Care of American Veterans and Their Families (218)

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Course price: $19

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Course Summary

This course addresses the healthcare challenges of today's returning Veterans and describes the resources available to them. It explains the importance of screening for military service by health professionals when seeing a patient for the first time. Following a discussion of the health conditions seen in Veterans, it explains the principles of rehabilitation and reintegration that underlie their focused care.

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Criteria for Successful Completions

80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

Course Objectives

When you finish this course you will be able to:

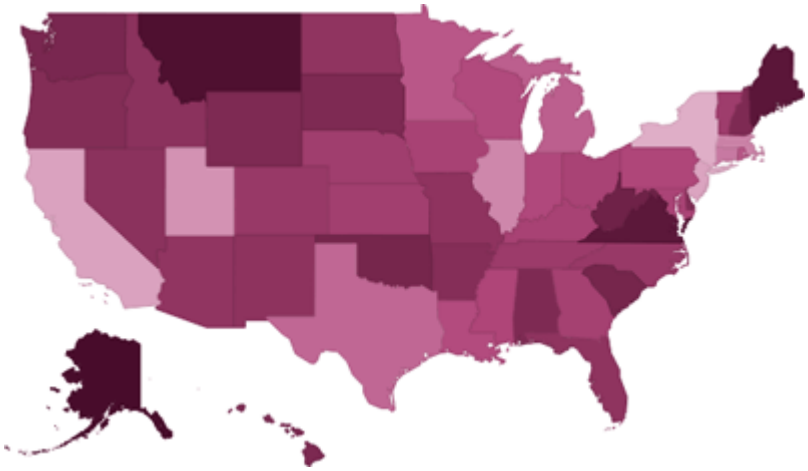
- Describe veterans' healthcare challenges and identify how to find the locations of VA health centers in the nation.
- Recount 4 ways that veterans can access community-centered healthcare if they cannot use a VA health center.
- Explain the importance of screening for military service, veteran status, or being a family member of a veteran.
- Discuss posttraumatic stress disorder, suicide risk, depression, grief, substance abuse, and intimate partner violence and explain how each may arise in military veterans and their families.
- Name 3 ways that providers can receive additional education or training to assist them in serving veterans and their families.
- Explain the principles of rehabilitation and reintegration and list 3 ways you can make appropriate referrals.

According to the United States Department of Veterans Affairs, in 2014 the U.S. Veteran population was estimated as follows (DVA 2016):

- Projected U.S. Veterans population: 21,681,000 (19,646,000 men and 2,035,000 women)
- Projected number of living WW II Veterans (as of 9/30/2015): 847,000
- Estimated number of WW II Veterans pass away per day: 465
- Percentage of Veteran population 65 or older: 45.82%
- Veteran population by race:
  - White 82.0%
  - Black 12.4%
  - Hispanic 6.9%
  - Asian/Pacific Islander 1.6%
  - American Indian/Alaska Natives 0.8%
  - Other 3.2%

A Veteran is any person who has served in the U.S. armed forces, including the National Guard and Reserve. A person need not have served in combat to be a Veteran. Veterans live in all states; the five states with the greatest Veteran populations are California, Florida, Texas, Pennsylvania, and New York.

Veteran Population by Percentage of State Population



The darkest color states have the largest percentage of veterans.
Source: DVA/NCVAS 2015. Google.com.

According to America's Wars Fact Sheet, published May 2017, the number of Veterans on benefits rolls as of April 2017 was:

- Gulf War Veterans—2,160,897
- Vietnam Era Veterans—1,544,274
- Korean Conflict Veterans—172,837
- World War II Veterans—120,240
- Philippines—1,548
- Peacetime—726,238 (DVA, 2017a)

The fastest growing cohort of U.S. Veterans is women. In 2015 women constituted 9.4% (about 2 million) of the total U.S. Veteran population of 21.7 million. By 2023 it is projected that women will make up 16.3% of all living Veterans (DVA/NCVAS, 2017).

Effective triage, trauma treatment, and recover maneuvers during Operation Iraqi Freedom and Operation New Dawn (OIF) in Iraq, and Operation Enduring Freedom (OEF) in Afghanistan, have resulted in extraordinary survival rates. However the number of physically and mentally wounded individuals exceeded 32,000 from OIF and 16,000 from OEF (Allen et al., 2015).

The mission of the U.S. Department of Veterans Affairs is "to fulfill President Lincoln's promise 'To care for him who shall have borne the battle, and for his widow, and his orphan' by serving and honoring the men and women who are America's Veterans." This mission is supported by five core values: Integrity, Commitment, Advocacy, Respect, and Excellence, which, taken together form the acronym "I CARE."

Executive Order 13625, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, was issued by President Barack Obama on August 31, 2012. It created the Interagency Task Force (ITF) on Military and Veterans Mental Health and tasked it with providing an annual review of agency actions, defining specific goals and metrics to aid in measuring progress, and making additional recommendations to improve mental health and substance use disorder treatment services for U.S. Veterans, service members, and their families.

Veteran Services

The Veterans Health Administration, commonly known as the VA, is America's largest integrated healthcare system, with over 1,700 sites of care, serving 8.76 million Veterans each year.

Providing primary care, specialized care, and a range of medical and social support services to U.S. Veterans, the VA is also the largest provider of healthcare education and training for physician residents and other healthcare professional trainees. The VA advances medical research and development in areas that most directly address the diseases and conditions that affect Veterans and their families (DVA, 2014).

VA services are provided to all Veterans who:

- Completed active military service in the Army, Navy, Air Force, Marines, or Coast Guard (or Merchant Marines during WWII)
- Were discharged under other than dishonorable conditions
- Were National Guard members or Reservists who have completed a federal deployment to a combat zone

The VA is working to better respond to Veterans' needs. New programs provide treatment for traumatic brain injuries, posttraumatic stress, suicide prevention, military sexual trauma, women Veterans, and more. VA has opened outpatient clinics and established telemedicine and other services to accommodate a diverse Veteran population. The VA participates in joint initiatives with other agencies in ongoing medical research and innovation to improve the lives of Veterans.

About the VA

Number of VA Employees: 367,480

Number of VA Hospitals: 144

Number of VA Outpatient Sites: 1,221

Number of VA Vet Centers: 300

Number of VBA Regional Offices: 56

Number of VA National Cemeteries: 133

Source: DVA, 2014.

In recent years, the VA has expanded its services by opening new medical centers and increasing the number of community-based outpatient clinics to improve Veterans' access to services. VA programs reduced the backlog of disability claims by 36% and reduced Veteran homelessness by over 24% between January 2010 and January 2013 (DVA, 2014).

The VA opened its first new medical center in 17 years in 2012 and, since January 2009, increased the number of community-based outpatient clinics by 55 to improve access for Veterans. The *VA Strategic Plan for FY 2014–2020* builds on past accomplishments and drives further improvements in the delivery of benefits and services to Veterans. It maintains a focus on increasing access to VA benefits and services; reducing, and ultimately, eliminating the disability claims backlog in 2015; and ending the rescue phase of Veteran homelessness, also in 2015.

The plan further articulates three strategic goals:

1. Work to ensure Veterans are empowered, independent, self-sustaining, and well equipped for civilian life.
2. Improve our ability to partner and work with those who provide benefits, services, and resources to Veterans through improved collaboration, business practices, and outreach.
3. Improve our business operations to efficiently and effectively serve our nation's Veterans. (DVA, 2014)

Not all Veterans live within a reasonable distance of a VA health center. Rural communities lack services. For this reason, the Veterans Choice Program was created.

Veterans Choice Program

The Veterans Choice Program is a benefit that allows eligible Veterans to receive healthcare in their communities rather than waiting for a VA appointment or traveling to a VA facility. The American Medical Association (AMA) is committed to connecting physicians with information, tools, and training materials to help assess and treat our nation's Veterans and their families. The AMA strongly supported the passage of the Veterans Access, Choice, and Accountability Act of 2014, which is designed to address challenges of the workforce and extend access to care at the VA. Veterans are eligible for the program if they (1) are unable to received timely care—defined as wait times of more than 30 days, or (2) live too far away from a VA facility (defined as more than 40 miles).

The Veterans Choice Program is making it easier for thousands of Veterans to receive their healthcare from providers outside of the VA system.

Patient-Centered Community Care

Patient-Centered Community Care (PC3) is a VA program to provide Veterans with access to some types of medical care when the local VA medical facility cannot readily provide that care; for example, this may be because there isn't an appropriate specialist at the local VA medical center or clinic. Eligible Veterans can receive access to primary care, inpatient specialty care, outpatient specialty care, mental health care, limited emergency care, and limited newborn care for enrolled female Veterans following the birth of a child.

TRICARE

The TRICARE program supports healthcare providers' work with service members and Veterans who are retired from the military by reimbursing for medical and behavioral health services provided outside of a military treatment facility. TRICARE is a part of the Military Health System, under the auspices of the Assistant Secretary of Defense for Health Affairs. It covers an ever-growing 9.5 million beneficiaries, including active duty members and families of the Army, Navy, Marine Corps, Air Force, and Coast Guard, as well as retirees from each of the above services and their families. TRICARE utilizes direct care in military treatment facilities as well as participating civilian healthcare professionals.

Mobile Vet Centers

In rural communities, gaining access to Veterans' healthcare services can be difficult. When those services come to patients on wheels, life gets a little more convenient.

The mobile vet centers (MVCs) of the Department of Veterans Affairs provide readjustment counseling and information resources to Veterans across the country. Like community-based vet centers, mobile vet centers focus on services that help Veterans make the difficult transition between military and civilian life.

Counseling sessions are one of the most important resources available at the Mobile Vet Centers which are equipped with videoconferencing equipment as well as WiFi and DVD hardware. Source: va.gov.

Resembling super-sized recreational vehicles, the 50 vans are driven to far-reaching rural areas to provide Veterans with services such as counseling for posttraumatic stress disorder and military sexual trauma, bereavement counseling, marriage and family counseling, and resources such as VA benefits information and suicide prevention referrals.

Jesse Davis made use of mobile vet services in a different way. He came to the vet center in Morgantown, WV, for employment assistance and was promptly hired as the driver for their mobile vet center.

Davis' experience as a seven-ton truck driver in the Marine Corps helped him qualify to drive the 38-foot long mobile vet vehicle. Since his employment, Davis has traveled to West Virginia, Pennsylvania, and Washington, DC, to help Veterans with VA information and referrals.

He greatly enjoys helping Veterans, especially because he can relate to the challenges of transitioning into civilian life. "The more Veterans I'm around, the more my confidence goes up. And the more my confidence goes up, the more I can help others with information. That's important for me and I love my job because of it."

Source: Megan Tyson, VA staff writer.

Stigma as Barrier to Veterans Getting Services

A 2012 survey of 1,200 West Virginia Veterans found that stigma surrounding treatment for mental health prevents many Veterans from seeking help. The survey found that those Veterans with the highest risk of committing suicide are the least likely to seek medical or mental healthcare. A 2011 study of 577 combat Veterans who were screened positive for posttraumatic stress disorder, depression, or generalized anxiety disorder 3 months after returning from Iraq, published in the *Journal of Nervous and Mental Disease*, found that negative views about treatment and, to a lesser extent, stigmatizing views of others' mental health problems were related to reduced interest in receiving help. Internal barriers to help seeking, such as not recognizing a problem or holding negative attitudes about mental health care and the people who seek it, may be difficult to overcome (VHA, 2012).

