2900-0659, and it expires 03/31/2027. Public reporting burden for this collection of information is estimated to average 45 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden to VA Reports Clearance Officer at VACOPaperworkReduAct@VA.gov. Please refer to OMB Control No. 2900-0659 in any correspondence. Do not send your completed VA Form 21-0781 to this email address.	

Appendix F

Personal Trauma Incident/ Marker Worksheet

Veterans Benefits Administration (VBA) claims processors use the Personal Trauma Incident/Marker Worksheet and follow the accompanying instructional guide to document evidence of a personal trauma (including military sexual trauma) when developing personal trauma-related claims. VBA provided this document to the committee in response to a request for information (Majors, 2026).

Personal Trauma Incident/Marker Worksheet

Purpose: This worksheet is intended to assist with the creation of examination requests that are as detailed as possible. Complete it following review of the Personal Trauma Incident/Marker Worksheet Instructional Guide, which includes additional details and resources.

Directions: Use this worksheet after completing all development actions for a claim(s) of a mental condition due to personal trauma.

Exception: The worksheet is not required for pre-discharge claims (Integrated Disability Evaluation System, Benefits Delivery at Discharge (BDD), or BDD-excluded claims).

Benefit Claim ID:			Claimant's Name:		
Section B: Condensed Incident Summary					
Provide a condensed incident summary. If available, include date(s) and place/location.					
Section C: Traumatic Event Documentation (Service Records)			Yes	No	
Is the traumatic incident documented in the service records?					
Note: Service records include, but are not limited to, service treatment records (STRs), personnel records, and/or clinical records as well as reporting option forms completed following the traumatic event during service (including DD Form 2910 or DD Form 2911), or positive DSAID results.			☐	☐	
Important: Evidence showing documentation the Veteran experienced a traumatic event should be used to consider service connection for non-PTSD diagnoses under 38 C.F.R. § 3.303, if claimed due to a personal traumatic event(s) or diagnosed in lieu of PTSD (Clemons v. Shinseki).					
If yes, complete the below summary of evidence, which should reference annotations in the claims file. Then, proceed to Section G.					

Personal Trauma Incident/Marker Worksheet

Note 2: Alternative evidence considered official documentation the Veteran experienced a personal traumatic event includes official reports or complaints to military or civilian entities filed at the time or shortly after the traumatic event. (e.g., civilian police reports, reports from a rape crisis center or domestic abuse center, reports to military officials, etc.) Note 3: Alternative evidence that can be used to concede the traumatic event along with a positive opinion from the examiner (38 C.F.R. § 3.304(f)(5)) (e.g., statements from fellow service members, family, or friends regarding changes in the Veteran's behavior and/or disclosures of the event, journal entries.) Note 4: Section F includes a section to identify post-service marker evidence. Important: Evidence showing official documentation the Veteran experienced a traumatic event should be used to consider service connection for non-PTSD diagnoses under 38 C.F.R. § 3.303, if claimed due to a personal traumatic event(s) or diagnosed in lieu of PTSD (<i>Clemons v. Shinseki</i>).		
If yes, complete the below summary of evidence, which should reference annotations in the claims file. Then, proceed to Section G.		
If no, continue to the next section.		
Summary of Evidence: (see instructional guide for resources, expectations, and ESR example)		
Example: Description – Statement from fellow service member confirming Veteran reported the incident to them Document Receipt Date – 01/01/2024 Document Type – VA Form 10210 Lay/Witness Statement Actual Date of Treatment/Evidence – 1/1/1988		
Text Example: Statement from fellow service member confirming the Veteran reported the incident to them; 01/01/2024; VA Form 10210 Lay/Witness Statement; 1/1/1988		

Personal Trauma Incident/Marker Worksheet

Section E: Review of Markers: In-Service		Yes	No
Is there a marker(s) <u>during service</u> that shows a change in behavior of the Veteran following the traumatic experience? Note: A marker is defined as "an indicator of the effect or consequences of the personal trauma on the Veteran." A marker could be one or more behavioral events or a pattern of changed behavior.		☐	☐
If yes , complete the below summary of evidence, which should reference annotations in the claims file. Then, proceed to the next section			
If no , continue to the next section.			
Summary of Evidence: (see instructional guide for resources, expectations, and ESR example)			
Example: Description – Self harm; referred to mental health Document Receipt Date – 01/01/2024 Document Type – STRs Actual Date of Treatment/Evidence – 02/04/1988			
Text Example: Self harm; referred to mental health; 01/01/2024; STRs; 2/4/1988			

