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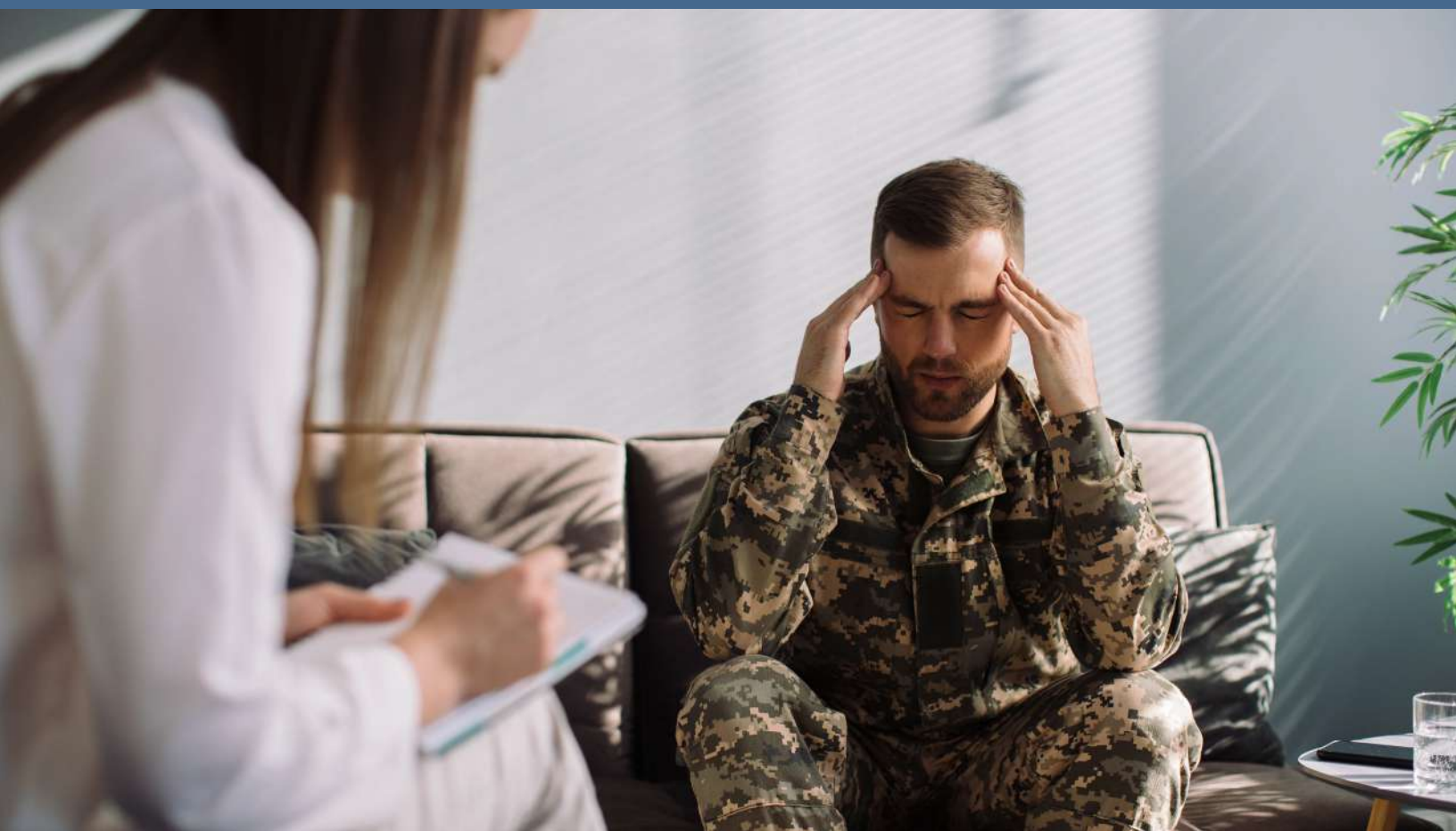
Mental Health Conditions Common Among Veterans and Their Family Members



Section 1: Introduction

References: 42, 52, 59, 60, 61

The United States Department of Veterans Affairs (VA) (2019) defines a Veteran as “a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable” (para. 3). According to the United States Census Bureau (2024), there were 15.8 million Veterans in the United States in 2023. The most significant number of military Veterans served in the Vietnam War, followed by those who served in the post-September 11th period and the Persian Gulf War. In addition to the total number of Veterans, just over 2 million troops were serving in active duty or the Reserves as of June 2024 (USAFacts, 2025). One estimate suggests that approximately 200,000 men and women transition out of active duty service and into civilian life each year, contributing to the total nuber of Veterans in the United States (Owens, 2022).