Wendy Tenhula, national mental health director for the integrated VA/DoD mental health program, explained why service members and Veterans might not seek treatment for mental health disorders:

- Fear there will be professional and social repercussions for seeking help
- Mistrust of medications or therapy or both
- Embarrassment
- Not wanting to be seen or labeled as weak, incompetent, or dangerous (Beaucar Vlahos, 2016)

Several factors influence an individual's level of stigma and resulting treatment-seeking behaviors:

- Attitudes of higher ranking military leaders
- Potential repercussions of admitting to mental health issues
- Gender

- Marital status
- Previous history of seeking treatment (Miggantz, 2014)

Military service members are exposed to significant traumas. It is important that these individuals believe it is acceptable to receive mental health treatment (Miggantz, 2014).

Launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in 2009, The Real Warriors Campaign is a multimedia public awareness campaign designed to encourage help-seeking behavior among service members, Veterans, and military families coping with invisible wounds. The campaign is an integral part of the Defense Department's overall effort to encourage warriors and families to seek appropriate care and support for psychological health concerns.

Screening for Military Service

The American Medical Association has urged healthcare providers to ask patients if they have served in the military and to include that experience in their records. At the request of the American Psychoanalytic Association, the AMA has changed the *Current Procedural Terminology [CPT] Evaluation and Management Services Guidelines* (Jordan, 2015).

The American Academy of Nursing launched an awareness campaign in 2013 to encourage health professionals to ask patients if they are Veterans or family members of Veterans. This question is not routinely asked by healthcare providers. Only a small percentage of Veterans receive services through the Veterans Administration. Many more Veterans receive healthcare through community providers.

Source: AAN, 2017.

Called "Have You Ever Served in the Military?" and accessed at http://www.haveyoueverserved.com/, the AAN program provides screening and intake questions and information on general areas of concern for all Veterans, such as posttraumatic stress, military sexual trauma, and blast concussions/traumatic brain injury (TBI), as well as health concerns for Veterans of specific conflicts or deployment conditions. The initiative aims to ensure that individuals have appropriate access to services and to increase provider awareness of service-related healthcare issues.

Cheryl Sullivan, CEO of the AAN remarked to a conference of State Directors of Veterans Affairs:

> Nurses are healthcare's equivalent to boots on the ground and are uniquely positioned to facilitate the change and ensure vital information is obtained and recorded so as to improve the healthcare provided to our Veterans and their families (Sullivan, 2013).

Importance of Screening

Assessing Veteran status is not included in traditional behavioral health screenings and a patient might not volunteer this information. Patients may be unwilling to discuss their military status and experiences, particularly if doing so causes mental suffering. Asking patients if they have served in the military has important implications for the available benefits and care. Screening for Veteran status:

- Ensures that each Veteran has access to the network of healthcare and support services he or she is eligible for.
- Informs treatment planning.
- Increases awareness of the strengths that Veterans often possess and the challenges they may face. (Seehusen, 2010)

Finding out if patients have close family members who are Veterans can help providers understand the patient's family context and determine if the family could benefit from connection to Veteran resources.

Determining Military History

The American Academy of Nursing suggests the following screening questions for determining military service of patients or family members of patients. The initiative to improve the health of Veterans, Have You Ever Served in the Military?, was implemented in all 50 states by April, 2015.

- Have you or has someone close to you ever served in the military?
- When did you serve?
- Which branch?
- What did you do while you were in the military?
- Were you assigned to a hostile or combative area?
- Did you experience enemy fire, see combat, or witness casualties?
- Were you wounded, injured, or hospitalized?

- Did you participate in any experimental projects or tests?
- Were you exposed to noise, chemicals, gases, demolition of munitions, pesticides, or other hazardous substances?
- Have you ever used the VA for healthcare?
- When was your last visit to the VA?
- Do you have a service-connected disability or condition?
- Do you have a VA primary care provider? (AAN, 2017)

Common Military Health Risks Nurses Should Know

- **Radiation Exposure/Nuclear Weapons** (WWII: Amchitka, Alaska, Hiroshima, Nagasaki, POW in Japan; Korea; sub-mariners exposed to nasopharyngeal radium treatment; Gulf Wars; Bosnia; Afghanistan): High risk for cancer.
- **Agent Orange Exposure** (Korea, Vietnam): High risk for cancers (including respiratory and prostate cancer), chloracne, type 2 diabetes, ischemic heart disease, soft tissue sarcoma, peripheral neuropathy, spina bifida in Veterans' biological children.
- **Camp Lejeune Water Contamination** (January 1, 1957–December 31, 1987): Veterans and families stationed at Camp Lejeune exposed to chemical contaminants in the groundwater and wells are at risk for the following cancers (bladder, blood dyscrasia, breast, esophageal, kidney, leukemia, lung, multiple myeloma, myelodysplastic syndromes, non-Hodgkin's lymphoma) and conditions (female infertility, hepatic steatosis, miscarriage, renal toxicity, scleroderma).
- **Hepatitis C** (Vietnam): Transfusions prior to 1992, battlefield exposures to blood and human fluids, group use of needles, razors, toothbrushes, and other personal items.
- **Exposure to Open Air Burn Pits** (Vietnam, Iraq, Afghanistan): High risk for respiratory illnesses and wide variety of cancers, including leukemia.
- **Gulf War Syndrome** (Gulf Wars): Characterized by fibromyalgia, chronic fatigue syndrome, headaches, gastrointestinal problems, cognitive impairment and pain, high rates of brain and testicular cancers, and neurodegenerative diseases (ALS, MS).
- **Depleted Uranium** (Gulf Wars, Bosnia, Afghanistan): Inhaled or ingested microfine particles (heavy metal toxicity). Risk for respiratory and kidney diseases.
- **Infectious Diseases** (Iraq & Afghanistan): Malaria, typhoid fever, viral hepatitis, leishmaniasis, TB, rabies resulting from animal bites. (AAN, 2017)

Good Clinical Practice in Caring for Veterans

Healthcare providers can recognize and successfully address the physical, mental, and emotional health of Veterans. Good clinical practices include the following:

- Thank the Veteran for his or her service.
- Ask about traumatic experiences (specifically ask about sexual trauma).
- Listen to the Veteran's story.
- Validate the Veteran's feelings about common trauma reactions.
- Screen for PTSD symptoms.
- Identify concern for the patient and emphasize the need for follow-up.
- Screen for suicidal ideation.
- Refer the Veteran to an appropriate healthcare professional for complete evaluation and treatment recommendations.
- Arrange for a follow-up assessment and health teaching (Rossignol, 2010).

Mental Health Issues

Veterans and their families may experience medical and mental health issues as they reintegrate into their communities during or after their terms of military service. The most common medical and mental health issues include PTSD, suicide, depression, grief, drug and alcohol abuse, and intimate partner violence or child abuse.

Signs of Mental Health Problems

Mental problems can cause physical problems, along with changes in thinking, feeling, and behavior:

- Feeling sad or nervous
- Changes in sleep, appetite, weight, or sex life
- Headaches or other physical pain
- Muscle tension and weakness
- Decreased energy, motivation, or interests
- Problems with attention, concentration, or memory
- Irritability, anger, or "short temper"
- Feelings of guilt, worthlessness, helplessness, or hopelessness
- Unhealthy behaviors (misusing drugs, alcohol, food, sex or other behaviors like gambling or spending too much money to cope with stress or emotions)
- Problems functioning at home, work, or school

Source: VHA, 2012.

Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) is a condition that can occur at any age, including childhood. Women are more likely to develop PTSD than men. PTSD is seen in war Veterans and survivors of physical and sexual assault, abuse, accidents, disasters, terrorist attacks, and many other serious events.

Not everyone with PTSD has been through a dangerous event. Some people get PTSD after a friend or family member experiences danger or is harmed. The sudden unexpected death of a loved one can also cause PTSD (NIMH, 2015).Mentally reliving a traumatic event can be almost as stressful and frightening to people with PTSD as the original trauma.

People with PTSD often experience frustration, embarrassment, and confusion, in addition to the physical and psychological symptoms. PTSD strains relationships because many people with PTSD detach themselves from friends and loved ones and the activities that they used to enjoy.

The number of Veterans with PTSD varies by deployment:

- Operations Iraqi Freedom (OIF) and Enduring Freedom (OEF): About 11–20 out of every 100 Veterans (or 11%–20%) who served in OIF or OEF have PTSD in a given

year.

- Gulf War (Desert Storm): About 12 out of every 100 Gulf War Veterans (or 12%) have PTSD in a given year.
- Vietnam War: About 15 out of every 100 Vietnam Veterans (or 15%) were currently diagnosed with PTSD at the time of the most recent study in the late 1980s, the National Vietnam Veterans Readjustment Study (NVVRS). It is estimated that about 30 out of every 100 (or 30%) of Vietnam Veterans have had PTSD in their lifetime. (DVA/NCPTSD, 2016)
- In 2015 nearly 48,000 women Veterans received compensation for PTSD. PTSD accounted for roughly 12 percent of all service connected disabilities for women Veterans. (DVA/NCVAS, 2017)

DSM-5 Diagnostic Criteria for PTSD

Healthcare providers should be aware of the DSM-5 diagnostic criteria for PTSD. Currently, diagnosis of PTSD is based on eight criteria from the DSM-5. The first DSM criterion has four components, as follows:

- Directly experiencing the traumatic event(s)
- Witnessing, in person, the event(s) as it occurred to others
- Learning that the traumatic event(s) occurred to a close family member or friend
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s); this does not apply to exposure through media such as television, movies, or pictures

The second criterion involves the persistent re-experiencing of the event in one of several ways:

- Thoughts or perception
- Images
- Dreams
- Illusions or hallucinations
- Dissociative flashback episodes
- Intense psychological distress or reactivity to cues that symbolize some aspect of the event

Did You Know. . .

Unlike adults, children re-experience the event through repetitive play rather than through perception.

The third criterion involves avoidance of stimuli associated with the trauma and numbing of general responsiveness, as determined by the presence of one or both of the following:

- Avoidance of thoughts, feelings, or conversations associated with the event
- Avoidance of people, places, or activities that may trigger recollections of the event

The fourth criterion comprises two or more of the following symptoms of negative alterations in cognitions and mood associated with the traumatic event(s):

- Inability to remember an important aspect of the event(s)
- Persistent and exaggerated negative beliefs about oneself, others, or the world
- Persistent, distorted cognitions about the cause or consequences of the event(s)
- Persistent negative emotional state
- Markedly diminished interest or participation in significant activities
- Feelings of detachment or estrangement from others
- Persistent inability to experience positive emotions

The fifth criterion is marked alterations in arousal and reactivity, as evidenced by two or more of the following:

- Irritable behavior and angry outbursts
- Reckless or self-destructive behavior
- Hypervigilance
- Exaggerated startle response
- Concentration problems
- Sleep disturbance

The remaining three criteria are as follows:

- The duration of symptoms is more than 1 month
- The disturbance causes clinically significant distress or impairment in functioning
- The disturbance is not attributable to the physiologic effects of a substance or other medical condition

PTSD Signs and Symptoms

PTSD can cause many symptoms. These symptoms may include:

Re-experiencing/intrusions

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- Bad dreams
- Frightening thoughts

Avoidance/numbing

- Staying away from places, events, or objects that are reminders of the experience
- Feeling emotionally numb
- Feeling strong guilt, depression, or worry
- Losing interest in activities that were enjoyable in the past
- Having trouble remembering the dangerous event
- Wanting to avoid thoughts about the trauma, including using alcohol or drugs

Increased arousal/vigilance

- Being easily startled
- Feeling tense or "on edge"
- Having difficulty falling or staying asleep
- Irritability or angry outbursts
- Difficulty concentrating

Other criteria for PTSD diagnosis

- Duration of at least one month
- Functional impairment (clinically significant)

It is natural to have some of these symptoms after a traumatic event occurs. Some people experience serious symptoms that go away after a few weeks. This is called acute stress disorder, or **ASD**, or acute stress response/reaction, or **ASR**. When the symptoms last more than a few weeks and become an ongoing problem, they might be PTSD. Some people with PTSD don't show any symptoms for weeks or months. (SCEPHTBI, 2013).