Personal Trauma Incident/Marker Worksheet

Section F: Review of Markers: Post-Service	Yes	No
Is there a marker(s) <u>post-service</u> that shows a change in the behavior of the Veteran following the traumatic experience? Note: A marker is defined as "an indicator of the effect or consequences of the personal trauma on the Veteran." A marker could be one or more behavioral events or a pattern of changed behavior.	☐	☐
If yes , complete the below summary of evidence, which should reference annotations in the claims file. Then, proceed to the next section		
If no , continue to the next section.		
Summary of Evidence: (see instructional guide for resources, expectations, and ESR example)		
Example: Description – Veteran's statement of inability to maintain steady employment or personal relationships (divorce) Document Receipt Date – 01/01/2024 Document Type – VA Form 21-4138, Statement in Support of Claim Actual Date of Treatment/Evidence: 1/1/2024		
Text Example: Veteran's statement of inability to maintain steady employment or personal relationships (divorce); 01/01/2024; VA Form 21-4138, Statement in Support of Claim; 1/1/2024		

Personal Trauma Incident/Marker Worksheet

Section G: Post-Service Medical Treatment		Yes	No
Is there evidence in the record showing post-service treatment for mental and/or physical health conditions related to a traumatic event?		☐	☐
Summary of Evidence: (see instructional guide for resources, expectations, and ESR example)			
Example: Description – Treated for anxiety and depression, receiving counseling Document Receipt Date – 01/01/2024 Document Type – CAPRI Date of Treatment – 02/04/2019 Text Example: Treated for anxiety and depression; receiving counseling; 01/01/2024; CAPRI; 02/04/2019			
By signing this document, you are certifying that you reviewed the claim and have used this document to determine the next appropriate action or that all appropriate actions have been taken.			
Employee Signature:			

Personal Trauma Incident/Marker Worksheet Instructional Guide

Directions for use: When entitlement has not been previously established for initial or supplemental claims and a complete application for benefits based on personal trauma has been received, this guide should be reviewed, and the corresponding Personal Trauma Incident/Marker Worksheet should be completed. The Personal Trauma Incident/Marker Worksheet must be completed and uploaded into the eFolder before the claims processor requests an examination or advances the claim to the rating activity for a complex medical opinion review or Ready for Decision (RFD). The worksheet is intended to ensure the examination request is as detailed as possible.

It should be completed and uploaded after all required development is complete or suspense dates have expired, at least one time at any of the following points in the claims process:

Prior to...	Claims Processor is Responsible When...
requesting an examination if a complex medical opinion review is not required	requesting an examination
requesting a complex medical opinion review	referring the claim for a complex medical opinion review
updating status of the claim to RFD	updating the claim status to RFD
requesting a complex medical opinion if the worksheet has not been previously completed	requesting the complex medical opinion
rendering a decision for the benefit sought if the worksheet has not been previously completed	rendering the decision on the claim

Section A: Veteran Details
Ensure the claimant's name and benefit claim ID are on each incident marker worksheet that you complete. Do not reuse a prior worksheet. A new worksheet must be completed for each claimant.
Section B: Condensed Incident Summary
In this section, complete a condensed event summary. Provide enough information for someone to have a general idea of the event. If there are multiple events, provide a summary for each event. It is not sufficient to only reference "see VAF 21-0781" or "see CAPRI record."
Example 1: The claimant reported that on or about 8/2012 in Seoul, South Korea, he was sexually assaulted by another soldier from his unit.
Example 2: The claimant was in a male-dominated unit where she experienced sexual harassment and assault. She experienced lewd remarks, touching when passing, and being ordered off a job. She was ordered to delay reporting the incidents or would be written up if she challenged authority.
Guidance for Completing Sections C – G: Evidence Review & Annotation Guidance
Review the evidence to determine if there is evidence of an in-service event, alternative evidence, or marker evidence that shows behavioral changes around the time of or after the traumatic event. Alternative, post-service marker evidence must also be identified. Identify all pertinent evidence within the Veteran's eFolder for the rating activity and/or examiner to review in connection with the examination, complex medical opinion review, and/or MST or Non-MST personal trauma medical opinion request. Indicating "see STRs" or "see VBMS Documents" is not sufficient. At a minimum, the evidence must be bookmarked or annotated with: • tab label • document receipt date • document type, and • date(s) of treatment, injury, or event
Example

