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Mental Health Care of American Veterans and Their Families (354)

Author: Sarah Reith, BA, MA

Contact hours: 3

Expiration date: April 1, 2028

Price: $29

Course Description

This course fulfills the requirement for training on mental health conditions common to veterans and family members of veterans and includes information about inquiring whether your patients are veterans or family members of veterans, screening for conditions such as post-traumatic stress disorder (PTSD), risk of suicide, depression and grief, and prevention of suicide.

Course Objectives

When you finish this course, you will be able to*:

1. Understand the number of military veterans in the United States.
2. Understand the purpose and mission of the Patient-Centered Community Care programs.
3. Define military cultural competence.
4. Describe the importance of screening for PTSD, depression, and substance abuse in military veterans and their families.
5. Define military sexual trauma.
6. Relate 1 individual, 1 relationship, 1 community, and 1 societal risk factor for suicide.
7. Relate the incidence of intimate partner violence among veterans and their families.
8. Explain 3 clinical best practices for referring veterans to healthcare services.

***Please note:** attainment of course objectives will be assessed in the course evaluation.

[Continue to next page to begin course]

1. United States Veterans

A veteran is a former member of the armed forces who was not dishonorably discharged from service in the active military, naval, or air service. Active military service is full-time, other than active duty for training, as a member of the Army, Navy, Air Force, Marine Corps, Coast Guard, or as a commissioned officer of the Public Health Service, Environmental Science Services Administration or National Oceanic and Atmospheric Administration, or its predecessor, the Coast and Geodetic Survey. This definition includes peacetime active-duty military personnel as well as those who served in combat. In some instances, it also applies to those who were injured during training in part-time units like the National Guard or reserves (DVA, 2024, October 7).

The U.S. Census Bureau, relying on the 2022 American Community Survey, provides a tally of 16.2 million military veterans in the United States, representing 6.2% of the total civilian population 18 and older. Just over 10% of those veterans are women. World War II veterans comprise 0.8% of the country's veterans as of 2022 (USDOL, 2024).

Additionally, 4.1% of today's veterans served in the Korean War, 33.6% in the Vietnam War, 24.4% in the first Gulf War (August 1990 to August 2001), and 26.3% in the second Gulf War, beginning September 2001 (US Census Bureau, 2023). According to a report from the U.S. Department of Labor, in August of 2023, there were more than million veterans with a service-connected disability in the civilian non-institutional population 18 years and older. Of those, 1,362,000 had a disability rating of 60% or higher (USDOL, 2024).

In 2023, the VA updated its 1959 mission statement, which was, "to fulfill President Abraham Lincoln's promise 'to care for him who shall have borne the battle, and for his widow, and his orphan.'" The new mission statement is, "To fulfill President Lincoln's promise to care for those who have served in our nation's military and for their families, caregivers, and survivors." The updated verbiage is designed to reflect a commitment to the 600,000 women veterans, 50,000 veteran caregivers, 600,000 veteran survivors, and millions of veterans who did not serve in combat. It is also supposed to represent veterans from a variety of racial and cultural backgrounds and those from the LGBTQ+ community.

An Executive Order, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, was issued by President Barack Obama in 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. The ITF is a collaborative effort across the Departments of Defense, Veterans Affairs, and Health and Human Services. It works to ensure that service members, veterans, and their families have access to needed mental health services and support (SAMHSA, 2024).

The Substance Abuse and Mental Health Services Administration (SAMHSA), provides technical assistance to a variety of interagency teams that are working to advance the mental health of service members, veterans, and their families and caregivers. It serves as a clearinghouse for information about trends in behavioral health treatments and who is providing what kind of treatment in which states and territories. It also consults with providers and trains them on how to deliver treatments in coordination among civilian, military and veteran service systems.

Key ITF recommendations include advancing suicide prevention, effective policy around substance use disorders, tracking outcomes, and enhancing community partnerships. The task force is responsible for the following activities (SAMHSA, 2023):

- Providing an annual review of agency actions
- Defining specific goals and metrics to aid in measuring progress
- Making additional recommendations as appropriate to the President.

According to SAMHSA, “Efforts need to be expanded, plans need to be refreshed, and lessons learned need to be shared. At this critical time, we must all work together to improve the capacity of our civilian behavioral health service system to serve service members, veterans, and their families. This can be accomplished by ensuring providers are informed on military culture and adopting promising, best, and evidenced-based practices. Service members, veterans, and their families deserve the highest level of care that can be delivered through an easy-to-navigate, coordinated system that allows them to access quality behavioral health care in their communities” (SAMHSA, 2024).

2. Veteran Services

The Veterans Health Administration, or VA, is the nation’s largest integrated single payer healthcare system, with nearly 1,400 healthcare facilities, including 170 medical centers and close to 1,200 outpatient clinics. It serves more than 9 million veterans each year (VA, 2024). Services include inpatient hospital care such as surgery, home-based rehabilitation, prescriptions, vaccinations, and mental healthcare. Healthcare for specific groups like geriatric patients and their caregivers, homeless veterans and rural veterans is also available.

There are a number of challenges associated with providing comprehensive healthcare to such a large population. Veterans are often clinically complex, with many suffering from chronic health problems like PTSD, traumatic brain injury and other service-related injuries. There is also a high prevalence of comorbid conditions such as cancer, diabetes, and hypertension. Many rural and low-income veterans receive most of their healthcare from VA (Rasmussen and Farmer, 2023). In recent years, the VA has expanded its offerings to include additional services such as optometry and ophthalmology (AOA, 2023).

In the wake of public attention to long wait times at VA clinics, Congress passed the *Veterans Access, Choice, and Accountability Act* in 2014. Known simply as the Veterans Choice Program, this benefit 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) strongly supported the passage of Veterans Choice in 2014. Veterans are eligible for the program if they are unable to receive timely care—defined as wait times of more than 30 days; or if they live too far away from a VA facility, defined as more than 40 miles.

Veterans Choice led to an expansion of the Community Care program, which allows the VA to contract its patients’ healthcare with other providers. This requires skillful coordination between healthcare systems, which are often sparse in rural and underserved areas.

2.1 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. 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.

2.1.2 TRICARE

The TRICARE program supports healthcare providers' work with active-duty and retired service members by reimbursing them for medical and behavioral health services provided outside of a military treatment facility. TRICARE is 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 (Health.mil, 2024).

2.1.3 Mobile Vet Centers

In rural communities, gaining access to veterans' healthcare services, including Vet Centers, can be difficult. Community-based Vet Centers provide social and psychological services, including professional counseling, to eligible veterans. Common challenges for veterans are transitioning from military to civilian life, overcoming trauma, and figuring out how to navigate the VA.

Veterans who live in communities that do not have Vet Centers may be able to utilize those same services at a Mobile Vet Center. These 83 vehicles have space for confidential counseling, and they can gain access to records through an encrypted connection (DVA, 2024, February 21). Veterans can use them to receive 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.

Counseling sessions are one of the most important resources available at the Mobile Vet Centers that are equipped with video-conferencing equipment as well as WIFI and DVD hardware. Source: va.gov.

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. His experience as a truck driver in the Marine Corps helped him qualify to drive the mobile vet vehicle. Since his employment, Davis has traveled to West Virginia, Pennsylvania, and Washington, DC, to provide information and referral services to veterans.

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.

2.2 Stigma as Barrier to Veterans Getting Services

Stigma, including self-stigmatization occurs in over 40% among adults suffering from PTSD. Even the name of the disorder can discourage people from seeking treatment, as indicated by a survey of over a thousand subjects, two-thirds of whom agreed that changing the name to post traumatic stress *injury* would reduce the stigma associated with having a disorder and increase the likelihood that patients would seek medical help (Lipov, 2023).

Stigma prevents many people, especially military personnel, from seeking mental healthcare. This includes public stigma as well as self-stigma. Stigma can be a particularly oppressive barrier in military culture, where mental or emotional disorders are viewed as a personal weakness. Public stigma can have real consequences, as active-duty military personnel in a recent study reported concerns that their careers could be negatively affected if they seek treatment.

Self-stigma is more nuanced, lowering self-esteem and the motivation to seek help. People are also less likely to seek help if they think their disorder is their own fault. This leads to efforts to hide or suppress signs of mental illness, rather than attempting to resolve the issue (McGuffin et al., 2021). While emotional distress often resolves over time, a persistent mental health disorder can deteriorate if left untreated.