According to the DoD, health professionals must evaluate patients who experience a traumatic event for acute stress reaction in these four areas:

1. **Physical**: exhaustion, hyper-arousal, somatic complaints, or symptoms of conversion disorder

2. **Emotional**: anxiety, depression, guilt/hopelessness
3. **Cognitive**: amnestic or dissociative symptoms, hypervigilance, paranoia, intrusive re-experiencing
4. **Behavioral**: avoidance, problematic substance use

Healthcare providers can learn more about PTSD in Veterans at the National Center for PTSD.

Afterdeployment.org offers trainings for healthcare providers on the topic of PTSD and special populations, including PTSD and aging; African American, Hispanic, Asian-American and Pacific Islander Veterans; and cross-cultural considerations.

Risk Factors for Developing ASD and PTSD

Pre-traumatic factors

- Ongoing life stress
- Lack of social support
- Young age at time of trauma
- Pre-existing psychological conditions or substance misuse or family history of psychological conditions
- History of traumatic events or abuse
- History of PTSD

Peri-traumatic or trauma-related factors

- Severe trauma
- Physical injury to self or others
- High-risk trauma (eg, combat, killing another person, torture, rape, assault)
- High perceived threat to life of self or others
- Mass trauma
- History of peri-traumatic dissociation

Posttraumatic factors

- Ongoing life stress
- Lack of positive social support
- Bereavement or traumatic grief
- Major loss of resources

- Negative social support (blaming environment)
- Poor coping skills
- Distressed spouse or children

PTSD Treatment for Veterans

No matter where a Veteran lives, PTSD treatment is available through the Department of Veterans Affairs. Each medical center within the VA has PTSD specialists, and there are nearly 200 specialized PTSD treatment programs throughout the country. Twenty-nine medical centers have Women's Stress Disorder Treatment Teams (WSDTT) outpatient programs and six VA medical centers have inpatient Women's Trauma Recovery Programs (WTRPs). A program locator for specialized VA PTSD clinics is available online at https://www.va.gov/directory/guide/PTSD.asp. The VA also partners with mental health professionals in the community. Large community-based outpatient clinics offer PTSD care.

Did You Know. . .

If no nearby facilities exist, **telemental health** (using technology to communicate), or referral to Veterans centers or community clinicians, is appropriate.

PTSD programs involve education, evaluation, and treatment. Services for Veterans with PTSD include:

- One-to-one mental health assessment and testing
- Medications
- One-to-one psychotherapy and family therapy
- Group therapy (covers topics such as anger and stress, combat support, partners) or groups for Veterans of specific conflicts or specific traumas

The VA provides treatments shown by research to be effective in treating Veterans. Not all VAs offer the same programs, and some specialty programs require a referral. Healthcare providers can help patients decide which program is best for them.

The U.S. Department of Veterans Affairs and the National Center for PTSD urge Veterans to **seek treatment because it works**. The two main types of treatment are psychotherapy, often called counseling or therapy, and medication. Many patients use a combination of psychotherapy and medication. The following treatments are effective for Veterans with PTSD:

- Cognitive Behavioral Therapy (CBT) includes Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE).
  - CPT works by giving patients skills to handle distressing thoughts and memories that may leave them feeling stuck and unable to make sense of the trauma experienced. CPT helps patients come to terms with how the trauma changed the way they view themselves, the world, and others. By becoming aware of one's thoughts and feelings, and then changing the thoughts, one can change one's feelings.
  - PE involves repeated exposure to thoughts, feelings and situations that the patient has been avoiding. PE includes four parts: education, breathing retraining, real world practice (in vivo exposure), and talking through the trauma (imaginal exposure).
- Eye Movement Desensitization and Reprocessing (EMDR), which has four parts: identification of a target memory, image and belief about the trauma; desensitization and reprocessing; installing positive thoughts and images; and body scan to change how the patient reacts to memories of the trauma.
- Medications called selective serotonin reuptake inhibitors (SSRIs), which raise the level of serotonin in the brain to make the patient feel better.

Screening for PTSD

Nurses should ask patients about PTSD. The American Academy of Nursing recommends asking the following questions of patients who are Veterans or family members of Veterans:

- Have you ever experienced a traumatic or stressful event which caused you to believe your life or the lives of those around you were in danger?
- Are you experiencing trauma-related thoughts or feelings?
- Having nightmares, vivid memories or flashbacks of the event?
- Feeling anxious, jittery?
- Experiencing a sense of panic that something bad is about to happen?
- Having difficulty sleeping or concentrating? (ADAA, 2017)

Several self-report measures exist to help screen patients for PTSD. Among these are:

- Chart: Adult PTSD Self-Report Measures
- Davidson Trauma Scale (DTS)
- Mississippi Scale for Combat Related PTSD (M-PTSD)

- Modified PTSD Symptom Scale (MPSS-SR)
- Posttraumatic Diagnostic Scale (PDS)
- Screen for Posttraumatic Stress Symptoms (SPTSS)
- Trauma Symptom Checklist–40 (TSC-40) (NCPTSD, 2015)

Descriptions and reviews of these tools are available on the National Center for PTSD website. There is no single best PTSD measure. The correct tool depends on the goal; for example, a quick screen self-report measure might be best, or a longer interview that assesses for frequency and severity of symptoms might be appropriate.

PTSD and Comorbidities

One study has examined rates of mental health comorbidity in OEF/OIF Veterans with PTSD. In an analysis of VA records of Veterans who served after 9/11, Dedert and colleagues found that 44% of those diagnosed with PTSD had comorbid current depression and 53% had comorbid lifetime substance use disorders (Dedert et al., 2012).

PTSD and Military Families

Families of Veterans and military service members may be affected by their loved one's PTSD. Living with someone with PTSD can be difficult, especially if that person is experiencing symptoms such as being easily startled, having nightmares, and avoiding social situations. Veterans suffering from PTSD sometimes feel detached from others and avoid emotions. This can cause problems in their personal relationships with a spouse or children.

Family members of a Veteran with PTSD may experience the following:

- Sympathy for the loved one's suffering (be careful not to treat him or her as a permanently disabled person)
- Negative feelings about the ways in which the loved one has changed
- Avoidance of situations that cause reminders of the trauma
- Depression among family members because the PTSD causes feelings of pain or loss; family members may lose hope that the family will ever "return to normal."
- Anger and guilt because you cannot make a difference for your loved one; anger may also arise if the loved one is irritable, cannot work, or drinks too much.
- Health problems can arise if bad habits such as drinking, smoking, not exercising get worse while trying to cope with the family member's PTSD. (DVA, NCPTSD, 2015)

Healthcare providers should encourage family members to care for themselves, even if their family member with PTSD doesn't seek treatment, and learn more about trauma and its effects. Family members can encourage the trauma survivor to seek treatment, education, and counseling, but should not try to force the person to get help. Providers can recommend classes or treatment for stress, anger management, substance use and addiction, couples counseling, and parenting.

Veterans' families can call Coaching Into Care at 888 823 7458 or log on to http://www.mirecc.va.gov/coaching/. Coaching Into Care is a free and confidential coaching service to help callers discover ways to talk with a Veteran in their life about their concerns and treatment options.

Secondary Traumatic Stress

Secondary traumatic stress is the emotional reaction to the traumatic experience of a significant other, such as a family member who is a Veteran. Secondary traumatization is the stress caused by providing help, or wishing to help, and offering emotional support to a traumatized person. **Secondary stress disorder (SSD)** as a syndrome is almost identical to PTSD except that indirect exposure to the traumatic event through close contact with the primary victim of trauma becomes the cause of the traumatic stress. The symptoms of secondary traumatization include nightmares about the person who was directly traumatized, insomnia, loss of interest, irritability, chronic fatigue, and changes in self-perception, perception of one's own life, and of other people. Physical symptoms may also be present, including headaches, indigestion, susceptibility to infections, and increased use of alcohol, drugs, or tobacco (Frančišković et al., 2007).

Secondary traumatic stress is a common occupational hazard for healthcare professionals working with traumatized individuals. Healthcare professionals who work directly with traumatized people, and are in a position to hear the recounting of traumatic experiences, are at risk of secondary traumatic stress. The risk appears to be greater among women and among individuals who are highly empathetic by nature or who have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload, are socially or organizationally isolated, or feel professionally compromised due to inadequate training. Protective against the development of secondary traumatic stress are factors such as longer duration of professional experience and the use of evidence-based practices in the course of providing care (NCTSN, 2015).

Relationships and PTSD

People with PTSD often experience strained relationships, even with close family and friends. Symptoms of PTSD can cause problems with communication, closeness, trust, and problem solving, which may negatively impact how the trauma survivor relates to others. They may feel detached, tense, angry or worried, or feel numb and distant from loved ones. Interest in social activities or sex may diminish, which can impair the ability to be intimate. Trauma survivors may become tense and demanding, or exhibit a need to protect their loved ones. Sleep with a spouse or partner may be diminished.

Family members, friends, and partners of people with PTSD may feel abandoned, hurt, or cut off from the trauma survivor. They may become anxious, angry, distant, depressed, or controlled. Family members of those with PTSD can sometimes experience some of the same feelings as the person who has lived through the trauma. In turn, the response of family members to the trauma survivor can affect the person who experienced the trauma.

Certain types of trauma appear to have a more severe effect on relationships. These include combat, terrorism, torture, prisoner of war, rape, domestic violence, or childhood sexual and physical abuse. Key symptoms in PTSD from these traumas are feelings of terror, horror, danger, and betrayal.

Good relationships can be maintained by:

- Building a personal support network while working on family and friend relationships
- Sharing feelings openly and honestly, with respect and compassion
- Building problem solving and connecting skills
- Incorporating play, creativity, relaxation, and ways to enjoy others

Partners of Veterans with PTSD should seek information and education about the effects of PTSD on trauma survivors and their families, support groups for themselves and their Veterans, individual therapy for themselves and their Veterans, and couples or family counseling. The VA Caregiver website (http://www.caregiver.va.gov/) has resources for families and partners of Veterans with PTSD.

Military Sexual Trauma (MST)

According to Title 38 U.S. Code 1720D, **military sexual trauma (MST)** is defined as:

> psychological trauma resulting from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training. (DVA, 2016a)

Sexual harassment is defined as:

> repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character. (DVA, 2016a)

Military sexual trauma refers to both sexual harassment and sexual assault that occurs in military settings. Veterans of all ages and genders; all ranks, branches, and areas of service; all racial, ethnic, and religious backgrounds; all sexual orientations; and all physical sizes and strengths have experienced MST. The perpetrator can be the same or different gender.

Sexual harassment is unwelcome verbal or physical conduct of a sexual nature that occurs in the workplace or an academic or training setting. Sexual harassment can include unwanted sexual attention, such as offensive comments about a person's sexual activities or body, and sexual coercion (such as stated or implied special treatment if you were sexually cooperative).

Sexual assault is any sexual activity between at least two people in which one person is involved against his or her will. Physical force may or may not be used. The sexual activity can include many different experiences including unwanted touching, grabbing, oral sex, anal sex, sexual penetration with an object, and/or sexual intercourse (Street & Stafford, 2014).