<i>Tab A – Treatment for depression and anxiety</i> <i>Document Receipt Date – 5/8/2024</i> <i>Document Type – STRs</i> <i>Date of Treatment – 6/18/2013</i> Once the Exam Scheduling Request (ESR) is built, the above information will display as shown below (note the Document Type, Document ID, and Upload Date are automatically pulled from VBMS). The Subject and Annotation are based on claims processor input. The page number automatically populates after the annotation is added. <i>Document Type: STR - Medical, Subject: Depression, Annotation: Treatment for depression and anxiety – 06/18/2013, Document ID: EDF61552-9EFD-47A4-BE67-9A1B05E9112E, Upload Date: 05/08/2024, Page number: 2</i> Important: In addition to identifying the evidence in Sections C-G for completion of the worksheet and bookmarking or annotating the Veteran's eFolder, the relevant evidence identified on both the worksheet and within the eFolder must also then be included within the examination request itself, as the three actions are separate and distinct from one another. Claims processors must ensure this is complete when automatic populations fail.	
Resources:	
M21-1 VIII.iv.1.E - Importance of Obtaining and Analyzing Available Evidence of Personal Trauma	Requirements for all claims processors to obtain all relevant records and review the claim for credible supporting evidence, including evidence of markers.
M21-1 VIII.iv.1.B - Procedure for Reviewing for Credible Evidence of a Personal Trauma Stressor	Review records for evidence of behavioral changes around the time of, and after, the incident(s). No limitation is placed on "after".
M21-1 IV.i.2.A - Referring Claims for Complex Medical Opinion Review	The development and rating activity will ensure that complex medical opinions are appropriately routed for preparation and entry.
M21-1 IV.i.2.A - Procedure for Identifying the Evidence in a Medical Opinion Request	Identify all pertinent evidence for examiner review in connection with the complex medical opinion.
M21-1 IV.i.2.A - Maintaining Objectivity in Medical Opinion Requests	Identify all relevant evidence for the examiner's review.
M21-1 IV.i.2.A - Requirement to Identify Relevant Evidence for the Examiner's Review	Ensure each piece of relevant evidence in the eFolder is either bookmarked or annotated using the functionality described in the <i>VBMS Core User Guide</i>
M21-1 VIII.iv.1.E - Alternative Sources of Evidence of In-Service Personal Trauma	Review records immediately following the incident or sometime later. No time limit for "later".
M21-1 VIII.iv.1.E - Evidence that May Constitute a Marker of Personal Trauma	Review records for evidence of behavioral changes around the time of, and after, the incident(s), as they may constitute a marker of a personal trauma PTSD stressor. Markers may be in both in-service and post-service records.
M21-1 VIII.iv.1.C - Requesting Examinations for PTSD Claims Based on Personal Trauma	When requesting an examination and/or medical opinion, claims processors must review the file to determine if the criteria for a PTSD personal trauma examination is met and of record in the eFolder.
M21-1 VIII.iv.1.E - Interpretation of Behavioral Changes as Markers of Personal Trauma	Claims processors must identify evidence of behavioral changes for clinician interpretation, when necessary to support the claim.
Section C: Traumatic Event Documentation (Service Records)	