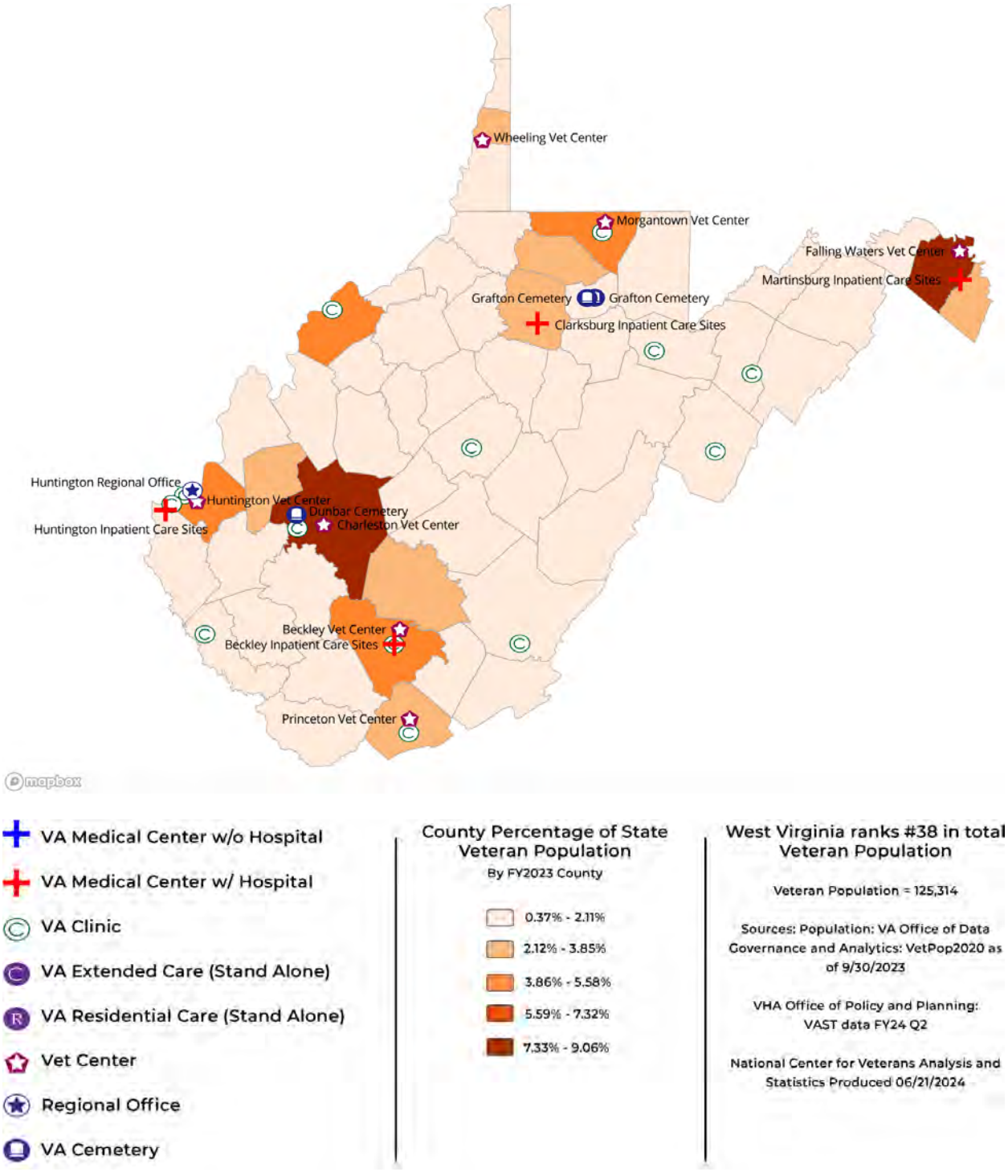
One of the VA's top clinical priorities is preventing veterans from committing suicide. The VA provides, pays for or reimburses the cost of suicide care and treatment at a VA or non-VA facility. This includes ambulance transportation, prescriptions, up to 30 days of inpatient or crisis residential treatment, and up to 90 days of outpatient care at no cost to veterans (Cox, 2023).

This means veterans can get mental healthcare treatment through the Community Care program, as well as directly through the VA. Veterans can also use a crisis hotline by calling 988, texting 838255, or chatting online with the Veterans Crisis line to get connected to a trained mental healthcare professional. The VA is also researching stigma and is offering counseling on how people can change their own perceptions of themselves and others. The Veteran Integrated Service Network 5 Mental Illness Research, Education and Clinical Centers offers a nine-session program on reducing stigma so veterans can get on with their recovery, and their lives (Love, 2024).

2.3 For Healthcare Providers in West Virginia

West Virginia is an example of a largely rural state with a large veteran population and high rates of poverty. According to a 2024 report, West Virginia scored of 49 (out of 50 states and the District of Columbia), on an analysis of state healthcare systems. Only Alabama and Mississippi fared worse. West Virginia is 44 in terms of affordability, and 48 in terms of health outcomes (McCann, 2024).

Among its civilian hospitals, West Virginia has 25 university-owned hospitals and 6 owned by the State Department of Health Facilities. As of 2023, West Virginia is home to more than 125,000 veterans (38th in total veteran population). IN West Virginia, there are 17 VA outpatient clinics and 4 VA hospitals, most of them clustered near the borders with Virginia and Pennsylvania, where the highest concentration of veterans live. Many counties in West Virginia do not have a VA clinic, making telehealth the best option for many veterans in those areas (US Census Bureau, 2023, October 19).



Source: Graphic courtesy of Department of Veterans Affairs, Distribution of Veterans by County (FY2023), West Virginia https://www.data.va.gov/stories/s/NCVAS-State-Summary-West-Virginia-FY2023/cgsj-chh2/

3. Military and Veteran Cultural Competency

[Unless otherwise noted, the information in this section is from Isserman and Martin, 2022].
Military members, veterans, and their families belong to a unique American subculture. Military culture, which is acquired through training and experiences that are integrated into the service members' mind, body, and spirit, is comprised of implicit values and beliefs shared through time-honored rituals, customs, and organizational traditions. For many healthcare providers, practicing culturally competent care can be challenging, especially if a provider has limited personal experience with the difficulties faced by service members and veterans.

While there is great diversity among the various sectors of the armed forces, there are implicit cultural values and beliefs shared across all components and service branches. For example, the concept of service before self is a core military value that stresses integrity and requires service members to place their duty responsibilities before their own personal interests and desires. These values are ingrained early in military training and remain with military members and their families even after transitioning from military service to veteran status.

Numerous studies have identified the need for healthcare professionals to acquire what is referred to as "military/veteran cultural competence" to effectively engage with this population. This allows clinicians to understand the importance of recognizing how a client's life experiences and relationships have been impacted by military service and veteran status.

Military cultural competence means developing an understanding of the basics of military life. This includes becoming familiar with the impact military lifestyles and duties have on behavioral and physical health, combat-related exposures, and family separations. Understanding workplace challenges confronting the armed forces—issues like sexual violence, addiction, and suicide are critically important.

Service members, veterans, and their family members expect providers to have a basic appreciation, understanding, and interest in their military-related experiences. This includes listening to their experiences, even when these stories may be horrific or painful. It is critical that healthcare providers not let their own personal biases interfere with an understanding of a client's unique military duty or military life experiences.

Healthcare providers can break down military cultural barriers by initiating discussions about specific problems related to trauma, military sexual trauma, intimate partner violence, PTSD, and behavioral health issues. Be aware that a client may be affected by conditions such as moral injury and challenges faced during deployment.

Key points about military/veteran cultural competence:

- Screen clients for military or veteran status.
- Become knowledgeable about military culture.
- Understand the cultural stigma clients face in reaching out to therapists for counseling.
- Understand any preconceptions you may hold about the military.
- Learn about the values and factors that impact a military client's behavioral and relational difficulties.

The American Academy of Nursing (AAN) encourages healthcare providers to ask patients if they are servicemembers, veterans, or family members of veterans. Called "Have You Ever Served in the Military?", the 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, as well as health concerns for related to specific conflicts or deployments. The goal is to increase provider awareness of service-related healthcare issues.

The first set of questions recommended by the AAN are as follows (AAN, 2017):

- 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 claim pending? If so, what is the nature of the claim?
- Do you have a VA primary care provider?
- Do you have a safe place to go when you leave today?
- Do you need assistance in caring for yourself or members of your household?

Healthcare providers can learn to recognize and successfully address the physical, mental, and emotional health needs of veterans by learning about military culture. Providers may have their own biases about military service, which they can examine using the *Self Awareness Exercise* available from the Uniformed Services University. There are many ways that providers can indicate respect and care for military veterans and their loved ones, from asking open-ended questions and recognizing the strengths that are emphasized in military culture. Rapport is key to engaging patients and improving their outcomes (Kleiman and Dolans, 2023).

4. Mental Health Issues

Although culture is a fluid concept, it is a central part of how we understand mental health. Culture influences what gets defined as a problem, how the problem is understood, and which solutions to the problem are acceptable. It has many layers, which interact with class, religion, language, nationality, and gender, each of which influences how an individual engages with and experiences mental health services (Salla et al., 2023).

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

The VA estimates that close to 60% of veterans using VA healthcare services since October 1, 2001 have been diagnosed with mental health disorders. Because over half of the military veterans receive healthcare services outside the VA system, it is important that healthcare providers screen patients for military service (DVA, 2024, October 16).

Signs of Mental Health Problems

Mental health problems can cause physical problems, along with changes in thinking, feeling, and behavior. This can include feeling sad or nervous, irritable, angry, or short tempered. Some people may experience decreased energy, lack of motivation, or loss of interest in activities. Other common symptoms can include:

- Changes in sleep, appetite, weight, or sex life
- Headaches, other physical pain, muscle tension, and weakness
- Problems with attention, concentration, or memory
- 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

4.1 Posttraumatic Stress Disorder (PTSD)

PTSD was first recognized as a psychiatric disorder in 1980 (Friedman, 2022). It is a complex, multi-faceted mental health condition that develops after experiencing or witnessing a life-threatening event. While trauma is always disruptive, PTSD can be debilitating, interfering with daily activities like going to work or school or spending time with friends and loved ones (NCPTSD, 2024, May). Both the American Psychological Association and the World Health Organization define traumatic events as experiences involving actual or threatened death, serious injury, sexual violence or events that are extremely threatening or horrific in nature (APA, 2024).

People who suffer from PTSD continue to re-experience memories of their trauma. These memories are accompanied by avoidance, negative thoughts and emotions, and hyperarousal, a state of heightened anxiety that can manifest as irritability or paranoia.

It is estimated that 60% of adults in the general population will suffer PTSD at some point in their lifetimes. The incidence among veterans is slightly higher, with 7 out of every 100 veterans experiencing PTSD. The average is increased by the 13% of female veterans who have suffered military sexual trauma, often from colleagues (NCPTSD, 2023, February).

PTSD and U.S. Veterans of Different Service Eras (NCPTSD, 2025)

Service Era	PTSD in the Past Year	PTSD at Some Point in Life
Operations Iraqi Freedom and Enduring Freedom	15%	29%
Persian Gulf War (Desert Storm)	14%	21%
Vietnam War	5%	10%
World War II (WWII) and Korean War	2%	3%

Note: The data in this table is from Veterans alive at the time of the study. As such, it does not include Veterans in any service area who have died and may have had PTSD. Source: https://www.ptsd.va.gov/understand/common/common_veterans.asp#:~:text=At%20some%20point%20in%20their,7%25)%20will%20have%20PTSD.