MST is associated with increased prevalence of a wide range of mental health disorders, including posttraumatic stress disorder among both men and women.

Some common difficulties related to MST are:

- Strong emotions: intense, sudden emotional reactions; feeling depressed, angry or irritable; feeling ashamed or "damaged"
- Feelings of numbness: feeling emotionally "flat"; difficulty feeling emotions like love or happiness
- Trouble sleeping: trouble falling or staying asleep; disturbing dreams
- Difficulties with attention, concentration, and memory: trouble staying focused; having a hard time remembering things
- Self-doubt or questioning: blaming yourself; questioning parts of who you are, like your masculinity/femininity or sexual orientation
- Problems with alcohol or other substances: drinking or using substances or getting "high" to cope or escape
- Self-harm or unsafe behaviors: suicidal thoughts or behaviors; cutting; risk-taking; aggression

- Difficulty with things that remind them of their experiences of sexual trauma: feeling on edge or "jumpy"; difficulty feeling safe; avoiding reminders of MST
- Difficulties in relationships: feeling isolated or disconnected; difficulty trusting; unsafe relationships; trouble with authority figures; frequent arguments
- Sexual difficulties: concerns about sex drive; problems with arousal, enjoyment, performance, or pain during sex; avoidance of physical intimacy
- Physical health problems: chronic pain; weight or eating problems; digestive problems (DVA, 2017b)

According to one study, MST is reported by 20% to 40% of female Veterans, resulting in PTSD, depression, and sleep difficulty (Maguen et al., 2012). Of those reporting MST, 66.4% suffered from chronic pain associated with abuse-related trauma, physical health problems, and trouble sleeping. This is consistent with other research that found, among women with PTSD, 31% screen positive for MST with associated comorbid depression, anxiety, and eating disorder diagnoses (Maguen et al., 2012).

Military sexual trauma has negative impacts on Veterans' physical and psychological health. Medical conditions identified with increased frequency in patients with histories of sexual trauma include arthritis, obesity, diabetes, hypertension, hyperlipidemia, myocardial infarction, chronic lung disease, endometriosis, miscarriage, and infertility.

Psychological and behavioral problems are common in people who have experienced MST. Depression, PTSD, suicidal ideation and attempts, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and substance abuse and dependence are frequently seen in women.

One study suggests that American servicewomen who are sexually assaulted do not seek medical care right away. Fewer than one-third of more than 200 women who said they had been sexually assaulted while in the service sought care after the attack. Only four received both medical and mental healthcare within six months. Military women face concerns regarding confidentiality and their military careers. Other research shows that women in the military experience higher rates of sexual assault than non-military women (Dotinga, 2015a).

Men who have experienced MST are often reluctant to talk about their experience. They may feel alone, assuming that MST does not happen to other men. They may blame themselves or believe they should have been able to stop or prevent the trauma. They may also have had uncontrollable biological reactions during the MST, such as an erection or ejaculation. Such biological reactions do not mean the man wanted or enjoyed the MST. It also does not mean anything about his sexual orientation (DVA, 2015).

Screening for MST

> Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is national VHA policy that all Veterans seen in VA health care are screened for experiences of MST. This is an important way to make sure that Veterans are aware of VA's MST-related services.
>
> DVA, 2017b

The American Academy of Nurses recommends that nurses in the community healthcare setting use the following questions to screen quickly for military sexual trauma:

- During military service, did you receive uninvited or unwanted sexual attention, such as touching, pressure for sexual favors, or sexual remarks?
- Did anyone ever use force or threat of force to have sexual contact with you against your will?
- Did you report the incidents to your command and/or military or civilian authorities? (AAN, 2017)

The DVA independent study course on MST recommends that clinicians use language that describes specific behavior rather than jargon or emotionally loaded terms such as "rape," "sexual assault," "domestic violence," "sexual abuse," or "incest." Healthcare professionals should take a nonjudgmental stance, and avoid negative questioning ("You were never raped during your time in the service, were you?"). Rather, providers should use normalizing statements to help introduce the questioning, including the following examples:

> "Violence is common in our society, so I ask all my patients about this."
>
> "Many of my patients have had upsetting experiences in their lives that may still bother them today."
>
> "In response to increased awareness that many men and women have experienced sexual harassment or sexual assault during their military service, VA has launched a national effort to identify those Veterans who may be in need of services, so all Veterans are now being asked about certain experiences." (DVA, 2004)

Another approach to gather information is to give patients a trauma questionnaire.

Trauma Questionnaire for Military Personnel

Some people experience traumatic events during their military service. We are trying to find out about these events and how they affect Veterans' lives. We also want to find out if Veterans want mental health help addressing these or other concerns. To answer a question, please check yes, no, or don't know. Thank you for your time.

	Yes	No	Don't know
Have you ever been involved in an major accident or disaster?			
Have you ever been physically assaulted or been a victim of a violent crime?			
At any time, has a spouse or partner (significant other) ever threatened to physically hurt you in any way?			
At any time, has a spouse or partner (significant other) ever hit you, kicked you, or physically hurt you in any way?			
Did this happen to you while you were in the military?			
Have you ever received uninvited and unwanted sexual attention (eg, touching or cornering, pressure for sexual favors, verbal remarks)?			
Did this happen to you while you were in the military?			
Has anyone ever used force or the threat of force to have sex with you against your will?			
Did this happen to you while you were in the military?			
Were you ever sexually assaulted or touched in a sexual way, by a person 5 or more years older than you, when you were younger than 13?			
Would you like to talk to a mental health worker about any of the above problems?			
Do you have any mental health questions or concerns that are not on this questionnaire?			

Would you like to talk to a mental health worker about these other problems?

Source: DVA, 2004.

Unique Aspects of MST

Further investigation into the topic of military sexual trauma is needed. However anecdotal evidence suggests that some aspects of MST are unique and may be associated with qualitatively or quantitatively different outcomes than civilian sexual trauma (Street & Stafford, 2014).

For example, MST typically happens in a setting where the victim lives and works. Therefore, the victim often must continue to live and work closely with the perpetrator(s). Victims may experience increased feelings of helplessness and powerlessness, as well as feelings of being continually at risk. Sometimes victims must rely on their perpetrators to provide for basic needs.

Another aspect of MST is that, because the trauma occurs in the workplace, it can disrupt the victims' career goals. Perpetrators may be peers or supervisors who make work-related performance evaluations and promotions. Victims may be forced to choose to continue their military careers where they have frequent contact with their perpetrators, or to sacrifice their career to protect themselves from further abuse. Furthermore, the high unit cohesion in the military, especially during combat, may play a negative role in the psychological effects associated with sexual harassment and assault. Victims may be reluctant to report any negative behavior of a fellow service member because it may affect their relationships with co-workers and peers (Street & Stafford, 2014).

Results of MST

Intensity, duration, and trajectory of psychological responses vary depending on the victim's previous trauma history, their thoughts about the event, and the quality of their support systems. Gender may also play a key role. Military sexual trauma may be even more stigmatizing for men than for women because the victimization falls outside the proscribed male gender role. These men may feel more shame about the event and be less likely to seek professional help.

For both men and women who have experienced MST, outcomes include poorer psychological well-being, more physical problems, and lower satisfaction with health and work. Victims have readjustment problems following discharge and a higher incidence of not working due to mental health problems.

Studies show that posttraumatic stress disorder is a frequent outcome in civilian sexual assault. Major depressive disorder (MDD) is another common outcome, as is increased substance use. Feelings of anger, shame, guilt, or self-blame are common. Victims of MST report problems in their interpersonal relationships, such as difficulty with trust, social activities, or sexual dysfunction. Male victims worry about their sexuality or their masculinity (Street & Stafford, 2014).Veterans who have experienced MST have access to a wide range of services at the VA, free of charge. A VA MST Coordinator serves as a contact person for MST-related issues at the facility and can help Veterans access services and programs.

Approximately 1 in 4 women and 1 in 100 men seen at the VA report a history of MST when screened by a VA provider. Given the far greater number of men in military service, this means there are significant numbers of both men and women who have experienced MST. In fact, over 40% of the Veterans seen in VA who disclose MST are men (DVA, 2017b).

Suicide Among Veterans

Suicide is a serious public health problem that has shattered the lives of millions of people, families, and communities nationwide. Centers for Disease Control and Prevention (CDC) data released in an April 2016 report indicated that between 1999 and 2014, suicide rates increased among the general population, for both males and females and for all ages.

Healthcare providers are in a unique position to identify individuals at risk for suicide and act to deliver care. However, everyone can help prevent suicide by being aware of the warning signs of suicidal behaviors. Here are some facts about suicide:

- Suicide is the tenth leading cause of death in the United States, claiming more than twice as many lives each year as homicides.
- On average, more than 33,000 Americans died each year between 2001 and 2009 as a result of suicide—more than 1 person every 15 minutes.
- In 2007 suicide rates were significantly elevated across all branches of the military. History of deployment to combat was associated with increased suicides in the Army in 2005 and in all services in 2007. (SAMHSA, 2012)
- In 2014, Veterans accounted for 18% of all deaths from suicide among U.S. adults, while Veterans constituted 8.5% of the U.S. population. In 2010, Veterans accounted for 22% of all deaths from suicide and 9.7% of the population. (DVA, 2016b)
- It is estimated that 20 Veterans died of suicide each day in 2014. Of those, 14 were not users of VA services. (VHA, 2014)

- In 2010 nearly 300 service members committed suicide; about half of these were people who had deployed to Iraq or Afghanistan. (IOM, 2013)
- The rate of suicide among female VHA users has increased 18.9 per 100,000, compared to 7.2 per 100,000 for females in the civilian population, or 2.4 times higher. (VHA, 2014)
- Approximately 66% of all Veteran deaths from suicide were the result of firearm injuries. (DVA, 2016b)
- There is continued evidence of high burden of suicide among middle-aged and older adult Veterans. In 2014, approximately 65% of all Veterans who died from suicide were aged 50 years or older. (DVA, 2016b)
- After adjusting for differences in age and gender, risk for suicide was 21% higher among Veterans when compared to U.S. civilian adults. (VHA, 2014; DVA, 2016b)
- After adjusting for differences in age, risk for suicide was 18% higher among male Veterans when compared to U.S. civilian adult males. (VHA, 2014; DVA, 2016b)

Members of the Armed Forces and Veterans of military service are among the populations at increased risk of suicide, along with individuals who have mental and/or substance use disorders; individuals bereaved by suicide; individuals in justice and child welfare settings; individuals who engage in non-suicidal self-injury; individuals who have attempted suicide; individuals with medical conditions; individuals who are lesbian, gay, bisexual, or transgender (LGBT); American Indians/Alaska Natives; men in midlife; and older men (SAMHSA, 2012).

It is easy to understand how many military personnel and Veterans may belong to more than one of these at-risk populations. A study published in 2015 looked at changes in suicide mortality of Veterans and nonVeterans by gender and history of VHA service use. It found that suicides among women Veterans increased by 40% from 2000 to 2010, compared to a 13% increase in women non-Veterans. The study also showed that among women Veterans, those who use VA care have suicide rates as much as 75% lower than those who do not. Male Veterans also saw reduction in suicide rates, about 20%, for those who used VHA services (Hoffmire et al., 2015).

The VA believes every Veteran suicide is a tragic outcome: one Veteran suicide is one too many. Throughout VA the message is “Suicide Prevention Is Everyone’s Responsibility.” In recent years the Department of Defense, VA, and HHS have strengthened their partnership to build on their suicide prevention efforts using evidence-based and best practices in the clinical and public health arenas (DVA, 2016).