A “yes” answer in this section applies when there is direct evidence that the incident occurred during a qualifying period of service (active duty or active or inactive duty for training). See M21-1 III.i.1.A., M21-1 VIII.iv.1.E., and VAOPGCPREC 8-2001. Note: This section <u>does not</u> apply to alternative evidence, in-service marker evidence that shows behavioral changes around the traumatic event, or post-service marker evidence.
Section D: Traumatic Event Documentation (Alternative Sources of Evidence) A “yes” in this section applies when there is evidence that is considered an alternative to official service records. This is evidence that helps concede a traumatic event, with or without explicit documentation of the event. This section <u>does not</u> include in-service evidence of the event shown in service records, in-service marker evidence that shows behavioral changes around the traumatic event, or post-service marker evidence. See M21-1 VIII.iv.1.E.
Section E: Review of Markers: In-Service A “yes” is applicable if service records do not contain explicit documentation of the personal traumatic event, and alternative evidence does not provide supporting evidence of the trauma, evidence of behavioral changes around the time of, and after, the event(s), may constitute a marker of a personal traumatic event. See M21-1 VIII.iv.1.E.
Section F: Review of Markers: Post-Service A “yes” is applicable if there is evidence of behavioral changes <u>following service</u> that are consistent with the type of trauma experienced by the claimant. These may constitute a marker of a personal traumatic event. See M21-1 VIII.iv.1.E.
Section G: Post-Service Medical Treatment A “yes” is applicable if there is evidence of post-service treatment for a mental and/or physical health condition related to a personal traumatic event. This is the appropriate location for documenting post-service, current, and/or recurring treatment.
Employee Signature By signing this section, the employee affirms they have completed the sections within the personal trauma incident/marker worksheet with accuracy and have taken all appropriate action(s) on the claim.

*The M21-1 is a living document. Updates may come from new procedural directives, regulatory changes, acts of Congress, judicial interpretations, internal reviews, and user feedback. It is the responsibility of the claims processor to ensure they follow the most recent guidance. References cited on this document may change.

REFERENCE

Majors, B. 2026. Veterans Benefits Administration response to November 2025 request for information–Personal trauma incident/marker worksheet and instructional guide, February 2, 2026.

Appendix G

Medical Opinion Disability Benefits Questionnaire

If requested by the Veterans Benefits Administration (VBA), examiners complete the Medical Opinion Disability Benefits Questionnaire to provide their clinical opinion of service connection. VBA provided this document to the committee in response to a request for information (VA, 2025).

 Department of Veterans Affairs		INTERNAL VETERANS AFFAIRS USE MEDICAL OPINION DISABILITY BENEFITS QUESTIONNAIRE	
Name of Claimant/Veteran: 		Claimant/Veteran's Social Security Number: 	Date of Examination:
Note to examiner - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.			
Is this questionnaire being completed in conjunction with a VA C&P examination request? ☐ Yes ☐ No How was the examination completed? (check all that apply) ☐ In-person examination ☐ Records reviewed ☐ Examination via approved video telehealth ☐ Other, please specify in comments box Comments: 			
ACCEPTABLE CLINICAL EVIDENCE (ACE)			
Indicate the method used to obtain medical information to complete this document: ☐ Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence. ☐ Review of available records in conjunction with an interview with the Veteran (without in-person or video telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.			
EVIDENCE REVIEW			
Evidence reviewed (check all that apply): ☐ Not requested ☐ VA claims file (hard copy paper C-file) ☐ VA e-folder ☐ No records were reviewed ☐ VA electronic health record ☐ Other, please specify in comments box Evidence comments: 			
SECTION I - DEFINITIONS			
Aggravation of preexisting nonservice-connected disabilities. A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease. Aggravation of nonservice-connected disabilities. Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected.			
SECTION II - RESTATEMENT OF REQUESTED OPINION			
2A. Insert requested opinion from general remarks: 			

2B. Indicate type of exam for which opinion has been requested (e.g. skin diseases): _____
SECTION III - MEDICAL OPINION FOR DIRECT SERVICE CONNECTION
Choose the statement that most closely approximates the etiology of the claimed condition.
☐ 3A. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in Section C.
☐ 3B. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale in Section C.
3C. Rationale:
SECTION IV - MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION
☐ 4A. The claimed condition is at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) proximately due to or the result of the Veteran's service connected condition. Provide rationale in Section C.
☐ 4B. The claimed condition is less likely than not (likelihood is less than approximately balanced or nearly equal) proximately due to or the result of the Veteran's service connected condition. Provide rationale in Section C.
4C. Rationale:
SECTION V - MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE
☐ 5A. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in Section C.
☐ 5B. The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale in Section C.
5C. Rationale:
SECTION VI - MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION
6A. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?
☐ Yes ☐ No
If "Yes" to question 6A, answer the following:
I. Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):
II. Provide the date and nature of the medical evidence used to provide the baseline:

III. Is the current severity of the (claimed condition/diagnosis) greater than the baseline?

☐ Yes ☐ No

If yes, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes (provide rationale in Section 6B.)
☐ No (provide rationale in Section 6B.)