PTSD can lead to a host of physical and psychiatric comorbidities, including suicide. A Swedish study found that 3.5% of suicides among women in Sweden were attributable to PTSD. More than half of the suicides among Swedes with PTSD were due to the diagnosis (Fox et al., 2021).

In the U.S., the risk for suicide among military veterans with combat experience is especially high, with combat survivors who were wounded at greatest risk. Some veterans suffering from PTSD experience recurring memories of trauma and guilt over actions taken during wartime (NCPTSD, 2022).

Though they do not experience combat as frequently as their male counterparts, female military veterans are also subject to experiences that lead to PTSD. Military sexual trauma (MST) is widespread among female military veterans, due to sexual assault and harassment from fellow soldiers. MST's most common mental health impact is PTSD, which rarely occurs in isolation, and may coincide with major depression, anxiety, eating disorders, substance use disorders, and increased suicidality. Physical health impacts include greater chronic disease burden (e.g., hypertension), and impaired reproductive health and sexual functioning (Galovski, 2022).

The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) groups PTSD symptoms into 4 categories:

1. Intrusion Symptoms (formerly called re-experiencing symptoms)
    - Intrusive thoughts
    - Nightmares
    - Flashbacks
    - Emotional distress after exposure to traumatic reminders
    - Physical reactivity to traumatic reminders
2. Avoidance Symptoms (avoiding trauma-related stimuli)
    - Trauma-related thoughts or feelings
    - Trauma-related reminders
3. Negative Alterations in Cognition and Mood (negative thoughts or feelings that began or worsened after the trauma)
    - Inability to recall key features of the trauma
    - Overly negative thoughts and assumptions about oneself or the world
    - Exaggerated blame of self or others for causing the trauma
    - Negative or flat affect
    - Decreased interest in activities
    - Feeling isolated
    - Difficulty experiencing positive affect

4. Alterations in Arousal and Reactivity (trauma-related arousal and reactivity and reactivity that began or worsened after the trauma)
    - Irritability or aggression
    - Risk or destructive behaviors
    - Hyper-vigilance
    - Heightened startle reaction
    - Difficulty concentrating
    - Difficulty sleeping

Though PTSD is separate from substance use disorder (SUD), the use of alcohol or drugs may become a management strategy. Anxiety and obsessive-compulsive behavior may also be associated with PTSD. Negative emotions like anger, shame or humiliation, sadness and guilt may also persist.

Other symptoms may include dysphoria, dissociative states, suicidal ideation, panic attacks, and somatic complaints like trembling, headaches, dizziness, and shortness of breath. Women and girls who have been diagnosed with PTSD are especially prone to somatic symptoms and high levels of negative emotions.

4.1.1 Risk Factors for Developing PTSD

Some groups are disproportionately represented among those experiencing trauma. This means that they may be exposed to trauma at particularly high rates or be at increased risk for repeated victimization. For these groups, co-occurring issues and unique adversities can complicate recovery from trauma. Others face significant challenges related to access to services or require services that are specially adapted for their needs (NCTSN, 2024).

PTSD has long been associated with military combat. The first assessment techniques were developed by researchers working with Vietnam-era veterans (Friedman, 2022). Younger veterans, especially those who served in the Gulf War, Iraq or Afghanistan, may be more likely than veterans of earlier conflicts to suffer adverse psychiatric outcomes. According to an analysis of the 2019-2020 *National Health and Resilience in Veterans Study*, younger veterans showed the greatest burden of trauma and were more likely to screen positive for PTSD. One in four Iraq/Afghanistan veterans in the study reported recent suicidal thoughts (Na et al., 2023).

Many veterans of Iraq and Afghanistan have experienced post-concussive symptoms from traumatic brain injuries. In the aftermath of brain injuries, some people experience psychiatric symptoms that are similar to PTSD, such as difficulty sleeping and concentrating, irritability, and depressed mood. The overlap between PTSD and the symptoms that can persist after a brain injury is now being studied, with one study finding that participants' post-concussive symptoms improved with treatments for PTSD (Porter et al., 2024).

Pre-existing attitudes can contribute to the likelihood of developing PTSD, including adherence to traditional masculine roles. Beliefs about the importance of adhering to masculine norms are strongly associated with the severity of patients' PTSD symptoms. Discussing emotions and feelings of fear and shame are antithetical to masculine norms about control, rationality, and fortitude. Veterans who are working hard to maintain an appearance of powerful masculinity may be less inclined to seek help or follow through with a therapeutic program (Neilson et al., 2020).

Secondary traumatic stress (STS), also known as compassion fatigue or vicarious traumatization, is the emotional distress caused by indirect exposure to other people's emotional hardship. The psychological symptoms are similar to PTSD, including anxiety and depression, insomnia and nightmares, intrusive thoughts, and maladaptive coping strategies such as alcohol and substance abuse (Maran et al., 2023).

STS is common among healthcare professionals and others in the helping professions, including unpaid family caregivers. Caregivers may suffer from self-criticism, a lack of self-compassion, and loss of compassion for others. This can lead to burnout and feelings of hopelessness (Halamová et al., 2022).

4.1.2 PTSD and Comorbidities

PTSD can lead to physical and mental health problems and affect emotional resilience. It is a complex diagnosis with links to neural disturbances, inflammatory conditions, and difficulties with regulating mood and attention.

PTSD can inhibit learning, interfere with executive function and concentration, and even prolong grief. People who survive a trauma but lose a loved one are at risk of developing PTSD. It can cause grief that is so unbearable it interferes with daily life and causes feelings of isolation from others. Researchers believe this may have implications for trauma survivors because it suggests that targeting the PTSD symptoms for treatment may also diminish the symptoms of complicated grief (Glad et al., 2021).

There also appears to be support for an association between asthma and PTSD, both of which afflict more women than men. A recent study in Atlanta involving more than 500 women with both conditions showed that the women with asthma had a higher risk of more severe PTSD and depression than those without asthma. Female military veterans with PTSD are more than one and a half times more likely to have asthma than those without PTSD (Lin et al., 2023).

PTSD is often traced to some form of violence. And there are some indications that people suffering from PTSD are more likely to commit violent crimes, themselves. Another Swedish study found that PTSD is linked to violent crime among veterans, though it is still unknown if such a link exists between PTSD and crimes committed by people in the general civilian population. However, the diagnostic criteria for PTSD include increased arousal, reactivity, and irritable behavior that often turns into aggression. Throughout 27 years of follow-up inquiry, the study found that individuals with a PTSD diagnosis had a higher absolute risk of being convicted for violent crime than individuals with no PTSD diagnosis (Paulino et al., 2022).

In addition to the social costs associated with violent crime, PTSD also creates an economic burden. Individuals who can't function properly due to a psychiatric diagnosis drive unemployment costs, disability, and direct healthcare. In 2018, the total excess economic burden of PTSD in the US was an estimated $232.2 billion. That came out to $18,640 per civilian with PTSD and $25,684 for each veteran with the condition (Davis et al., 2022).

4.1.3 Treatment Options

The VA offers a variety of treatment options for veterans seeking mental healthcare, from evidence-based therapies and medications to mental health apps. Veterans have access to in-person care at a VA clinic or through Community Care referrals. They can also speak with a provider using video or telephone options that do not require travel. The VA also offers mental health apps and a self-help portal where veterans can anonymously take free courses to address a variety of concerns, including sleep issues, anger management or parenting (DVA, 2022, March).

The most effective evidence-based therapies include:

- **Cognitive Processing Therapy (CPT)** helps Veterans identify how traumatic experiences have affected their thinking, to evaluate those thoughts, and to change them. Through CPT, veterans may develop more healthy and balanced beliefs about themselves others, and the world.
- **Prolonged Exposure (PE)** helps Veterans to gradually approach and address traumatic memories, feelings, and situations. By confronting these challenges directly, Veterans may see PTSD symptoms begin to decrease.
- **Cognitive Behavioral Conjoint Therapy (CBCT)** helps couples understand the effect of PTSD on relationships and can improve interpersonal communications. Veterans may also experience a change in thoughts and beliefs related to their PTSD and relationship challenges.
- **Eye Movement Desensitization and Reprocessing (EMDR)** helps Veterans process and make sense of their trauma. It involves calling the trauma to mind while paying attention to a back-and-forth movement or sound (like a finger waving side to side, a light, or a tone).

There are very few FDA-approved drugs for treating PTSD. The *Veterans Health Administration* recommends psychotherapies put forth by the APA but acknowledges that medications can be an effective option when psychotherapy is not available. Medications prescribed for PTSD act upon neurotransmitters affecting the fear and anxiety circuitry of the brain including serotonin, norepinephrine, gamma-aminobutyric acid (GABA), the excitatory amino acid glutamate and dopamine, among others (Holzheimer and Montaño, 2024).

Evidence for PTSD pharmacology is strongest for specific selective serotonin reuptake inhibitors (SSRIs)—sertraline (Zoloft) and paroxetine (Paxil)—and a particular serotonin norepinephrine reuptake inhibitor (SNRI), venlafaxine (Effexor). Currently, only sertraline and paroxetine are approved by the FDA for PTSD. From the FDA perspective, all other medication uses are off label (Holzheimer and Montaño, 2024).

Greater social and organizational support is needed for military caregivers, as well as treatment from informed medical providers who can guide them to the appropriate resources. Social support and task-focused coping strategies have been shown to be correlated with lower levels of STS, though there is little research into protective factors (Gagliano, 2020).

The Blue Star Families Caregiving Report of 2021 recommends identifying caregivers and what constitutes caregiving tasks, so that more caregivers can be informed about available resources. The report argues that caregiving needs to be normalized and included in discussions about personal and professional life. However, high-quality respite care for caregivers is a vital but scarce resource, which the report recommends expanding. Efforts to improve caregivers' quality of life, like student loan relief and affordable childcare, could also ease financial strain and improve quality of life (Blue Star Families, 2020).