A report by Schwam et al. (2024) on Veteran families aimed to capture the number of Veteran households in the United States and create a profile of them. This report utilizes data from the American Community Survey, conducted by the United States Census Bureau, from 2018 to 2022. In the report, a Veteran household is defined as “one in which either the head of household or their spouse (if present) is a Veteran” (p. 2). The report found that there are over 14 million Veteran households in the United States, which accounts for approximately 11% of all households in the country. The majority of these households consist of married or partnered couples. The majority also have an adult age 65 or older as the head of household, with children being over 18 years old. The report notes that there may be additional households where a parent or adult child who is a Veteran lives in the same home. However, these households were not counted in

this report, so the number of Veteran families is likely larger than 14 million (Schwam et al., 2024).

There are numerous adjustments for Veterans and their families when returning to civilian life. Their lives change in many different areas, including employment, finances, housing, relationships, social support, and physical and mental health. There can also be a change in identities and self-perceptions, as well as a significant shift in culture from a collective to an individualized one. Research has shown that a range of 44% to 72% of Veterans experience high levels of stress during these adjustments. Contributing to this stress is a delay in accessing supportive resources, which is estimated to occur approximately 50% of the time. Without supportive resources, behavioral health conditions can arise and become exacerbated by stress. One estimate states that just over 5 million Veterans experienced a behavioral health condition in 2020. Additionally, another estimate shows that more than 50% of Veterans with a mental health condition and more than 90% of Veterans with a substance use disorder did not receive treatment (Owens, 2022).

With the number of Veterans and their families in the United States, and the prevalence and impact of behavioral health conditions, mental health professionals need to be skilled in determining if a patient is a Veteran or a family member of a Veteran, knowledgeable about mental health conditions that are common in Veterans, competent in evidence-based interventions, and trained in suicide prevention.

Section 1 Key Terms

The Reserves consist of two parts: the National Guard and the Reserves. These are individuals trained to serve during times of war, national emergencies, or security threats. People may be in the Reserves on a full-time or part-time basis.

Active duty is working full-time for the military. People may live on a military base and be deployed at any time (The Council of State Governments, 2023).

Veterans are individuals who have served in the active military, naval, or air service and were discharged under conditions other than dishonorable (United States Department of Veterans Affairs, 2019).

Civilian life refers to the life and responsibilities that exist outside of the military, including work, family, and relationships.

Section 1 Reflection Questions

Do you work with Veterans in your practice? If not, do you know a Veteran personally?

What types of adjustments have you observed when they return to civilian life?

Section 2: Screening for Veteran Status

References: 9, 18, 37, 39, 47, 77, 79, 80

Research has shown that Veterans and their family members often do not disclose their service history to healthcare providers (Moore et al., 2023). A few reasons for the lack of disclosure are the ingrained military culture of self-reliance and not admitting any vulnerability or pain, and the stigma that can come with having physical problems (Vest et al., 2018b).

There is also some overlap in these reasons in mental healthcare. Stigma is also one of the main reasons that Veterans do not seek this type of care. Some Veterans do not want to be perceived as weak, either in how they view themselves or how others view them. They may also fear that having a mental health condition would harm their career (Brown, 2025; RAND Health Care, n.d.).

Additionally, Veteran status is not commonly asked in traditional behavioral health assessments or primary care clinics (United States Department of Veterans Affairs, n.d.; Vest, 2018a). Due to the lack of disclosure of Veteran status in healthcare and mental healthcare, professionals need to screen for military service during their assessments (Moore et al., 2023).

Mental health professionals should continue to conduct comprehensive assessments when initially meeting with their clients, encompassing the cognitive, emotional, behavioral, social, and physical aspects of their lives. The American Psychological Association (2021) states that mental health professionals should ask all clients about their past military status during an assessment. This question is noted to be “simple, quick, and can have important implications for available benefits and care” (United States Department of Veterans Affairs, n.d., para 2).

Moore et al. (2023) provide recommendations for questions to include during the assessment process regarding military service. As a starting point, they suggest asking if the client or someone close to them has ever served in the military. If the answer is yes, asking about the following aspects of military service helps learn more about the client or their family system:

- Service period
- Service in the Reserves, National Guard, or any active duty
- Responsibilities and roles
- Service in a combat or hostile area
- Experiences such as enemy fire, and witnessing combat or casualties
- Wounds, injuries, or hospitalizations
- Exposures such as chemicals, gases, noise, or other hazardous substances

- Utilization of the VA for care and services

(Moore et al, 2023; United States Department of Veterans Affairs, n.d.)