If "No" to question 6A, answer the following:

I. Provide rationale as to why a baseline cannot be established (e.g. medical evidence is not sufficient to support a determination of a baseline level of severity):

II. Regardless of an established baseline, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by (insert "service connected condition")?

☐ Yes (provide rationale in section 6B.)
☐ No (provide rationale in section 6B.)

6B. Provide rationale:

VII - GULF WAR OPINION

7A. Please evaluate the medical records for this Veteran with Southwest Asia service for any chronic disability pattern. For each condition and/or symptom identified in the Gulf War General Medical Examination questionnaire or any other associated questionnaire, determine whether the Veteran's disability pattern is:

(1) an undiagnosed illness
(2) a diagnosable but medically unexplained chronic multi-symptom illness of unknown etiology (MUCMI)
(3) a diagnosable chronic multi-symptom illness with a partially explained etiology, or
(4) a disease with a clear and specific etiology and diagnosis.

If, after reviewing the claims file, you determine that the Veteran's disability pattern was either (1) an undiagnosed illness; or (2) MUCMI, then please provide a medical statement identifying which disability pattern (1 or 2) is present with supporting rationale in 7B and/or 7C. For any signs or symptoms described in the Gulf War General Medical Examination questionnaire or any other associated questionnaire, identify those that are attributable to each undiagnosed illness or MUCMI.

If, after reviewing the claims file, you determine that the Veteran's disability pattern was either (3) a diagnosable chronic multi-symptom illness with a partially explained etiology, or (4) a disease with a clear and specific etiology and diagnosis, then please provide a medical statement identifying which disability pattern (3 or 4) is present and provide a medical statement with supporting rationale in 7B and/or 7C. The rationale must address both the etiology and pathophysiology for each disability pattern. Also complete the Medical Opinion for Toxic Exposure Risk Activities (TERA) in Section VIII.

7B. Medical statement with supporting rationale explaining disability pattern (for each condition):

7C. Are any of the diagnoses a gastrointestinal disorder? ☐ Yes ☐ No

If yes, indicate if the gastrointestinal disorder is functional (disability pattern 1 or 2), or structural (disability pattern 3 or 4).

☐ Functional ☐ Structural

Provide an explanation of whether the disorder is functional or structural and discuss any testing (if available) that was completed identifying the specific gastrointestinal disorder diagnosed.

SECTION VIII - MEDICAL OPINION FOR TOXIC EXPOSURE RISK ACTIVITIES (TERA)

Choose the statement that most closely approximates the etiology of the claimed condition.

☐ 8A. The claimed condition was at least as likely as not (likelihood is at least approximately balanced or nearly equal, if not higher) caused by the indicated toxic exposure risk activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in Section C.
☐ 8B. The claimed condition was less likely than not (likelihood is less than approximately balanced or nearly equal) caused by the indicated toxic exposure risk

activity(ies), after considering the total potential exposure through all applicable military deployments of the Veteran and the synergistic, combined effect of all toxic exposure risk activities of the Veteran. Provide rationale in Section C.

8C. Provide rationale:

SECTION IX - OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

9. I have reviewed the conflicting medical evidence and am providing the following opinion:

SECTION X - REMARKS

10A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XI - EXAMINER'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

11A. Examiner's signature:

11B. Examiner's printed name:

11C. Date signed:

11D. Examiner's phone/fax numbers:

11E. National Provider Identifier (NPI) number:

11F. Medical license number and state:

11G. Examiner's address:

REFERENCE

VA (Department of Veterans Affairs). 2025. *Internal Veterans Affairs use medical opinion Disability Benefits Questionnaire*. v25_1.