4.1.4 Screening for PTSD

There are several tools a healthcare provider can use to screen for PTSD. The CAPS-5, or Clinician-Administered PTSD Scale for DSM-5, is the gold standard, according to the VA's National Center for PTSD. This is a 30-item structured interview that was designed to be administered by clinicians and clinical researchers who have a working knowledge of PTSD, but it can also be administered by appropriately trained paraprofessionals. The full interview takes 45 minutes to an hour. Non-VA providers can request the form and the curriculum from the VA.

Other screening tools include the PTSD Symptom Scale Interview (PSS-I and PSS-I-5), which are semi-structured interviews. The PSS-I is a 17-item interview about a single traumatic event. It is designed to assess the severity of symptoms in the past two weeks and takes about 20 minutes to administer. The PSS-I-5 is an updated version which corresponds with the DSM-5.

The Structured Clinical Interview, PTSD Module is a semi-structured interview designed to be administered by a trained mental health professional. This instrument can take anywhere from fifteen minutes to several hours, and all symptoms are coded as present, subthreshold, or absent.

Structured interviews and self-reporting screening tools are also helpful for determining treatment options (APA, 2023).

4.1.5 PTSD and Military Families

PTSD can have a huge impact on family life, as loved ones struggle to provide care to a family member whose behavior has changed abruptly. The Blue Star Families Military Family Lifestyle Survey found that over a quarter of caregivers felt excessively burdened by their caregiving tasks. that military caregivers report more financial stress than civilian peers, and that they experience a high degree of mental health challenges and sleep issues. Military caregivers also tend to be younger than civilian caregivers and are often caring for children and parents in addition to the wounded service member or veteran (Blue Star Families, 2020).

At a 2024 Policy Dialogue Series, the American Academy of Nurses focused on the health of military families. Distinguished speakers noted an increase in mental health and weight-related diagnoses in military children during the course the COVID-19 pandemic. Military spouses reported increasing levels of dissatisfaction with military life, which presents unique stressors like frequent relocation, isolation, lack of social support and continuity in professional lives or education, and exposure to physical and psychological injury. Speakers addressed the need for multi-faceted care for military families, with some framing their health as imperative to service members' ability to focus on the mission. The AAN recommendations include promoting military cultural awareness among providers and expanding education and outreach to improve awareness among providers and families of the resources that exist to help them (AAN, 2024).

Caregivers are subject to emotional hardships themselves, as they struggle to adjust to new responsibilities and experience a decrease in their social, leisure, and professional opportunities. Being young, female, with low income and a low level of education are all risk factors for caregiver PTSD. The risk of PTSD climbs with time spent in the ICU or bedside with seriously ill patients. The type of relationship between the caregiver and patient, illness-related distress, and the availability of support networks and wholesome coping mechanisms also play their roles in the psychiatric well-being of caregivers (Carmassi et al., 2020).

Caring for people with severe mental illness can also lead to PTSD. In one study of caregivers for people with schizophrenia or bipolar disorder, 15.17% met the diagnostic criteria for PTSD. These caregivers work under a great deal of stress, with many of them being subject to aggression and experiencing a low quality of life. Like many others who suffer PTSD, caregivers often blame themselves for poor outcomes, experiencing high levels of stress over hospitalizations and keeping track of medications. Stress burden was higher among caregivers in developing countries, which may be due to better health facilities and less stigma surrounding mental illness in more developed countries (Rady et al., 2021).

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 expressing emotions. This can cause problems in their personal relationships with a spouse or children.

It is important that family members of people with PTSD understand that it is not selfish to take care of themselves. They can attend to their health by eating and sleeping regularly, getting plenty of sleep and exercise, and making sure they attend to their own medical appointments. It's also important not to get isolated and to set boundaries for how much they can do to care for their loved one. Sometimes, getting therapy for their own feelings of stress and anxiety as they take on a caregiving role can be vital. Maintaining friendships and enjoyable activities are also key to well-being.

There are some resources available to military family members struggling to cope with their loved ones' PTSD symptoms. A free, private and confidential hotline is accessible by dialing 988 or logging onto www.988lifeline.org. These are not only for crisis situations. They are also available for advice, help or just support. The VA caregiver support line at 1-855-260-3274 offers information about connecting with the caregiver support team at the nearest VA medical center.

Talking to children about an adult family member's PTSD helps them cope with their own fear and confusion. Children should know what is causing their loved one's behavior, but they don't need graphic details about what caused the PTSD. Too much frightening information can cause secondary trauma. Children should know that the adult relative's mental health condition is not their fault. They should know that they can talk about their own concerns and feelings. The VA has an extensive video series featuring veterans and their family members discussing PTSD and what helped them at https://www.ptsd.va.gov/apps/AboutFace/ (NCPTSD, 2024).

4.2 Depression

Depression is a highly prevalent health problem in the military, due to many factors like separation from loved ones and familiar support systems, and the stress of being deployed in combat. Depression manifests in many ways that can make a diagnosis difficult to ascertain. It is often a major contributing factor in suicidal ideation, suicide attempts, and suicide.

The World Health Organization estimates that the global yearly prevalence of depression is 4.4%, with 5.1% of females and 3.6% of males experiencing the condition. It is much more common among older people of both sexes, and the rates of depression went up 18.4% between 2005 and 2015 (Meade et al., 2020).

Major depressive disorder (MDD) may have a neurobiological basis, but there are several factors that can predispose someone to MDD. Unemployment and financial stress can contribute, as can female gender or family history of depression. Lifetime incidence for depression among females can be as high as 25%, while for males it can be closer to 12%. The risk for depression among Gulf War veterans is more than twice that of the civilian population (Moore et al., 2023).

Online Resource

Video: Coping with Depression [4:49]

https://www.bing.com/videos/riverview/relatedvideo?q=veterans+and+depression&mid=DE503D1A556CC1BB9F56DE503D1A556CC1BB9F56&mcid=F7609A9FA4014BBF91909207229AB6CA&FORM=VIRE

Source: Veterans Health Administration, 2017.

4.2.1 Symptoms of Depression

Depression is far more complex than sadness, which occurs in response to a specific event. Typically, someone who is sad can muster up some enjoyment in some things, while depression prevents enjoyment of all kinds. Symptoms include loss of interest in most or all activities, insomnia (inability or extreme difficulty falling or staying asleep), hypersomnia (sleeping excessively) or fatigue, fluctuations in weight, reduced ability to concentrate, feelings of worthlessness, excessive or inappropriate guilt, or even thoughts of suicide.

Psychomotor retardation may be present when thoughts and movements slow down significantly, or physical agitation or indecisiveness. To receive a diagnosis for a major depressive episode according to the Diagnostic and Statistical Manual of Mental Illness (DSM-5), a patient must have five or more symptoms for over two weeks and show no manic or hypomanic behavior. A minor depressive episode consists of 2 to 4 symptoms for over two weeks (Truschel, 2022).

4.2.2 Comorbidities

Depression often occurs in tandem with other severe mental disorders, such as anxiety, PTSD, substance use disorder, and many physical ailments. Depression is a frequent companion to chronic physical health conditions like cardiovascular disease, stroke, diabetes, hypotension, arthritis, rheumatoid arthritis and COPD (Meade et al.). Untreated depression causes emotional suffering, reduced productivity, lost wages, impaired relationships, and increased comorbidity risk (Siniscalchi et al., 2020).

Multimorbidity, which is three or more disorders occurring in one patient, is especially high among veterans using the VA. In one large national sample of VA patients receiving treatment for depression, nearly all screened positive for one comorbidity. Over 75% screened positive for comorbid panic/phobia, PTSD, or Generalized Anxiety Disorder (GAD). Nearly half of the respondents screened positive for four or more comorbid mental disorders (Ziobrowski et al., 2021).

One study of veterans suffering from Cannabis Use Disorder (CUD) found that veterans who had been diagnosed with CUD and PTSD were also more likely to have comorbid diagnoses of depression, panic disorder, alcohol use disorder, opioid use disorder and insomnia, than veterans without a PTSD diagnosis. Younger veterans in particular have high levels of comorbidities, due perhaps to long deployments, high unemployment after separating from the military, and experiencing lifelong complications from surviving horrific injuries that were fatal in previous eras (Bryan et al., 2021).

4.2.3 Screening for Depression

Identifying and treating depression effectively includes the increased use of screening tools (Siniscalchi et al., 2020). There are many screening tools for depression, with the Public Health Questionnaire (PHQ) being the most common and effective. The PHQ-2 tool consists of 2 questions about frequency of depressed mood and anhedonia, scoring each as 0 (“not at all”) to 3 (“nearly every day”). The PHQ-9 consists of 9 items based on the 9 *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, fifth edition) criteria for major depressive disorder (Siniscalchi et al., 2020).

Another tool, the Beck Depression Inventory for Primary Care (BDI-PC) has been used in over 7,000 studies. A variation of the BDI is used to determine severity, but the specificity of this tool is lower than the PHQ (Moore et al., 2023). A simple self-administered five-question tool by the World Health Organization, the WHO-5, has a sensitivity of 86% and specificity of 81%. The questions are meant to reflect the respondents’ state in the past two weeks. Each question has a possible score of 1-5. The raw score is multiplied by four, with a score of zero representing the worst possible mental health and 100 representing the best possible state. Anything below 50 is an indication of poor mental health and the need for further assessment (WHO, 2024-01).

Depression is expensive, costing an estimated $210 billion in annual medical care and lost productivity. The US Preventive Services Task Force recommends depression screening for all adults, in addition to support systems and evidence-based protocols (Siniscalchi et al., 2020).

4.2.4 Treatment for Depression

A variety of medications and therapies are available to treat depression. Treatments should be tailored to the individual patient, since everyone experiences the disorder differently.

Psychotherapy encompasses several types of talk therapy, including CBT (cognitive behavioral therapy), interpersonal psychotherapy, behavioral activation, problem-solving therapy, supportive psychotherapy, and psychodynamic psychotherapy. The VA offers many of these treatments, both at VA clinics and through the Community Care referral program.