The National Association of Social Workers (NASW) (2012) states that it can also be helpful to ask about a person's background on joining the military (personal choice vs. draft), the location(s) where they were stationed, the number of deployments and adjustments to civilian life, type of discharge, and prisoner of war status.

Once it has been determined that a client is a Veteran, there are screening tools that can be used to help mental health professionals learn more about whether the Veteran is experiencing symptoms of a behavioral health condition and if they are at risk for suicide. The next section of this course outlines common behavioral health conditions in Veterans.

Section 2 Key Term

Stigmas are beliefs and attitudes about specific aspects of a person's life that others may perceive to be negative or bad. People may experience self-stigma, feeling ashamed or bad about themselves. There is also anticipated stigma when people fear that they will be treated differently in the future because of negative stereotyping or prejudice. Additionally, there is public stigma, which is a collective set of beliefs that can cause discrimination against a group of people (American Addiction Centers, 2025).

Section 2 Reflection Questions

In your work, do you know a client's Veteran status before meeting with them? If not, do you ask about Veteran status during the assessment process?

If you are not currently inquiring about Veteran status, how will you incorporate it, along with other assessment questions, into your practice?

Section 3: Behavioral Health Conditions in Veterans

References: 1, 4, 6, 7, 8, 10, 11, 12, 13, 15, 16, 19, 20, 21, 22, 23, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 40, 43, 44, 46, 48, 51, 55, 65, 67, 68, 69, 70, 74, 75

Several different behavioral health conditions can impact Veterans, including anxiety disorders, depressive disorders, posttraumatic stress disorder, substance use disorders, and grief. Mental health professionals need to be aware of these disorders, including their definitions, risk factors, symptoms, screening tools, diagnostic criteria, and evidence-based interventions.

A comprehensive assessment that provides insight into a Veteran's current situation as well as their prior physical and mental health concerns, substance abuse history, family history, personal and social history, and development history, all done through a lens that is sensitive to trauma, is essential. In addition to completing a comprehensive assessment, mental health professionals consult and collaborate with other professionals involved in a Veteran's care, including primary care physicians and psychiatrists. A multi-disciplinary approach provides the best care possible for a Veteran, especially because they may be dealing with concerns issues in areas other than mental health. Having a complete picture of the Veterans' history and current situation helps a mental health professional understand if they have a behavioral health condition and recommend interventions that would be effective in treating it (Moore et al., 2023).

Behavioral Health Conditions

Anxiety

While experiencing anxiety at times can be considered a regular part of life, anxiety disorders arise when people have excessive and persistent worry about various things in their daily lives. This type of worry and feelings of anxiety interfere with daily activities, are hard to control, and can last for long periods (Mayo Clinic, 2018).

The American Psychological Association (2018a) defines anxiety as:

> *"An emotion characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune. The body often mobilizes itself to meet the perceived threat: Muscles become tense, breathing is faster, and the heart beats more rapidly. Anxiety may be distinguished from fear both conceptually and physiologically, although the two terms are often used interchangeably. Anxiety is considered a future-oriented, long-acting response broadly focused on a diffuse threat, whereas fear is an appropriate, present-oriented, and short-lived response to a clearly identifiable and specific threat (para.1)."*

Risk Factors for Anxiety

The nature of being in the service and exposure to life-threatening situations are risk factors for anxiety that are unique to Veterans. Stress, physical trauma, health conditions, and substance use are other risk factors that may impact Veterans (American Addiction Centers, 2024).

Symptoms of Anxiety

Common symptoms of anxiety include:

- Feeling nervous, on edge, restless, or tense
- Having a sense of impending danger or doom
- Irritability
- Increased heart rate
- Rapid breathing, sweating, or trembling
- Gastrointestinal issues
- Aches and pains
- Weakness or fatigue
- Difficulty concentrating
- Trouble sleeping
- Persistent worry that is hard to control
- Avoiding people, situations, or things that trigger anxiety

(Mayo Clinic, 2018; Munir & Takov, 2022)

Results from one study by Macdonald-Gagnon et al. (2024) suggest that 3 out of 10 Veterans in the U.S. report anxiety symptoms, and that those with symptoms were younger, from a racial or ethnic minority group, more likely to be female, and more likely to have served two or more deployments.

Anxiety Disorders

There are many unique stressors, traumas, and uncertainties related to military service that can have lasting impacts on a Veteran's mental health. Anxiety in Veterans can be linked to combat, survivor's guilt, and the transition to civilian life.