Substantial, coordinated efforts to expand suicide prevention include:

- Suicide Data Repository stores all mortality-related information including suicide-related data for service members and Veterans to support researchers and decision makers.
- Veterans Crisis Line answered 2.3 million calls and made more than 289,000 chat connections and more than 55,000 texts between 2007 and May 2016.
- Suicide Safe, a suicide prevention app for mobile devices from SAMHSA launched in 2016, helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients. Based on SAMHSA's Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card, the app has been downloaded 34,000 times in the first year.
- Outreach programs and campaigns to prevent suicide include Military OneSource (confidential, face-to-face, online, telephone, and video non-medical counseling and specialty consultation), and "Power of One" Suicide Prevention Campaign promotes the message that one person, one conversation, or one small act has the power to help prevent suicide. (DOD/DVA/DHHS, 2016)

U.S. National Suicide Prevention Lifeline

The number for the suicide prevention lifeline is

800 273 TALK (8255)

Healthcare providers should consult the Suicide Risk Guidelines published by the VA/DoD and available at

www.healthquality.va.gov/guidelines

A convenient pocket guide helps in the assessment and management of patients at risk for suicide.

Suicide Risk Guidelines

The VA and Department of Defense published *Clinical Practice Guidelines for Patients at Risk for Suicide* in a pocket guide format. Key elements of the suicide risk guidelines include:

Assessment and determination of risk

- Identify warning signs for suicide
- Assess for suicidal ideation, intent, and behavior
- Assess risk and protective factors affecting suicide risk

- Evaluate patients at intermediate and high risk for suicide by behavioral health providers

Initial management of patient at risk for suicide

- Determine level of risk for suicide attempt
- Determine appropriate care setting
- Educate patient and family on risk and treatment options
- Limit access to lethal means
- Establish a safety plan

Treatment of a patient at high risk for suicide

- Interventions addressing the suicide risk:
  - Suicide-focused psychotherapies shown to be effective in reducing the risk for repeated self-directed violence:
    - Cognitive therapy for suicide prevention (CT-SP)
    - Problem-solving therapy (PST) addressing the risk for suicide behaviors
- Interventions addressing the underlying conditions:
  - Optimize treatment for any mental health and medical conditions that may be related to the risk of suicide
  - Modify care for the relevant condition-focused treatments
  - to address the risk of suicide
  - Provide psychotherapy/pharmacotherapy interventions for co-occurring mental disorders to reduce the risk of suicide (DVA/DoD, 2013a)

Recognizing Signs of Suicidal Behavior

Many Veterans may not show any signs of intent to harm themselves before doing so, but some actions can be a sign that a Veteran needs help. Veterans in crisis may show behaviors that indicate a risk of harming themselves.

Veterans who are considering suicide often show signs of depression, anxiety, low self-esteem, and/or hopelessness, such as:

- Appearing sad or depressed most of the time
- Clinical depression: deep sadness, loss of interest, trouble sleeping and eating—that doesn’t go away or continues to get worse
- Feeling anxious, agitated, or unable to sleep

- Neglecting personal welfare, deteriorating physical appearance
- Withdrawing from friends, family, and society, or sleeping all the time
- Losing interest in hobbies, work, school, or other things one used to care about
- Frequent and dramatic mood changes
- Expressing feelings of excessive guilt or shame
- Feelings of failure or decreased performance
- Feeling that life is not worth living, having no sense of purpose in life
- Talk about feeling trapped—like there is no way out of a situation
- Having feelings of desperation, and saying that there's no solution to their problems

Their behavior may be dramatically different from their normal behavior, or they may appear to be actively contemplating or preparing for a suicidal act through behaviors such as:

- Performing poorly at work or school
- Acting recklessly or engaging in risky activities—seemingly without thinking
- Showing violent behavior such as punching holes in walls, getting into fights or self-destructive violence; feeling rage or uncontrolled anger or seeking revenge
- Looking as though one has a "death wish," tempting fate by taking risks that could lead to death, such as driving fast or running red lights
- Giving away prized possessions
- Putting affairs in order, tying up loose ends, and/or making out a will
- Seeking access to firearms, pills, or other means of harming oneself

Veterans' Self-check Quiz

The Department of Veterans Affairs and the National Suicide Prevention Lifeline have joined with the American Foundation for Suicide Prevention to create the Veterans Self-Check Quiz. This is a safe, easy way to learn whether stress and depression might be affecting you. Using this service is completely voluntary and confidential. The Self-Check Quiz is available at

www.vetselfcheck.org

Suicide Warning Signs

Warning signs are observations that signal an increase in the probability that a person intends to engage in suicidal behavior in the immediate future (minutes to days). Warning signs present tangible evidence to the clinician that a person is at heightened risk for suicide in the short term. **Warning signs may be experienced in the absence of risk factors.**

Direct and Indirect Warning Signs of Suicidal Behavior

Direct warning signs portend the highest likelihood of suicidal behaviors occurring in the near future.

Suicidal communication	Writing or talking about suicide, wish to die, or death (threatening to hurt or kill self) or intention to act on those ideas
Preparations for suicide	Evidence or expression of suicide intent, and/or taking steps towards implementation of a plan. Makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.
Seeking access or recent use of lethal means	Owning or planning to acquire weapons, medications, toxins, or other lethal means.

Indirect warning signs are presentations or behavioral expressions that may indicate increased suicide risk and urgency in a patient at risk for suicide.

Substance abuse	Increasing or excessive substance use (alcohol, drugs, smoking)
Hopelessness	Expresses feeling that nothing can be done to improve the situation
Purposelessness	Express no sense of purpose, no reason for living, decreased self-esteem
Anger	Rage, seeking revenge
Recklessness	Engaging impulsively in risky behavior
Feeling Trapped	Expressing feelings of being trapped with no way out
Social Withdrawal	Withdrawing from family, friends, society
Anxiety	Agitation, irritability, angry outbursts, feeling like wants to "jump out of my skin"
Mood Changes	Dramatic changes in mood, lack of interest in usual activities/friends
Sleep	Insomnia, unable to sleep or sleeping all the time

Direct and Indirect Warning Signs of Suicidal Behavior	
Guilt or Shame	Expressing overwhelming self-blame or remorse

Source: VA/DoD, 2013b.

Risk Factors for Suicide

Providers must be on the lookout for both acute risk factors and chronic risk factors for suicide. **Acute risk factors** include acute (of brief duration) and stressful episodes, illnesses, or life events. While not usually internally derived, these events can build upon and challenge a person's coping skills. **Chronic risk factors** are pre-existing and include relatively enduring or stable factors that may increase a person's susceptibility to suicidal behaviors, such as genetic and neurobiologic factors, gender, personality, culture, socioeconomic background and level of isolation.

Psychological factors

- Suicide of relative, someone famous, or a peer
- Suicide bereavement
- Loss of loved one (grief)
- Loss of relationship (divorce, separation)
- Loss of status/respect/rank (public humiliation, being bullied or abused, failure work/task)

Social factors

- Stressful life events (acute experiences)
  - Breakups and other threats to prized relationships
  - Other events (eg, fired, arrested, evicted, assaulted)
- Chronic stressors (ongoing difficulties)
- Financial problems
  - Unemployment, underemployment
  - Unstable housing, homeless
  - Excessive debt, poor finances (foreclosure, alimony, child support)
- Legal problems (difficulties)
  - DUI/DWI, lawsuit, criminal offense and incarceration
- Social support
  - Poor interpersonal relationship (partner, parents, children)

- Geographic isolation from support
- Recent change in level of care (discharge from inpatient psychiatry)

Mental disorders

- Mood or affective disorder (major depression, bipolar, postpartum)
- Personality disorder (especially borderline and antisocial)
- Schizophrenia
- Anxiety (PTSD, panic)
- Eating disorder
- Sleep disturbance or disorder
- Trauma (psychological)

Medical conditions

- History of traumatic brain injury
- Terminal disease
- HIV/AIDS
- New diagnosis of major illness
- Having a medical condition
- Intoxication
- Substance withdrawal (alcohol, opiates, cocaine, amphetamines)
- Use of prescribed medication w/ warning for increased risk of suicide
- Physical symptoms
  - Chronic pain
  - Insomnia
  - Function limitation

Military specific

- Disciplinary actions (UCMJ, NJP)
- Reduction in rank
- Career-threatening change in fitness for duty
- Perceived sense of injustice or betrayal (unit/command)
- Command/leadership stress, isolation from unit
- Transferring duty station (PCS)

- Administrative separation from service/unit
- Adverse deployment experience
- Deployment to a combat theater

Pre-existing and non-modifiable

- Age (young, elderly)
- Gender (male)
- Race (white)
- Marital status (divorce, separate, widowed)
- Family history of:
  - Suicide/attempt
  - Mental illness (including SUD)
  - Child maltreatment trauma, physical/psychological/sexual
  - Sexual trauma
- Lower education level
- Same-sex orientation (LGBT)
- Cultural or religious beliefs (VA/DoD, 2013)

Protective Factors Against Suicide

Social context support system

- Strong interpersonal bonds to family/unit members and community support
- Employed
- Intact marriage
- Child rearing responsibilities
- Responsibilities/duties to others
- A reasonably safe and stable environment

Positive personal traits

- Help seeking
- Good impulse control
- Good skills in problem solving, coping and conflict resolution
- Sense of belonging, sense of identity, and good self-esteem
- Cultural, spiritual, and religious beliefs about the meaning and value of life

- Optimistic outlook—Identification of future goals
- Constructive use of leisure time (enjoyable activities)
- Resilience

Access to healthcare

- Support through ongoing medical and mental healthcare relationships
- Effective clinical care for mental, physical and substance use disorders
- Good treatment engagement and a sense of the importance of health and wellness (VA/DoD, 2013)

Suicide and Sexual Assault

Sexual assault and suicide are important concerns among both military and civilian populations. There are few published studies on the association between sexual assault and suicidal ideation, attempts, or death by suicide in American military populations.

According to a white paper published by the Military Suicide Research Consortium, research in civilian populations has provided evidence that sexual assault is associated with increased risk for suicidal ideation, attempts, and death by suicide. Much of this research has been conducted on women and has found that being sexually assaulted as an adult is significantly associated with higher rates of suicidal ideation and attempts.

Sexual assault also has been found to increase the risk for death by suicide by as much as 14 times for female victims compared to women who have never been assaulted, even after controlling for psychiatric diagnoses present prior to the assault. There is some evidence that civilian male sexual assault victims are at higher risk of suicide compared to those who have never been assaulted, and that they may have adverse mental health responses to sexual assault similar to civilian women (MSRC, 2012).

Sexual assault is also commonly associated with adverse mental health outcomes such as depression, anxiety, substance abuse, and non-suicidal self-injury, which are also commonly associated with suicidal ideation, attempts, and death by suicide (MSRC, 2012).

Veterans Crisis Line

The responders at the Veterans Crisis Line are specially trained and experienced in helping Veterans of all ages and circumstances—from Veterans coping with mental health issues that were never addressed to recent Veterans struggling with relationships or the transition back to civilian life. Veterans Crisis Line responders provide support when these and other issues—such as chronic pain, anxiety, depression, sleeplessness, anger, and even homelessness—reach a crisis point. Some of the responders are Veterans themselves and understand what Veterans and their families and friends have been through.

Confidential Help for Veterans and Their Families

The Veterans Crisis Line is a toll-free, confidential resource that connects Veterans in crisis and their families and friends with qualified, caring U.S. Department of Veterans Affairs (VA) responders.