CBT is often a front-line treatment, with a wealth of research supporting its efficacy for many people. is a collaborative treatment plan that takes 16-20 weeks to complete. Clinicians work with patients to address treatment goals and assign a curriculum of interventions, from how to relax, how to deconstruct destructive thoughts, ask questions, and keep up with weekly assignments to achieve treatment goals. According to one treatment guide, CBT can be summarized this way (Crane and Watters, 2019):

- Cognitive refers to the act of knowing or recognizing our experiences.
- The cognitive model focuses on thinking and how our thoughts are connected to our mood, physiological responses, and behaviors.
- Cognitive therapy will teach you to change your thoughts, beliefs, and attitudes that contribute to your depression.

Online Resource

Video: VA's Proven Therapies for Depression [1:20]

https://www.youtube.com/watch?v=IXbJjL6St6g

Source: Veterans Health Administration.

Further examples of treatments available to veterans suffering from depression include (DVA, 2023):

- **Acceptance and Commitment Therapy for Depression (ACT-D)** can help veterans overcome their emotional pain by promoting positive actions and choices that align with their values. Through this therapy, you may increase your ability to recognize and achieve what truly matters most to you in life.
- **Cognitive Behavioral Therapy for Depression (CBT-D)** is a structured, time-limited therapy that can help veterans with depression develop balanced and helpful thoughts about themselves, others and the future. CBT-D can help you modify your thought patterns to change negative moods and behaviors. It can also help you achieve personal goals by developing new skills.
- **Interpersonal Psychotherapy for Depression (IPT-D)** is focused on identifying and evaluating relationship issues that may be the cause or result of depression. IPT-D can also help you build social skills to deal with problems in your relationships and improve your overall quality of life.
- **Problem-Solving Therapy (PST)** helps veterans recover from difficult situations and learn skills to improve their daily life. This therapy can improve your ability to cope with major life circumstances and stressors and develop a response plan.
- **Behavioral Activation** helps veterans learn how their behaviors are connected to their moods, and how to develop responses to improve their daily satisfaction. This therapy will ask veterans to identify their values and goals and engage in more meaningful activities to achieve them.

Many medications are also available. Antidepressants may take 4-8 weeks to start working, and it is common for patients to try more than one category or dosage before finding the right regimen.

Serotonin reuptake inhibitors (SSRI's), which increase the levels of serotonin in the brain, are often the first choice for major depressive disorder, though other classes of drugs, including ketamine and bupropion (which is also a treatment for seasonal affective disorder and to help patients stop smoking) are also options. Electroconvulsive therapy, which uses an electrical current in the brain to induce a cerebral seizure, is generally reserved for severe cases (Moore et al., 2023).

Serotonin and norepinephrine reuptake inhibitors (SNRIs) help regulate mood by increasing levels of serotonin and norepinephrine. Common SNRIs include venlafaxine and duloxetine. Sometimes these medications cause side effects or don't work. Atypical antidepressants include Mirtazapine, which can also help with sleep difficulties or loss of appetite; or Trazodone, which can also help with insomnia and anxiety. An older category of medications includes tricyclics, tetracyclics, and monoamine oxidase inhibitors (MAOIs). Possible side effects include nausea and vomiting, weight gain, diarrhea, sleepiness, and sexual problems (NIMH, 2023).

Because depression so often co-occurs with other mental health and behavioral problems, the Substance Abuse and Mental Health Services Administration (SAMHSA) has created a treatment protocol for integrated treatment, calling for rigorous screening and assessment of co-occurring disorders, as well as training for practitioners in different but similar fields, stating that, "Counselors and other providers must understand how to recognize signs of highly comorbid mental illnesses, know how these disorders affect treatment decision making, and recognize the trauma history and risk of self-harm associated with these disorders. Equally important, clinicians should learn how to differentiate independent mental disorders from substance-induced mental disorders, as the latter are often treated differently than the former" (SAMHSA, TIP 42, 2020).

Online Resource

Video: Screening and Treatment for Co-Occurring Mental Health and Substance Use Disorders [2:11]

https://www.youtube.com/watch?v=nqjrhF5ZtXM

Source: SAMSHA, 2021.

4.3 Substance Abuse

According to the 2020 National Survey on Drug Use and Health, 5.2 million veterans in the US over the past year had a mental illness and/or a substance use disorder. Twelve percent, or 2.4 million, had a substance use disorder, with 41.9% of those using illicit drugs, 70.1% struggling with alcohol, and 12% using both alcohol and illicit drugs (SAMHSA, 2020).

Marijuana is by far the most-used illicit drug, with three million reported users in the past year. Psychotherapeutic drugs came in a distant second, with 721,000 reported users. Methamphetamines, at just over a quarter million users, was the third most-used illicit drug, with cocaine and hallucinogens almost tied for fourth place, at just over 230,000 (SAMHSA, 2020).

Alcohol Use Disorder (AUD) is a brain disorder that includes alcoholism as well as alcohol abuse, dependence and addiction. It's characterized by a limited ability to stop drinking or to drink in moderation, in spite of the negative consequences it has on social or professional life or overall health. While genetics do contribute to the disorder, environmental factors like trauma and early childhood adversities like abuse and neglect play a role as well.

AUD is also more common among men, which may offer some explanation as to why the rates of AUD among veterans are almost twice as high as they are among the general population (Horvath, 2023). However, researchers from the University of Pennsylvania who analyzed the VA's Million Veteran Program found that, in that initiative, Black and Hispanic military veterans were more likely to be diagnosed with AUD than white veterans, even when reported drinking levels were the same, raising questions about the diagnostic process (Horvath, 2023).

The National Institute on Alcohol Abuse and Alcoholism (NIAA) recommends that healthcare providers integrate an Alcohol Symptom Checklist into primary care and have patient-centered, non-judgmental conversations to help destigmatize any conditions around alcohol so that patients will agree to treatment. A helpful checklist and more information are available at the National Institute on Alcohol Abuse and Alcoholism:

https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/screen-and-assess-use-quick-effective-methods

Alcohol screening and brief intervention can reduce drinking levels, which can decrease accompanying health problems. This may also help the entire family, since the relatives of people with AUD also suffer more health problems and have more costly health care than people who do not have a family member with AUD (NIAAA, 2022). A quick and effective screening tool is the AUDIT-C, or Alcohol Use Disorders Identification Test—Consumption, which consists of three questions developed by the WHO.

Question	**Answer**	**Score**
1. How often did you have a drink containing alcohol in the past year?	Never	0 point
	Monthly or less	1 point
	2 to 4 times per month	2 points
	2 to 3 times per week	3 points
	4 or more times per week	4 points
2. On days in the past year when you drank alcohol how many drinks did you typically drink?	0, 1, or 2	0 point
	3 or 4	1 point
	5 or 6	2 points
	7–9	3 points
	10 or more	4 points
3. How often did you have 6 or more (for men) or 4 or more (for women and everyone 65 and older) drinks on an occasion in the past year?	Never	0 point
	Less than monthly	1 point
	Monthly	2 points
	Weekly	3 points
	Daily or almost daily	4 points

https://www.hepatitis.va.gov/alcohol/treatment/audit-c.asp

Scoring:

- The minimum score (for non-drinkers) is 0 and the maximum possible score is 12.
- The Department of Veteran Affairs (VA) and Department of Defense (DoD) currently considers a screen positive for unhealthy alcohol use if the Alcohol Use Disorders Identification Test - Consumption (AUDIT-C) score is 5 points or greater (DVA, 2024, October 14).

After determining that a patient drinks heavily (which may not mean the presence of an AUD), the provider can administer brief interventions, typically 5-15 minutes and reinforced over future visits. These are not usually sufficient on their own but may lay the foundation for patients to develop the motivation to change their heavy drinking habits (NIAAA, 2022).

There are many treatments for alcohol as well as other substance use disorders. The VA recommends evidence-based treatments like CBT and other forms of structured talk therapies. Medications are also available for the most common substances that interfere with the health of veterans (DVA, 2024, August):

- **Opioid Use Disorder.** Options include methadone, buprenorphine and buprenorphine combination products like Suboxone, and injectable, extended-release naltrexone.
- **Alcohol Use Disorder.** Options include acamprosate, disulfiram, naltrexone and topiramate.
- **Tobacco Use Disorder.** Options include nicotine replacement therapy, bupropion and varenicline.

The VA also recommends having naloxone on hand. This is a nasal spray that can block the effects of an opioid during overdose and save the life of someone who has lost consciousness due to an overdose.

Though Substance Use Disorder (SUD) is separate from PTSD, many veterans suffering from PTSD or other mental health conditions also start misusing substances in an effort to mitigate their suffering from trauma. According to the National Center for PTSD, more than 20% of veterans with PTSD also have SUD. About 10% of veterans returning from Iraq and Afghanistan who seek medical care at the VA have an alcohol or drug problem. Each VA medical center has an SUD-PTSD specialist who is trained to treat both conditions, and evidence shows that the two conditions can be treated at the same time. (NCPTSD, 2023, November).

For veterans who may not be ready to talk to a provider about their SUD, there is an app called VetChange, developed by the VA's National Center for PTSD in partnership with VA Boston Healthcare System and Boston University.

Online Resource

Video: Introduction to the VetChange app for PTSD and problem drinking [5:24]

https://www.youtube.com/watch?v=evmtnKSMe5Q

Source: Veterans Health Administration, 2022.

5. Military Sexual Trauma (MST)

> Following an investigation into harassment at Ft. Hood in Texas, Secretary of the Army Ryan D. McCarthy stated that it had found "major flaws" at Ft. Hood and a command climate "that was permissive of sexual harassment and sexual assault." He ordered that 14 officials, including several high-ranking leaders, be relieved of command or suspended. He promised sweeping reform that would extend far beyond Ft. Hood. McCarthy invited those who don't trust the chain of command to go directly to him with their reports of harassment.
>
> NYTimes, December 8, 2020

Online Resource

Secretary of the Army Addresses the SHARP Program (1:38), Public domain

"The appearance of U.S. Department of Defense (DoD) visual information does not imply or constitute DoD endorsement."

https://www.dvidshub.net/video/773252/secretary-army-addresses-sharp-program

As a society, our view of, and attitudes toward, sexual violence—how we define it, how we treat its victims, how (or if) we punish the perpetrators, and what we try to do to prevent it—have been changing. In many people's minds, sexual assault is synonymous with rape (an act of unwanted sexual intercourse), an act perpetrated by males against females, and, while generally considered a crime, its investigation, prosecution, and punishment are often affected by variations in state laws, social mores, and local attitudes. Negative perceptions and judgments of victims have figured prominently in our social view of sexual assault.

Military sexual trauma (MST) is defined by law as "Physical assault of a sexual nature, battery of a sexual nature, or sexual harassment ["repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character"] that occurred while a veteran was serving on active duty or active duty for training." Some studies suggest that over half of female veterans suffer from MST. This does not mean that men are entirely spared.

According to the Department of Defense, 5.7% of male service members have experienced military sexual harassment and 1.6% have been sexually assaulted. These estimates are probably low, given the reluctance to report and disclose these traumas, even in a healthcare setting (Livingston and Blaise, 2024). Military sexual assault is strongly associated with PTSD and suicidal ideation and suicide attempts, leading to calls for better understanding of how to address suicide risk among survivors of MST.

Veterans suffering from MST should know that they can get help free of charge, even if they do not have a disability rating. There is no time limit, and they do not need to have documented the incidents at the time that they occurred. A VA provider can make a referral to the community, so veterans who live far from a VA center can receive counseling if they want it.

Online Resource

Video: About Military Sexual Trauma [4:59]

https://www.youtube.com/watch?v=b9snig5gZfk&t=166s)

Source: Veteran's Health Administration, 2024, October.

In addition to suicidal ideation and even suicide attempts, MST is strongly associated with sexual dysfunction disorders like sexual arousal disorder, sexual pain disorder and sexual desire disorder. (Monteith et al., 2023). Various analyses suggest that between 23.6%-52.5% of female veterans report MST. Some non-DoD studies estimate that up to 8.9% of male veterans have reported unwanted sexual attention or assault while in the military (Doucette et al., 2022). Risk factors for MST in both men and women include early-life exposures to violence, especially warfare or domestic violence, and child abuse. High-stress environments, such as are typical in the military, especially during deployment, are also predictors for MST. Non-white service members are also at higher risk for sexual predation, as are lower enlisted personnel.

Male service members are also three times likelier than their female colleagues to perceive their sexual victimization as a hazing ritual, or simple bullying, suggesting that the predictors for MST are different for men than they are for women (Doucette et al., 2022).

A recent study suggests an association of MST with a greater risk of all physical health conditions except cancer. This ranged from 9% greater odds of rheumatic disease to 5.4 times greater odds of PTSD (Sumner et al., 2021). Though most studies of female veterans with MST have focused on those of reproductive age, the consequences can follow women throughout their lives. A recent study of female veterans aged 45-64 examined associations between MST, menopause and mental health. The study concluded that exposure to MST is common among midlife women veterans and shows strong and independent associations with clinically significant menopause and mental health symptoms, highlighting the importance of trauma-informed care for female veterans (Travis et al., 2024).

5.1 Screening for MST

Many veterans do not report MST the first time they are screened. But the strong association between MST and suicidal ideation and post-military suicide attempts makes it essential that this population be rescreened, multiple times if necessary. Many veterans screen as positive for MST in research studies, but they give conflicting answers during screenings in clinical settings. In one random sample of female veterans, 15.4% of respondents screened positive for MST during their first screening; however, an additional 6.4% who had previously screened negative switched their answers in a follow-up screening (Monteith et al., 2023). Reproductive healthcare clinics may be a promising setting for uncovering MST and offering treatment options, since many of the conditions arising from MST are related to sexual and reproductive health.

However, individuals who have experienced MST may blame themselves for what happened. They may fear retaliation, negative social consequences, or a breach in confidentiality. Many people are reluctant to talk about trauma, and that could explain why they do not endorse MST in screenings.

One study found that 60% of women veterans who had not screened positive for MST in a clinical setting reported MST by survey, indicating that the screenings provided by the VA were not capturing all the patients with MST. Researchers suggest that providers communicate empathetically with patients in a confidential setting with no other family members nearby and be prepared to re-screen respondents and offer them resources to address their trauma. Some women may not realize that sexual harassment is a form of MST, though persistent harassment has been shown to have negative health repercussions (Hargrave et al., 2022).

The VA's National Center for PTSD recommends the following for providers screening a veteran for MST (Street et al., 2023):

- Create a context that facilitates disclosure; it is a necessary first step. Perform screening in a private setting without risk of interruptions. Ensure that your speech is unhurried and has a supportive tone. Make good eye contact and ensure that your nonverbal behavior conveys your comfort with the topic and the sense that this is an important issue.

- Next, help Veterans feel at ease by normalizing the screening process—say something like, "Stressful life experiences like the ones I'm going to ask about next unfortunately occur so frequently that I ask all my clients whether they experienced them." When asking the screening questions use language that describes behavior and avoids technical or legal language (e.g., avoid "rape" or "sexual assault") and negative phrasing (e.g., "nothing like that has ever happened to you, right?"). The questions used as part of the VA's universal MST screening program provide an example of this approach:

    1) When you were in the military, did you ever receive unwanted sexual attention you found threatening (for example, touching, cornering, pressure for sexual favors, sexual texts or online messages, or inappropriate verbal remarks, etc.)?

    2) Did you have sexual contact against your will or when you were unable to say no (for example, after being forced or threatened or to avoid other consequences)?

- Finally, respond supportively regardless of the Veteran's answer to screening questions. This can include providing support, education, and connection to resources for Veterans who respond "yes" and leaving the door open for future conversations if the Veteran responds "no" (e.g., "I'm glad to hear that. Since those experiences can be tough to talk about, I wanted to ask about them specifically so that you know it's ok for us to talk about difficult topics.").

For mental health professionals who provide care for those who have experienced MST, conducting a solid functional assessment is an important starting place for delivering effective treatment. When the traumatizing event is MST, this assessment should include gathering basic information about the MST experience that may be associated with the complexity of the following symptoms (e.g., was the experience sexual harassment, sexual assault or both?; was it a single incident or an ongoing series of events?; what support was received from others at the time?). The type and course of treatment will determine and whether a more detailed assessment of the specifics of an MST experience is necessary.

Although PTSD is one of the most common mental health diagnoses among individuals who experienced MST, not everyone who experiences MST will go on to develop PTSD. As such, diagnostic assessment should include clear elaboration of any PTSD symptoms but also a focus on any additional relevant psychiatric and physical health comorbidities.

Finally, understanding the extent to which an individual is dissatisfied with their functioning in important life domains (e.g., relationships, work/school, housing/finances, health management) will provide important information for the focus of care.

Prolonged exposure and cognitive processing therapy are strongly recommended for survivors, though some may wish to prioritize psychoeducation and developing adaptive skills.

6. Suicide Among Veterans

Nationwide, more than 30,000 active-duty service members and veterans of the post 9/11 wars have died by suicide, significantly more than the 7,057 killed in combat. A disproportionate number of service members who die by suicide are young males in their twenties, white, non-Hispanic in the Army or Marine Corps (Suitt, 2021).

In 2024, suicide rates among active-duty military personnel rose by 10%, from 331 to 363. John Bateson, former executive director of a Bay Area crisis intervention and suicide prevention center, recommends multiple suicide evaluations for all troops returning from deployment, as well as their families. This should include rigorous reintegration training upon separation from the military, more efficient treatments and benefits for veterans, enforcing the stated policy of zero tolerance for sexual harassment and assault, and a major cultural shift to banish stigma around mental illness (Bateson, 2024).

Why U.S. military personnel and veterans are at increased risk for suicide compared to civilians is the focus of ongoing research. Key issues include military- and non-military-related trauma, combat-related experiences, military sexual assault, difficulty reintegrating into civilian life, and access to guns. Some have a history of childhood abuse and intimate partner violence, and high rates of posttraumatic stress disorder, a known risk factor for both suicidal ideation and behaviors (Holliday et al., 2020).

Despite efforts to address suicide among veterans and service members, little is known about what interventions they are willing to receive. A survey of communication and intervention preferences for veterans and service members found that nearly 90% of respondents indicated that they were willing to speak to someone when having thoughts of suicide. Most indicated they were far less likely to talk about their thoughts of suicide with non-military friends than military friends. They were also considerably less likely to talk about their thoughts of suicide with the Veterans Crisis Line or National Suicide Prevention Line, chaplains, veteran service organizations, other healthcare providers, or their boss. About 10% stated that they would not trust talking with anyone about their thoughts of suicide (Beatty et al., 2023).

6.1 Suicide Warning Signs

Though not everyone who is contemplating suicide gives indications of the extent of their distress, the National Institute of Mental Health has identified some common warning signs (NIMH, revised 2022):

Talking about:

- Wanting to die
- Great guilt or shame
- Being a burden to others

Feeling:

- Empty, hopeless, trapped, or having no reason to live
- Extremely sad, more anxious, agitated, or full of rage
- Unbearable emotional or physical pain

Changing behavior, such as:

- Making a plan or researching ways to die
- Withdrawing from friends, saying goodbye, giving away important items, or making a will
- Taking dangerous risks such as driving extremely fast
- Displaying extreme mood swings
- Eating or sleeping more or less
- Using drugs or alcohol more often

If these warning signs apply to you or someone you know, get help as soon as possible, particularly if the behavior is new or has increased recently.