Veterans and their loved ones can

- Call 800 273 8255 and Press 1
- Chat online at VeteransCrisisLine.net
- Send a text message to 838255

to receive free, confidential support 24 hours a day, 7 days a week, 365 days a year, even if not registered with VA or enrolled in VA healthcare.

Between its launch in 2007 and May 2016, the Veterans Crisis Line answered more than 2.3 million calls. In 2009 the Veterans Crisis Line added an anonymous online chat service and has engaged in more than 289,000 chats. In November 2011 the Veterans Crisis Line introduced a text-messaging service to provide another way for Veterans to connect with confidential, round-the-clock support, and since then has responded to more than 55,000 texts. The service has initiated the dispatch of emergency services to callers in imminent suicidal crisis over 61,000 times and provided over 376,000 referrals to a VA Suicide Prevention Coordinator (SPC), thus ensuring Veterans are connected to local care. In 2011 the National Veterans Suicide Prevention Hotline was renamed the Veterans Crisis Line to encourage Veterans and their families and friends, who may be the first to realize a Veteran is in emotional distress, to reach out for support when issues reach a crisis point, even if it is not a suicidal crisis.

VA is working to make sure that all Veterans and their loved ones are aware of the Veterans Crisis Line. To reach as many Veterans as possible, VA is coordinating with communities and partner groups nationwide, including community-based organizations, Veterans service organizations, and local healthcare providers, to let Veterans and their loved ones know that support is available whenever, if ever, they need it.

Depression

Major depressive disorder (MDD), or depression, is a persistent medical illness that manifests as sadness that doesn't resolve within a few days. People with depression feel discouraged, sad, hopeless, unmotivated, and disinterested in life. If such feelings persist for two weeks or more, or when the feelings interfere with daily activities such as going to work, taking care of family, or spending time with people, it is likely to be a major depressive episode, or major depressive disorder (ADAA, 2015).

Depression affects how an individual functions, behaves, feels, and thinks. Some describe it as a total loss of energy or enthusiasm to do anything. Others describe depression as living with a constant feeling of impending doom. Depression can cause a variety of emotional and physical problems. However MDD is a treatable chronic illness.

Symptoms of Depression

A major depressive episode (MDE) may include these symptoms:

- Persistent sad, anxious or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities, including sex
- Decreased energy, fatigue, feeling "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Low appetite and weight loss or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and pain for which no other cause can be diagnosed.

Major depressive episodes may happen once or twice in a person's life, or may recur frequently. Some people with depression may decide that life is too painful to go on living and attempt suicide.

Persistent Depressive Disorder (PDD)

Also called *dysthymic disorder*, or *dysthymia*, **persistent depressive disorder (PDD)** is characterized by long-term (2 years or longer) symptoms that may not be severe enough to disable a person but can prevent normal functioning or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes (NIMH, 2011).

Comorbidities

Major depression among soldiers and Veterans often occurs with other physical and behavioral health issues, including TBI, PTSD, and anxiety. As such, depression can complicate detection of and treatment for other physical or behavioral health issues that coincide with it. Both diagnosed and undiagnosed depression can increase the risk associated with other at-risk outcomes such as suicide and partner aggression (Army Gold Book, 2012).

Those among the U.S. population ". . . with lifelong history of major depression, were 10 times as likely to report having thoughts of suicide." Additionally, in one study the "presence of depressive symptoms was positively associated with the presence and severity of domestic violence. . . . For each 20% increase in depressive symptoms, there was a 74% increase in the likelihood of husband-to-wife aggression"; this positive correlation was also found among Vietnam Veterans (Army Gold Book, 2012).

Substance abuse has also been linked to depression and PTSD. One study found that individuals suffering from depression were twice as likely to have a co-occurring substance use disorder. The same study reported that 20% to 67% of the people who sought alcohol treatment had experienced depression.

Substance use may initially minimize or moderate the mood disorder symptoms, but withdrawal and chronic abuse typically exacerbate mood degradation, leading to abuse and dependence. Given the association of alcohol and drug use with mood disorders and particularly depression, soldiers and Veterans being treated for either substance use disorder or major depressive disorder should be evaluated for the other (Army Gold Book, 2012).

Screening for Depression

The **PHQ-9** is the most commonly used screening tool to identify depression. It is a ten-question self-screening interview available at https://www.myhealth.va.gov. Veterans and family members can answer the questions to evaluate the last two weeks and determine their need for diagnosis and treatment.

Treatment for Depression

A variety of medications and therapies are available to treat depression. Antidepressant medications help to stabilize mood. Psychotherapy can help people manage their symptoms. Often a combination of the two is the most effective treatment.

Medications to treat depression are known as *antidepressants*. They work by affecting neurotransmitters in the brain, especially serotonin and norepinephrine. There are several classes of antidepressants, including selective serotonin reuptake inhibitors (SSRIs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclic antidepressants, and monoamine oxidase inhibitors (MAOIs). The medications that are included in these classes are numerous and each has different side effects. It is common for people with depression to need to try different medications to find one that relieves their depression and has tolerable side effects (SAMHSA, 2015).

Cognitive Behavior Therapy (CBT) blends cognitive therapy and behavioral therapy. By focusing on a person's thoughts and beliefs, and how they influence feelings, mood, and actions, CBT works to change the depressed person's thinking to be more healthy. The therapist encourages the patient to identify negative self-talk and distorted thoughts, change inaccurate beliefs, do more enjoyable activities, relate in more positive ways to self and others, learn problem-solving and coping skills, and change behaviors (MIRECC, 2011).

Assertive Community Treatment (ACT) is an effective approach for individuals who are in the greatest need, such as those who have been hospitalized more than once. In ACT, and interdisciplinary team of professionals, such as case managers, a psychiatrist, nurses, and social workers, substance abuse treatment specialists, and others, provide care and coverage 24 hours, 7 days per week. Treatment includes crisis intervention, medication management, individual therapy, substance abuse treatment, rehabilitation, and peer support (MIRECC, 2011).

Electroconvulsive Therapy (ECT) is a treatment procedure for severe or life-threatening depression. It is used when antidepressants and psychotherapy have not worked. The patient's brain is stimulated by electrical currents via electrodes placed on the head. It is believed that ECT works to alleviate depression by altering neurochemicals including serotonin and endorphins. ECT is usually provided along with medication, psychotherapy, family therapy, and behavioral therapy (MIRECC, 2011).

Depression's Effect on Family Members

Depression, as with all mental illness, affects family members as well as the person feeling depressed. Treating families can help the person with depression as well as his or her loved ones. Family psycho-education is a way to work toward recovery. A clinician meets with the family to discuss the problems they are having. Family members then attend educational sessions to learn about mental illness, coping skills, problem-solving skills, communication skills, and other ways they can work together toward recovery (MIRECC, 2011).

Family members can help their loved one with depression by encouraging the person to get treatment and providing support in following through with medication adherence and attendance of psychotherapy sessions. They can provide support by listening sympathetically to their loved one's feelings, remembering the person is in pain, and being understanding and not critical (MIRECC, 2011).

It is important for family members to understand that depression is an illness, not a moral weakness or deficiency. Research shows that family members who believe that depression is a medical illness are less critical of their depressed loved one and have greater feelings of warmth, sympathy, and willingness to help (MIRECC, 2011).

Did You Know. . .

> There is a strong relationship between critical and hostile attitudes on the part of family members and relapse among people who are depressed (MIRECC, 2011).

Family members of Veterans who have depression must remember to take care of themselves. They are not responsible for solving the problem of depression themselves.

Grief

Veterans reintegrating into civilian life after their military service frequently experience grief over the loss of friends and comrades. If the death was sudden or violent, as from combat or disaster, it can be even more distressing. Experiencing grief often involves the following emotions: denial, disbelief, confusion, shock, sadness, yearning, anger, humiliation, despair, and guilt. Acute grief is often experienced as physical symptoms, including stomach pain, loss of appetite, intestinal upsets, sleep disturbances, and loss of energy. Illnesses may worsen and new conditions may develop. Emotions brought on by grief can result in anxiety attacks, chronic fatigue, depression, and suicidal thoughts (MHA, 2015).

Veterans and Families Experiencing Grief

When a friend or loved one dies we must allow time to grieve. There are many ways to cope effectively. Mental Health America recommends these coping tactics.

- Seek out caring people. Tell relatives and friends how you feel; it will help you to work through the grieving process. Join a support group with others who have experienced similar losses and understand how you feel. Most military installations have support groups. Ask for help if you feel overwhelmed; it's not a sign of weakness. Seek out companionship; do not become isolated. Talk about your feelings with a trusted relative, friend, family services staffer, minister or rabbi. Military chaplains can be helpful, as most receive training in pastoral counseling and crisis.
- Take care of your health. Eat properly, exercise, and get plenty of rest. Be aware of the danger of using medication or alcohol to deal with your grief. See your doctor regularly.
- Be patient. Absorbing a loss takes effort and time. You must accept that your life has changed and strive to live in the present and not dwell on the past.
- Seek help. If your feelings become too much to bear, seek professional assistance to work through your grief. It's a sign of strength, not weakness, to seek help.

Helping Others Grieve

If someone you care about has lost a loved one, you can help him or her through the grieving process.

- Listen. Encourage the person to talk about his or her feelings and to share memories of the deceased. Remember, it may take the person a long time to recover from the loss.
- Don't offer false comfort. It doesn't help the grieving person to say "You'll get over it in time." Instead, offer a simple expression of sorrow and take time to listen.

- Offer practical help. You can help someone who is grieving by babysitting, cooking, and running errands.
- Encourage professional help when needed. Recommend professional help if you feel someone is experiencing too much pain to cope alone.

Tragedy Assistance Program for Survivors assists people who have lost family members in the Armed Forces. TAPS provides a survivor-peer support network, grief counseling referrals, and crisis information. TAPS can be reached at 800 959 TAPS (8277) or www.taps.org.

Substance Abuse

Substance use and abuse is a significant problem in the United States. It affects people of every race, ethnicity, gender, and location. Substance use disorder is to be suspected when using drugs or alcohol continues despite its causing physical, psychological, and emotional pain.

- 60.1 million aged 12 or older were current (past month) binge drinkers.
- 24.6 million aged 12 or older were current users of illicit drugs.
- 19.8 million aged 12 and older were current users of marijuana. (SAMSHA, 2014)

According to the DVA, about 20% of Iraq and Afghanistan Veterans come home with posttraumatic stress disorder, and more than 20% of Veterans diagnosed with PTSD also suffer from substance use disorder. A study of VA healthcare users reports that more than 11% of OEF and OIF Veterans have been diagnosed with a substance use disorder (SUD)—an alcohol use disorder, a drug use disorder, or both. In addition, the data available for alcohol use show that some Veterans use alcohol to self-medicate. VA data show that almost 22% of OEF and OIF Veterans with posttraumatic stress disorder (PTSD) also have an SUD (SAMHSA, 2012a).

Furthermore, a 2013 study by Golub and colleagues, published in *Military Medicine* using data from the 2004 to 2010 National Survey on Drug Use and Health, examined the prevalence of unmet mental health needs among Veterans aged 21 to 34. Researchers found that 16% of Veterans in the general population had an untreated substance use disorder (Golub et al., 2013). Veterans may turn to drugs and alcohol as a way to cope with trauma they have experienced during their military service.

SBIRT

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a public health approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders. Health professionals in community settings can provide early intervention for people at risk before more serious consequences can occur. According to SAMHSA, SBIRT involves the following:

- **Screening** quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- **Brief intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- **Referral to treatment** provides those identified as needing more extensive treatment with access to specialty care. (SAMHSA, 2017)

Screening

Screening is incorporated into the normal routine in medical and community settings to identify individuals with problems related to alcohol and substance use. Adults are screened using tools such as ASSIST, AUDIT, and DAST. After the screening, the healthcare provider determines whether the patient receives brief intervention, brief treatment, or referral to a behavioral health clinician for more intensive treatment (SAMHSA/HSRA, n.d.).

From the Alcohol Use Disorders Identification Test (AUDIT):

1. How often do you have a drink containing alcohol?
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
3. How often do you have six or more drinks on one occasion?
4. How often during the last year have you found that you were not able to stop drinking once you had started?
5. How often during the last year have you failed to do what was normally expected from you because of drinking?
6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
8. How often during the last year have you had a feeling of guilt or remorse after drinking?
9. Have you or someone else been injured as a result of your drinking?

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down? (WHO, 1982)

Brief Intervention

After a screening test indicates moderate risk, healthcare providers should provide brief intervention, which includes motivational discussion to raise the person's awareness of their substance use and its consequences, to motivate them toward behavioral change. Healthcare professionals should also provide support for the client's empowerment toward making a behavioral change (SAMHSA/HSRA, n.d.).

(Brief) Treatment

After a result of moderate to high risk, brief treatment including motivational discussion and client empowerment. It also includes assessment, education, problem solving, coping mechanisms, and building a supportive social environment (SAMHSA/HSRA, n.d.).

Referral to Treatment

If the screening finds severe use or dependence, the healthcare provider should make a referral to treatment that facilitates access to more extensive care (SAMHSA/HSRA, n.d.).

Definition of Drinking Levels

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines drinking levels as follows.

Low Risk for Developing an Alcohol Use Disorder (AUD)

As defined by NIAAA, for women, low-risk drinking is no more than 3 drinks on any single day and no more than 7 drinks per week. For men, it is defined as no more than 4 drinks on any single day and no more than 14 drinks per week. NIAAA research shows that only about 2 in 100 people who drink within these limits have an AUD. Even within these limits, people can have problems if they drink too quickly or have other health issues (NIAAA, 2015).

Moderate Alcohol Consumption

According to the Dietary Guidelines for Americans, moderate drinking is up to 1 drink per day for women and up to 2 drinks per day for men.

Binge Drinking

NIAAA defines binge drinking as a pattern of drinking that brings blood alcohol concentration (BAC) levels to 0.08 g/dL. This typically occurs after 4 drinks for women and 5 drinks for men—in about 2 hours.

The Substance Abuse and Mental Health Services Administration (SAMHSA), which conducts the annual National Survey on Drug Use and Health (NSDUH), defines binge drinking as drinking 5 or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days.

Heavy Drinking

SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

Substance Abuse and Its Effects on Families

Substance use disorder is called a family disorder because it affects the entire family and close friends, even if only one family member has it. Health problems, marital problems, emotional abuse or violence, legal problems, financial problems, and effects on children are significant stressors caused by substance abuse by Veterans. Divorce is 7 times more likely in families who have a family member with a substance use disorder. Substance use can lead to financial problems such as job loss, unpaid bills, loss of money spent on substances, and legal problems such as DUI and other crime.

Children whose parents abuse drugs or alcohol experience increased risk for:

- Substance use (they are four times more likely to develop a substance use disorder)
- Behavior problems, including frustration and an increased risk of aggression and crime
- Academic problems, such as learning difficulties, poor concentration, and disruptiveness
- Emotional problems, such as anger, poor self-esteem, withdrawal, and sadness

Family members of Veterans with substance use disorders should be reminded that the problem is not their fault. They did not cause the disorder and they cannot make it stop. Action steps that family members can take are:

1. Ask for help; be open about the problem.
2. Get help for their loved one.
3. Find out about treatment options; many treatments for addiction work.
4. Talk with children about what is happening and help them with their fears and feelings.

Providers can find more information about substance use disorder and recovery online at the SAMSHA store: https://store.samhsa.gov/.

Intimate Partner Violence and Child Maltreatment

Military and Veteran families experience family violence. "The Army has experienced a dramatic increase in domestic violence/child abuse referrals to the Family Advocacy Program (FAP), which reflects a dramatic increase in leader surveillance, detection, and response to potential domestic abuse offenses. Total referral numbers for soldier offenders of domestic violence increased by 50% while child abuse referrals increased by 62% from FY2008–2011" (Army Gold Book, 2012).

Research has found that the "presence of depressive symptoms was positively associated with the presence and severity of domestic violence. . . . For each 20% increase in depressive symptoms, there was a 74% increase in the likelihood of husband-to-wife aggression" (Army Gold Book, 2012). Co-occurring PTSD, depression, and substance use disorder factor into intimate partner violence.

Intimate Partner Violence (IPV)

Intimate partner violence (IPV), commonly known as *domestic abuse*, is a repetitive pattern of behaviors to maintain power and control over an intimate partner. These are behaviors that physically harm, arouse fear, prevent partners from doing what they wish, or force them to behave in ways they do not want. Abuse includes the use of physical and sexual violence, threats and intimidation, emotional abuse, and economic deprivation. Many of these forms of abuse can be going on simultaneously (http://www.thehotline.org/is-this-abuse/abuse-defined/).

Victims of IPV are often afraid to get help. They may love their abusive partner, want to remain in the relationship, and hope that the abuse will stop. They may feel shame for tolerating abuse and may fear losing financial support provided by the abuser. They may also fear that seeking help or reporting the abuse will lead to a loss of benefits or damage to their partner's career.

A 2005 review of literature on the prevalence, consequences, correlates, and treatment of IPV perpetration among military Veterans and active duty servicemen by Marshall and colleagues (2005) found that the rate of intimate partner violence across active duty and Veteran populations ranged from 13.5% to 58%:

> For both military Veterans and active duty servicemen, IPV results in significant victim injury and negative child outcomes, and problematic substance use, depression, and antisocial characteristics are psychiatric correlates of IPV perpetration.

> For Veterans, posttraumatic stress disorder is also an important correlate that largely accounts for the relationship between combat exposure and IPV perpetration. Additional correlates include military service factors, relationship adjustment, childhood trauma, and demographic factors. (Marshall et al., 2005)

According to the National Center for PTSD, IPV can happen to anyone. In the United States, about 1 in 4 women (27%) and 1 in 10 men (11%) report having been harmed by sexual or physical violence, or by stalking by an intimate partner at some point in their lives. People who have experienced IPV may have more physical health problems, and IPV can lead to depression, feelings of worthlessness, anxiety, emotional numbness and difficulty connecting with others, problems with substances such as alcohol and drugs, or suicidal thoughts and behavior. People who have experienced IPV may have posttraumatic stress disorder.

The VA has resources for men and women who have experienced IPV, and is in the process of implementing domestic violence coordinators at VA facilities. The VA coordinators can assist Veterans with safety planning, mental health counseling, and safe housing or shelter.

Furthermore, each VA Medical Center has a women Veterans program manager to assist female Veterans. "Some research suggests that women Veterans and active duty military personnel are even more likely than non-Veterans to have experienced IPV. Among women Veterans receiving healthcare in VA, 30% to 70% report having experienced IPV at some point in their lives. In active duty women, more than 36% report having experienced one or more types of IPV during their service" (NCPTSD, 2015).

The VA recognizes that, compared to male Veterans, women Veterans are more likely to have mental health conditions such as depression and anxiety, as well as co-occurring mental and physical health problems. These can influence treatment planning and the need for coordinated care among various specialists and clinics. Women Veterans are also more likely than their male counterparts to experience certain types of gender-based violence, such as intimate partner violence and military sexual trauma. For more information on VA's mental health services for women Veterans, please visit Women Veterans Mental Health online (see box).

National Domestic Abuse Hotline

The National Domestic Abuse Hotline is available online at

http://www.thehotline.org

or by phone at

800 799 SAFE (7233)

Individual risk factors for IPV include:

- Low self-esteem
- Low income
- Low academic achievement
- Young age
- Aggressive or delinquent behavior as a youth
- Heavy alcohol and drug use
- Depression
- Anger and hostility
- Antisocial personality traits
- Borderline personality traits
- Prior history of being physically abusive
- Having few friends and being isolated from other people
- Unemployment
- Emotional dependence and insecurity
- Belief in strict gender roles (eg, male dominance and aggression in relationships)
- Desire for power and control in relationships
- Perpetrating psychological aggression
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration)
- History of experiencing poor parenting as a child
- History of experiencing physical discipline as a child (CDC, 2015)

Child Maltreatment

Child maltreatment is defined by the CDC as any act or series of acts of commission or omission by a parent or other caregiver (eg, clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child.

Acts of commission (child abuse): Words or overt actions that cause harm, potential harm, or threat of harm. Acts of commission are deliberate and intentional; however, harm to a child might not be the intended consequence. Intention only applies to caregiver acts —not the consequences of those acts. For example, a caregiver might intend to hit a child as punishment (ie, hitting the child is not accidental or unintentional), but not intend to cause the child to have a concussion. The following types of maltreatment are acts of commission:

- Physical abuse
- Sexual abuse
- Psychological abuse

Acts of omission (child neglect): Failure to provide needs or to protect from harm or potential harm. Acts of omission are the failure to provide for a child's basic physical, emotional, or educational needs or to protect a child from harm or potential harm. Like acts of commission, harm to a child might not be the intended consequence. The following types of maltreatment involve acts of omission:

- Physical neglect
- Emotional neglect
- Medical and dental neglect
- Educational neglect
- Inadequate supervision
- Exposure to violent environments (CDC, 2015)

There is substantial evidence pointing to the association between child maltreatment (CM) and a broad range of emotional, behavioral, and physical health problems. These consequences may vary depending on a child's age when victimized, duration and severity of the abuse or neglect, the child's innate resiliency, and co-occurrence with other maltreatment or adverse exposures such as the mental health of the parents, substance abuse by the parents, or violence between parents. Aggression, conduct disorder, delinquency, antisocial behavior, substance abuse, intimate partner violence, teenage pregnancy, posttraumatic stress disorder, anxiety, depression, and suicide are among the emotional and behavioral problems associated with CM (CDC, 2014).

Individual risk factors for child maltreatment include:

- Parents' lack of understanding of children's needs, child development and parenting skills
- Parents' history of child maltreatment in family of origin
- Substance abuse and/or mental health issues including depression in the family
- Parental characteristics such as young age, low education, single parenthood, large number of dependent children, and low income
- Non-biological, transient caregivers in the home (eg, mother's male partner)
- Parental thoughts and emotions that tend to support or justify maltreatment behaviors

Family risk factors include:

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions (CDC, 2015)

Healthcare providers should report signs of intimate partner violence or child maltreatment.

Education for Healthcare Providers

To make it easier for community healthcare professionals to understand Veterans and their military experience, VA and the Department of Defense have developed a free online continuing education course*, Military Culture: Core Competencies for healthcare Professionals.* The free interactive course is aimed at helping providers to better serve Veterans and service members by increasing their knowledge and awareness of military culture and experiences. Health professionals who take this course are eligible for 8 continuing education units. Click here for more information.

VHA TRAIN (https://vha.train.org/) is a gateway into TRAIN National, a free service of the Public Health Foundation and one of the most widely used learning management systems, providing a comprehensive catalog of public health learning products. VHA TRAIN is supported by the Veterans Health Administration Employee Education System, an internal education and training program office in the DVA. The learning programs found in the VHA support the professional development needs of public health and healthcare providers, with a focus on Veteran patient care.