Video

Comprehensive Suicide Prevention Means All of the Above (1:05) CDC, 2024 CDC suicide prevention video https://www.youtube.com/watch?v=6DTStWXoKz0

Suicide is a preventable public health problem, according to the CDC (Centers for Disease Control and Prevention), which has drawn up a prevention resource, with strategies from strengthening economic supports to teaching coping and problem-solving skills. Though many factors contribute to suicide, the COVID-19 pandemic and the overdose epidemic have taken an outsized toll on mental health in America.

Even very young people are susceptible to suicide. In 2020, suicide was the second leading cause of death for people ages 10-14 and 25-34 years. Non-Hispanic American Indian or Alaska Native (AI/AN) people have the highest suicide rates, followed by non-Hispanic White people. Racism, historical trauma, and long-lasting inequities such as disproportionate exposure to poverty have contributed to higher suicide rates among non-Hispanic AI/AN youth and other groups who have been marginalized. Between 2009-2019, Black adolescents were estimated to have the highest prevalence of suicide attempts. Veterans are also disproportionately affected, as are people who live in rural areas. Transition periods are high-risk, such as the transition between military and civilian life, work into retirement, and high school to college (CDC, 2022).

6.2 Risk Factors for Suicide

Suicide is often preventable. But according to the CDC, there are many categories of risk factor, from a personal history of trauma and dysfunctional relationships to community stressors (CDC, 2022):

Individual risk factors: Previous suicide attempt, history of depression and other mental illnesses, serious illness such as chronic pain, criminal/legal problems, job/financial problems or loss, impulsive or aggressive tendencies, substance misuse, current or prior history of adverse childhood experiences, sense of hopelessness, violence victimization and/or perpetration.

Relationship risk factors: Bullying, family/loved one's history of suicide, loss of relationships, high conflict or violent relationships, social isolation.

Community risk factors: Lack of access to healthcare, suicide cluster in the community, stress of acculturation, community violence, historical trauma, discrimination.

Societal risk factors: Stigma associated with help-seeking and mental illness, easy access to lethal means of suicide among people at risk, unsafe media portrayals of suicide.

Substance use disorders and adverse childhood experiences are associated with suicide risk, especially early use of alcohol. Losing a loved one to overdose or suicide during childhood can increase a person's risk of overdose or suicide later in life (CDC, 2022).

6.3 Protective Factors Against Suicide

The presence of risk factors does not mean suicide is inevitable. There are many protective factors that can promote resilience, both at the individual and community levels (CDC 2022):

Individual protective factors: Effective coping and problem-solving skills, reasons for living (for example, family, friends, pets, etc.), strong sense of cultural identity.

Relationship protective factors: Support from partners, friends, and family, feeling connected to others.

Community protective factors: Feeling connected to school, community, and other social institutions, availability of consistent and high quality physical and behavioral healthcare.

Societal protective factors: Reduced access to lethal means of suicide among people at risk, cultural, religious, or moral objections to suicide.

Stable housing initiatives have been shown to reduce suicide among veterans, such as the Health Care for Homeless Veterans and Safe Haven programs. Rapid rehousing programs for veterans and their families, such as the Supportive Services for Veteran Families, transitional housing and permanent supportive housing through the US Department of Housing and Urban Development and VA, have all reduced homelessness among veterans, removing a significant risk factor for suicide.

In terms of mental health delivery, especially in poverty-stricken rural areas, telehealth has been shown to decrease suicidal ideation.

The CDC also recommends gatekeeper training, using Applied Suicide Intervention Training Skills (ASIST) for counselors responding to calls on suicide prevention hotlines. Another training program, the Garrett Lee Smith Suicide Prevention Program, is in use in 50 states and by 50 tribes. One evaluation found that there were fewer suicide deaths among young people in the counties that were using the GLS program.

Interventions are key and should be repeated. Making a safety plan with someone who is considering suicide is also important. The suicidal person and a provider or trusted friend or family member should know what their warning signs are and how to implement a coping strategy. This could be as simple as going for a walk, listening to uplifting music, or talking to a friend or a professional counselor. Counselors are available for free, confidential consultations by dialing 988 and selecting option 1 for veterans. Interventions should be followed up with at least two structured contacts.

6.4 Screening for Suicidal Ideation

Suicide can often be prevented. Screening tools such as the *Columbia Suicide Severity Risk Scale*, can be used in many settings. The scale was first developed to reduce suicide among adolescents and is now used throughout the world. Over 600 peer-reviewed studies have shown its effectiveness, citing one large acute care system that saw a 50% reduction in suicides since implementing the scale (Columbia University, 2021).

The protocol is intended to be used by people who have been trained in administering it and are able to take the recommended steps if the person answering the questions shows a high risk of suicidality. It contains six questions (Columbia Lighthouse Project, 2016):

1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you actually had any thoughts about killing yourself?
3. Have you thought about how you might do this?
4. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you having the thoughts but you definitely would not act on them?
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6. Have you done anything, started to do anything, or prepared to do anything to end your life?

6.5 Acknowledging Grief

Grief, especially complicated grief, is a common reaction that often co-occurs with PTSD and major depressive disorder. Complicated grief can be associated with intense yearning and preoccupation with the deceased, experiences of emotional pain and numbing, feelings that life is meaningless, and difficulties engaging in social relationships and activities associated with their loss (Gros et al., 2023). It may also lead to heightened suicide risk and physical health problems like high blood pressure and heart troubles. Yearning is specific to complicated grief, though the disorder often co-occurs with depression and PTSD.

Though almost everyone will experience grief at some point in their lives, approximately 10% of bereaved people will have a prolonged grief reaction that causes significant functional impairment. A recent study of veterans seeing mental healthcare found that nearly half exhibited symptoms of complicated grief. The loss of a fallen fellow service member can reverberate for decades, at levels similar to spousal loss. This is significant, because patients who are overwhelmed by grief often do not respond as successfully to treatments for PTSD as those whose grief is less severe (Simon et al., 2020).

The loss of a loved one often comes with many painful adjustments, like being forced into single parenthood and making tough financial decisions. In addition to emotions like denial, guilt and anger, the recently bereaved may experience physical illnesses, anxiety attacks, and chronic fatigue. People grieving should be encouraged to seek the company of friends and family who care about them, support groups or pastoral care from a spiritual advisor. They should be counseled to take care of themselves by eating properly, exercising, resting, and staying away from alcohol and drugs. A mental health clinician can offer guidance as the bereaved work through their loss.

It can be especially difficult for a recently widowed parent to help a child grieve in a healthy way. Children may have outbursts, revert developmentally, or talk incessantly about death. Being able to model appropriate coping skills may be the most difficult parenting task a parent will ever have. Mental Health America offers a variety of resources (MHA, 2024):

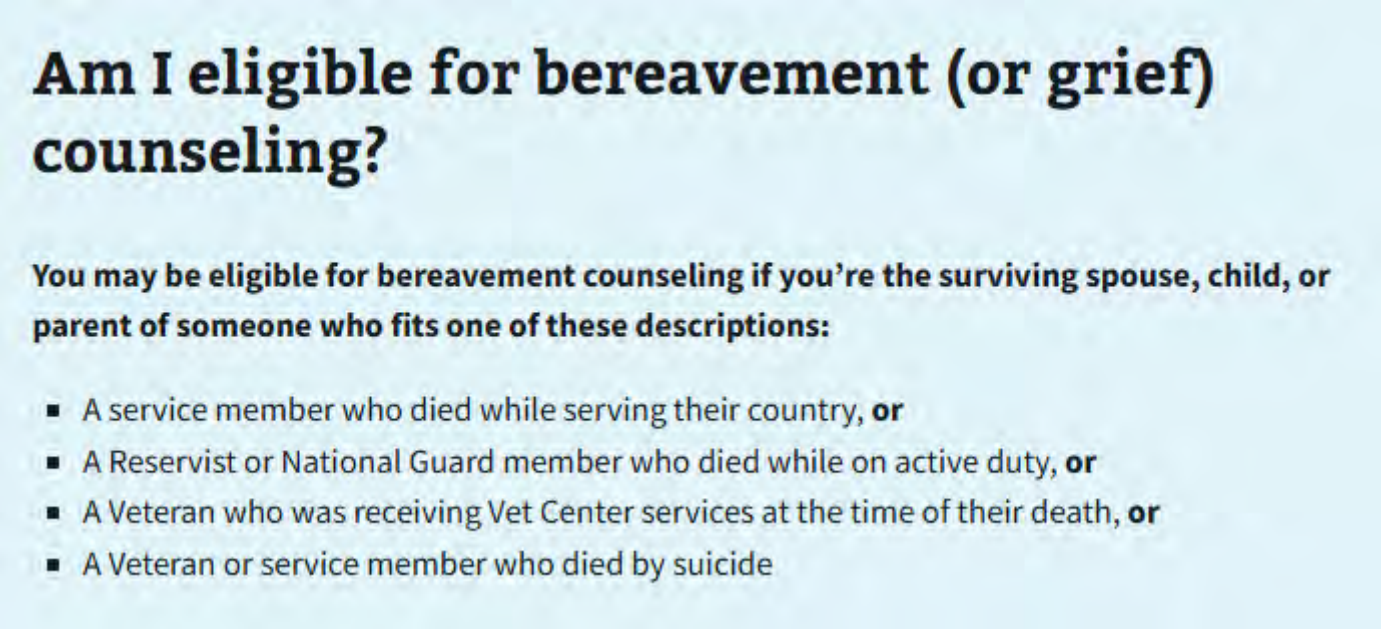
- Tragedy Assistance Program for Survivors, Inc. assists people who have lost family members in the Armed Forces. TAPS provides a survivor-peer support network, grief counseling referrals, and crisis information and can be reached at 1-800-959-TAPS (8277) or www.taps.org.

- The Army Family Assistance Hotline is 1-800-833-6622, and the Army Reservist Hotline is 1-800-318-5298.

- The number for Marine Corps Community Service Centers West of the Mississippi is 1-800-253-1624; and, East of the Mississippi, the number is 1-800-336-4663.

You may be eligible for bereavement counseling if you're the surviving spouse, child, or parent of someone who fits one of these descriptions (DVA, 2025, January 6):

- A service member who died while serving their country, or
- a Reservist or National Guard member who died while on active duty, or
- a Veteran who was receiving Vet Center services at the time of their death, or
- a Veteran or service member who died by suicide.



Source: Department of Veterans Affairs, Bereavement Counseling
https://www.va.gov/burials-memorials/bereavement-counseling

The surviving spouse, child, or parent of a service member or veteran who died may qualify for bereavement counseling. Free services include outreach, counseling and referrals, at community-based Vet Centers or other locations, or through telehealth (DVA, 2024, October 30).

7. Intimate Partner Violence and Child Maltreatment

Domestic violence, including intimate partner violence and child abuse, is common among veteran and active-duty families. This may be due to the co-occurrence of PTSD and substance misuse, especially alcohol, that are prevalent among service members.

7.1 Intimate Partner Violence (IPV)

Intimate partner violence consists of verbal, emotional, physical or sexual abuse, including stalking, between current or former intimate partners. Perpetrators have often been victims of IPV, and in some relationships, both partners perpetrate IPV on one another. Examples of IPV include any use of force or coercion, isolation, controlling the partner's activities or money, embarrassing the victim in front of others to make a point, controlling what the victim wears or where he or she goes, or threatening to harm the victim or loved ones, including pets (DVA, 2024, October 3).

IPV is a serious problem among veterans and their families. A 2018 study found that 36% of women and 34% of men will experience IPV at some point in their lives. Among veterans and service members, the estimate skyrockets to 58%. Since 2019, the VA has required all VA facilities to have an IPV specialist on hand, but inconsistent training and the lack of standardized program evaluations have led to inconsistent delivery of these specialized services (Spotswood, 2022).

The VA estimates that one-third of women veterans will experience IPV, as opposed to less than a quarter of civilian women. Women veterans who identify as LGBTQ+ are two to three times more likely other women veterans to report IPV. This also drastically increases their rates of housing instability and homelessness (DVA, 2024, October 3). The majority of IPV perpetrators are men, suggesting that "men's use of violence should comprise a foremost priority for initiatives aiming to reduce the burden of IPV" among service members and veterans (Cowlishaw et al., 2022).

7.2 Child Maltreatment

There are high rates of substance abuse, trauma, and intimate partner violence among active-duty military personnel and veterans. A recent review found that major contributing factors to child maltreatment were parental substance abuse and intimate partner violence. Social support was the most significant protective factor across all maltreatment types except sexual abuse (Younas, Morrison Gutman, 2022).

Many military veterans were abused as children themselves, which often leads to aggression and other maladaptive behaviors in adulthood. PTSD and substance misuse, which are common among the military and veteran populations, are also common contributors to violent behavior (Massa et al., 2022).

The federal definition of child abuse, according to the Federal Child Abuse Prevention and Treatment Act, defines child abuse and neglect as, at minimum (USDHHS, 2023):

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act which presents an imminent risk of serious harm.

This is a narrow definition, which refers to parents and other caregivers. States and territories may also have definitions of child abuse in their laws. The four most common types of abuse and neglect are (CDC, 2024):

- **Physical abuse** is the intentional use of physical force that can result in physical injury.

Examples include hitting, kicking, shaking, or other shows of force against a child.

- **Sexual abuse** refers to any completed or attempted sexual acts or sexual contact with a child by a caregiver. Examples include fondling, penetration, and exposing a child to other sexual activities.
- **Emotional abuse** refers to behaviors that harm a child's self-worth or emotional well-being. Examples include name-calling, shaming, rejecting, and withholding love.
- **Neglect** is the failure to meet a child's basic physical and emotional needs. These needs include housing, food, clothing, education, access to medical care, and having feelings validated and appropriately responded to.

At least one in seven children experience child abuse or neglect. In 2021, more than 1,800 children in the U.S. died of abuse and neglect. Poverty is a major factor, with poor children experiencing abuse and neglect at five times the rate of those living in more financially comfortable situations. As a public health problem, it is also costly. The total lifetime economic burden associated with substantiated cases of child abuse and neglect in the U.S. was around $592 billion in 2018 (Klika et al., 2020).

8. Making Appropriate Referrals

The Veterans Administration and Department of Defense have developed numerous government programs, services, and benefits for veterans and their 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. The VA provides many free healthcare services, including counseling and therapy, for veterans and their families. These are available at VA facilities, online or over the phone through telehealth, or by referring patients to civilian providers. Primary care and behavioral health providers in the civilian sector can make a positive difference in the lives of veterans and their families by instituting the following three clinical best practices:

1. Ask and assess: Screen for military service and veteran status, then screen for comorbid physical and mental health problems. These include:

- PTSD
- Military Sexual Trauma, or MST
- Suicide risk
- Depression
- Grief
- Substance abuse

2. Intervene: Healthcare professionals can provide brief interventions such as giving feedback on screening results, describing risks associated with behavioral health disorders, 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: Brief Interventions and Brief Therapies for Substance Abuse
- TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment

3. Refer: If health screenings indicate the need for specialized care for behavioral or mental health problems, 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.

The Uniformed Services of the Health Sciences, a university within the office of the Assistant Secretary of Defense for Health Affairs, has partnered with the Center for Deployment Psychology, to provide training for healthcare professionals who offer services to military personnel and veterans. "*Military Culture: Core Competencies for Healthcare Professionals*," is a four-module course that invites healthcare providers to reflect on potential biases that might affect their work with members of the military culture. The modules also cover military organization and roles, stressors and resources, and treatment.

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[Continue to next page to start quiz]

Quiz: Mental Health Care of American Veterans and Their Families (354)

1. A veteran is a former member of the armed forces who was not dishonorably discharged from service in the active military, naval, or air service.

a. True
b. False

2. Services offered to veterans through the VA medical system include inpatient hospital care, surgery, home-based rehabilitation, prescriptions, vaccinations, and mental healthcare.

a. True
b. False

3. Sometimes veterans suffering from mental illness stigmatize themselves, creating barriers to treatment.

a. True
b. False

4. Screening is key to determining if a patient served in the military and is eligible for treatment of many health problems common to veterans.

a. True
b. False

5. Providers may have biases about military culture they are unaware of.

1. a. True
b. False

6. PTSD is a common mental health problem among veterans.

a. True
b. False

7. Symptoms of PTSD include re-experiencing the trauma, avoidance behaviors or numbing, including self-medicating with alcohol or drugs, hypervigilance and difficulty concentrating.

a. True
b. False

8. People experiencing PTSD are always harmless to others.

a. True
b. False

9. There are no evidence-based treatments for PTSD.

a. True
b. False

10. Burnout has a real impact on caregiver effectiveness and mental health.

a. True
b. False

11. The American Academy of Nurses recommends healthcare providers develop cultural competency in order to better treat service members and veterans.

a. True
b. False

12. Depression often occurs in tandem with other mental, behavioral, and physical health problems.

a. True
b. False

13. Depression often has many comorbidities, including substance use disorder, anxiety, PTSD and grief, and physical ailments.

a. True
b. False

14. Substance use disorder, although not the same as PTSD, depression or grief, may stem from many other disorders.

a. True
b. False

15. MST can result from persistent verbal harassment as well as sexual assault.

a. True
b. False

16. Even harassment can have negative health consequences.

a. True
b. False

17. Asking someone if they are thinking about suicide can be the first step to getting help.

a. True
b. False

18. Serious hardships and transitions present an especially high suicide risk for people who have a history of depression, adverse childhood experiences, or a history of being bullied or beaten up.

a. True
b. False

19. Protective factors for suicide include developing individual coping skills as well as strong community connections.

a. True
b. False

20. Complicated grief is often made even more challenging by financial strain, single parenthood, and managing the grief of young children.

a. True
b. False

21. Intimate partner violence includes threats of harm and the use of humiliation and control, as well as actual physical violence.

a. True
b. False

22. Substance abuse, trauma and intimate partner violence, as well as a history of child abuse, all of which are common among active-duty military personnel and veterans, may predict high rates of child maltreatment.

a. True
b. False

[Continue to next page for answer sheet]

Answer Sheet: Mental Health Care of American Veterans and Their Families (354)

Name (Please print) _____

Date _____

Passing score is 80%

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____

[Continue to next page for course evaluation]

Evaluation: Mental Health Care of American Veterans and Their Families (354)

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:

1. Understand the number of military veterans in the United States.	1 2 3 4 5
2. Understand the purpose and mission of the Patient-Centered Community Care programs.	1 2 3 4 5
3. Define military cultural competence.	1 2 3 4 5
4. Describe the importance of screening for PTSD, depression, and substance abuse in military veterans and their families.	1 2 3 4 5
5. Define military sexual trauma.	1 2 3 4 5
6. Relate 1 individual, 1 relationship, 1 community, and 1 societal risk factor for suicide.	1 2 3 4 5
7. Relate the incidence of intimate partner violence among veterans and their families.	1 2 3 4 5
8. Explain 3 clinical best practices for referring veterans to healthcare services.	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
*Did this course contain discriminatory or prejudicial language?	Yes No
*Was this course free of commercial bias and product promotion?	Yes No
*As a result of what you have learned, will 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 satisfaction 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 _____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. _____Social Media

_____Other _____

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:

[Continue to next page for registration and payment]

Registration and Payment: Mental Health Care of American Veterans and Their Families (354)

Please answer all the following questions (* required).

*Name: _____

*Email: _____

*Address: _____

*City and State: _____

*Zip: _____

*Country: _____

*Phone: _____

*Professional Credentials/Designations:_____

*License Number and State: _____

Payment Options

You may pay by credit card, check, or money order.
Fill out this section only if you are paying by credit card.
3 contact hours: $29

Credit card information

*Name: _____
Address (if different from above):
*City and State: _____
*Zip: _____
*Card type: Visa Master Card American Express Discover
*Card number: _____
*CVS#: _____ *Expiration date: _____