Providers can also consult *Building Bridges to Support Military and Veteran Families: Healthcare Providers Resource Guide*, developed in 2009 by SAMHSA, DoD, VA, Vet Centers, and the Health Resources and Services Administration. The guide is meant to assist medical and mental health providers with their work in helping service members, Veterans, and their families maintain health and positive family functioning (DCEPHTBI, 2009).

Making Appropriate Referrals

The Veterans Administration and Department of Defense have developed numerous government programs, services, and benefits for Veterans and family members. The Substance Abuse and Mental Health Services Administration offers publications to educate and support healthcare providers who are treating Veterans and their families. Providers are encouraged to learn about the unique needs and challenges of Veterans.

Primary care and behavioral health providers can make a positive difference in the lives of Veterans and their families.

Ask and assess: Providers can screen for military service and Veteran status. Then they can screen for PTSD; substance abuse; depression; risk for suicide, grief, and domestic violence; and other behavioral health issues.

Intervene: Healthcare professionals can provide brief interventions such as giving feedback on screening results, describing risks associated with behavioral health disorders the Veteran may be experiencing, and advising the Veteran and family about ways to address substance use or mental health issues such as depression and PTSD.

SAMHSA provides the following useful publications:

- TIP 34: Quick Guide for Clinicians Based on Treatment Improvement Protocol: Brief Interventions and Brief Therapies for Substance Abuse
- TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

Refer: If health screenings indicate that a Veteran is in need of specialized care for behavioral or mental health problems, providers should refer the Veteran for a thorough assessment, diagnosis, and appropriate treatment. Evidence-based treatments are available for substance use and mental disorders, including psychotherapies, behavioral and pharmacologic therapies, and combination therapies. Evidence-based treatment for PTSD includes exposure therapy, cognitive processing therapy, eye movement desensitization and reprocessing, and cognitive behavioral therapy (SAMHSA, 2012).

Community healthcare providers are encouraged to refer Veterans and their families to local VA medical centers, behavioral health counselors, and local Veterans' organizations and support groups. Alcoholics Anonymous and Narcotics Anonymous groups specifically for Veterans exist in some communities.

The Veterans Administration has a website for healthcare providers who treat Veterans.

There, healthcare providers can learn about military culture, find links to assessment tools, to information about how to connect with the VA and why they should consider the VA an important member of the treatment team. Mini-clinics on the topics of mental and behavioral health for Veterans offer clinicians easy access to useful Veteran-focused treatment tools. The mini-clinics provide information on assessment, training, and educational handouts. Click here for mini-clinics for providers.

Providing Services to Family Members of Veterans

Providing care to a Veteran's family member is often the first step in providing care to the Veteran.

> Veterans spouses and other family members are often more willing than Veterans to seek care, making families important links to Veterans' recovery and well-being. Family members are an important part of the services team. Family members' referrals to resources and educational materials can be the first step to a Veteran's healthful adjustment to civilian life and recovery. (SAMHSA, 2012)

Rehabilitation and Reintegration

The Iraq and Afghanistan wars have been the longest sustained U.S. military operations since Vietnam. More than 2.2 million all-volunteer U.S. troops went into battle, resulting in more than 6,000 deaths and 48,000 injuries (IOM, 2013). For many, returning home and reintegrating into life away from war happens with few difficulties. For others, however, complicated multidimensional health problems make readjusting to home, family relationships, and employment or school a struggle. According to a congressionally mandated report by the Institute of Medicine, 44% of troops report difficulties after returning home.

Problems with traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), depression, and substance misuse and abuse are common. Furthermore, many of these military personnel and Veterans have more than one condition. "The most common overlapping health disorders are PTSD, substance use disorders, depression, and symptoms attributed to mild TBI" (IOM, 2013).

In addition to health problems, Iraq and Afghanistan Veterans face other reintegration difficulties. Unemployment for all post 9/11 Veterans ages 18 to 24 was 30.2%, compared with 16.1% for non-Veterans of the same age. Military sexual trauma also impacts returning soldiers (IOM, 2013).

The IOM report recommends that the DoD and the VA continue to improve the quality, timeliness, and followup of evidence-based treatment of Veterans and military personnel, especially therapies to treat PTSD, depression, and substance use disorders (IOM, 2013).

Furthermore, the IOM report recommends strengthening military families because strong, supporting families undergird service members' resilience to stressors and assist in reintegration. The DoD definition of *family*, however, must be extended to include the full constellation of military families, including nontraditional households such as unmarried partners, same-sex couples, single parents, and stepfamilies. The IOM recommends that the DoD make reducing domestic violence, such as intimate partner violence and child abuse, a priority (IOM, 2013).

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Post Test (Care of American Vets 218)

Use the answer sheet following the test to record your answers.

1. The mission of the Veterans Health Administration is to:

    a. Know exactly how many Veterans in the nation are still alive.
    b. Ensure that peacetime Veterans access fewer benefits than wartime Veterans.
    c. Care for Veterans and their families.
    d. Register all Veterans as people with mental health disorders.

2. What is a significant challenge to delivering healthcare to U.S. Veterans:

    a. Nearly all Veterans refuse to be treated at a VA health center.
    b. Nearly all Veterans suffer from depression, PTSD, suicide, and grief.
    c. Many states have no VA health centers to serve Veterans.
    d. Rural communities often lack services for Veterans.

3. Nurses should screen patients to find out if they are Veterans or family members of Veterans because screening ensures that:

    a. Veterans have access to the network of healthcare and support services for which they are eligible.
    b. The nurse fulfills her VA requirements for compensation.
    c. The Veteran's family members receive government reimbursement for any out of pocket healthcare expenses.
    d. All Veterans are registered as people with mental health disorders.

4. PTSD symptoms include:

    a. Excessive sleep with a total absence of dreaming.
    b. Wanting to watch war films 24/7.
    c. Re-experiencing, avoidance, and increased arousal.
    d. Perseverating and constantly discussing the trauma.

5. Prolonged Exposure therapy as a treatment for PTSD includes:

    a. Taking medications that raise the level of serotonin in the brain.
    b. Becoming aware of thoughts and feelings and then changing the thoughts to change the feelings.

c. Acting out the trauma in dramatic role playing sessions with therapists.

d. Education, breathing retraining, real world practice, and talking through the trauma.

6. What is secondary traumatic stress:

a. The blaming of a trauma survivor for weakness in the face of the trauma.

b. The emotional reaction to the traumatic experience of a significant other.

c. The treatment therapy whereby the therapist reenacts the trauma in dramatic role playing sessions.

d. The realization by the trauma survivor that he or she is mentally ill and will never be free of the trauma.

7. Which behavior could be a sign that a person is actively contemplating or preparing to commit suicide:

a. Giving away prized possessions.

b. Signing up to coach Little League next season.

c. Seeking treatment for substance abuse.

d. Cleaning and maintaining a firearm.

8. Risk factors for suicide include:

a. Fear of travel, same-sex orientation, asthma.

b. Married for 20 years, command stress, elderly parents.

c. Deployment to combat, substance use disorder, loss of a loved one.

d. New job, oldest child getting married, youngest child in high school.

9. Sexual assault is associated with adverse outcomes such as depression, anxiety, substance abuse, and non-suicidal self-injury, which are also commonly associated with suicidal ideation, attempts, and death by suicide:

a. True

b. False

10. What medical conditions commonly occur with major depression:

a. Allergies, asthma.

b. Traumatic brain injury, PTSD.

c. Irritable bowel syndrome, vision disturbances.

d. Rheumatoid arthritis, urticaria.

11. Treatment for depression includes medications known as antidepressants. They work by affecting neurotransmitters in the brain, especially serotonin and norepinephrine:

a. True

b. False

12. The purpose of SAMHSA's SBIRT program is to:

a. Provide early intervention in community settings for people at risk before more serious consequences can occur.

b. Diagnose complex behavioral and mental health disorders in community settings.

c. Train community health professionals more thoroughly so they are better at providing motivation toward behavioral change.

d. Address substance abuse in community settings rather than urban treatment centers because they have the most experience.

13. Apart from depression, what adverse outcomes can a victim of intimate partner violence experience:

a. Dependence on antidepressants for the high they provide.

b. Bipolar disorder, schizophrenia.

c. Asthma, arthritis, and heart problems.

d. Anxiety, emotional numbness, substance abuse, suicidal thoughts or behaviors.

14. All but one of the following is defined as child maltreatment:

a. Physical and emotional neglect.

b. Exposure to violent environments.

c. Sexual abuse.

d. Strict behavior codes.

15. The VA and Department of Defense have developed educational materials for healthcare providers who treat Veterans to make it:

a. Easier for them to understand Veterans and their military experience.

b. Clear that they lack adequate experience to provide services to Veterans and their families.

c. Possible for them to prove their credentials to military families, who may have a variety of non-VA providers.

d. More challenging for them to apply for compensation for their work with Veterans, thereby saving government expenditures.

16. The Department of Defense recommends strengthening military families because supportive families:

a. Are immune to the effects of both physical and emotional neglect.

b. Raise the next generation of tough, dutiful soldiers.

c. Help increase service members' resilience to stressors and assist in reintegration.

d. Virtually eliminate the likelihood that a service member will experience mental health issues.

Answer Sheet (218)

Care of American Veterans and Their Families

Name (Please print your name): _____

Date: _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____

Course Evaluation (Care of American Veterans 218)

Please use this scale for your course evaluation. Items with asterisks * are required.

- 1 = Strongly agree
- 2 = Agree
- 3 = Neutral
- 4 = Disagree

5 = Strongly disagree

* Upon completion of the course, I was able to:

a. Describe veterans' healthcare challenges and identify how to find the locations of VA health centers in the nation.

○1 ○2 ○3 ○4 ○5

b. Recount 4 ways that veterans can access community-centered healthcare if they cannot use a VA health center.

○1 ○2 ○3 ○4 ○5

c. Explain the importance of screening for military service, veteran status, or being a family member of a veteran.

○1 ○2 ○3 ○4 ○5

d. Discuss posttraumatic stress disorder, suicide risk, depression, grief, substance abuse, and intimate partner violence and explain how each may arise in military veterans and their families.

○1 ○2 ○3 ○4 ○5

e. Name 3 ways that providers can receive additional education or training to assist them in serving veterans and their families.

○1 ○2 ○3 ○4 ○5

f. Explain the principles of rehabilitation and reintegration and list 3 ways you can make appropriate referrals.

○1 ○2 ○3 ○4 ○5

* The author(s) are knowledgeable about the subject matter.

1 2 3 4 5

* The author(s) cited evidence that supported the material presented.

1 2 3 4 5

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satsfaction with this learning activity?

1 2 3 4 5

* Navigating the ATrain Education website was:

- Easy.
- Somewhat easy.
- Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- 60 minutes (or more) per contact hour
- 50-59 minutes per contact hour
- 40-49 minutes per contact hour
- 30-39 minutes per contact hour
- Less than 30 minutes per contact hour

I heard about ATrain Education from:

- Government or Department of Health website.
- State board or professional association.
- Searching the Internet.
- A friend.
- An advertisement.
- I am a returning customer.
- My employer.
- Other
- Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form (218)

Please print and answer all of the following questions (* required).

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

* License Number and State: _____

* Please email my certificate:

◯ Yes ◯ No

(If you request an email certificate we will not send a copy of the certificate by US Mail.)

Payment Options

You may pay by credit card or by check.
Fill out this section only if you are **paying by credit card.**
4 contact hours: $19

Credit card information

* Name: _____

Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

◯ Visa ◯ Master Card ◯ American Express ◯ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____