Veterans who have experienced combat may have heightened states of arousal and specific phobias related to it, and they may relive traumatic events. Veterans who survive combat may feel survivor's guilt about being alive when others are not. Survivor's guilt can lead to self-blame and intrusive thoughts that are anxiety-provoking. The transition to civilian life can also have many unknowns and adjustments that trigger anxiety (High Focus Treatment Centers, 2024).

There are several different types of anxiety disorders, including generalized anxiety disorder, panic disorder, social anxiety disorder, and specific phobias (United States Department of Veterans Affairs, 2025a).

Generalized Anxiety Disorder

Generalized anxiety disorder is one of the most common mental health disorders. It can feel like a constant, exaggerated worry, accompanied by irrational thoughts about various aspects of daily life, including work, finances, relationships, and health.

Some research has shown that Veterans experience symptoms of generalized anxiety disorder at higher rates than the general population, with rates of anxiety in Veterans estimated to be around 5% to 12%. The rate for the general population is approximately 3% (Close, 2024).

To screen for generalized anxiety disorder, mental health professionals can use the following tools:

- Generalized Anxiety Disorder 2-item (GAD-2) - A short questionnaire that includes the first two questions of the GAD-7. These questions are focused on the feelings of nervousness/anxiety/being on edge and uncontrollable worry.
- Generalized Anxiety Disorder 7-item (GAD-7) - The complete questionnaire to screen for generalized anxiety symptoms.

(Lawthorne-Scott & Philpott, 2013; United States Department of Veterans Affairs, 2024c)

The VA also offers a tool on its website for Veterans to screen themselves for generalized anxiety disorder (United States Department of Veterans Affairs, 2025a).

For a diagnosis, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) criteria state that the excessive worry and anxiety about a variety of things must be present on most days for at least 6 months and cause significant distress or impairment. A person must also find it difficult to control the worry, which is accompanied by at least three of the following six anxiety symptoms for more days than not in the same 6-month period:

- Restlessness
- Easy fatigue
- Trouble concentrating
- Irritability
- Muscle tension
- Difficulty sleeping.

Additionally, the anxiety is not better explained by the effects of a substance, another mental health condition, or a physical issue (Lawthorne-Scott & Philpott, 2013; Munir & Takov, 2022; United States Department of Veterans Affairs, 2025a).

Panic Disorder

Panic disorder brings sudden, unexpected episodes of intense fear or terror called panic attacks. These episodes are accompanied by physical symptoms, such as a pounding heart, trouble breathing, sweating, chest pain, nausea, trembling, chills

or feeling hot, lightheadedness or dizziness, and numbness or tingling in the extremities. During these episodes, people may feel disconnected from reality, experience a loss of control, and fear impending doom. They may also feel like they are close to death or losing their mind. People who have panic attacks live in a state of worry about when the next one will happen, so they may start to avoid places or situations that trigger panic (also called agoraphobia), ultimately limiting their functioning and quality of life (Degeorge, et al., 2022; Lawthorne-Scott & Philpott, 2013; United States Department of Veterans Affairs, 2025a).

Some research has shown that about 6% to 8% of Veterans have been diagnosed with panic disorder (Gros et al., 2023).

To screen for panic disorder, mental health professionals can use the following tool:

- Patient Health Questionnaire - Panic Disorder (PHQ-PD) - A 15-item measure to screen for panic symptoms and attacks (Degeorge et al., 2022).

The VA also offers a tool on its website for Veterans to screen themselves for panic disorder (United States Department of Veterans Affairs, 2025a).

For a diagnosis, the DSM-5-TR criteria state that panic attacks are recurrent and unexpected. They reach a peak within minutes, during which time at least 4 of the physical symptoms noted above occur. The panic attacks are also followed by one month or more of constant worry about having another panic attack, and/or maladaptive changes in behavior related to the attack. Additionally, the panic attack is not better explained by the effects of a substance, another mental health condition, or a physical issue (Degeorge et al., 2022).

Social Anxiety Disorder

Social anxiety disorder is intense, long-lasting anxiety related to everyday social situations. People can become self-conscious and have a constant fear of being

watched and judged by others. Physical symptoms include sweating, trembling, blushing, nausea, and difficulty speaking. People may worry for days or weeks before a social situation, often dreading it, and the worry ultimately interferes with their ability to participate, causing them to think about how others judged them for hours afterwards. The worry and fear can also be significant enough to impact relationships, work, and other aspects of life. (Lawthorne-Scott & Philpott, 2013; United States Department of Veterans Affairs, 2025a).

One study showed that about 9% of Veterans experience symptoms of social anxiety disorder in their lifetime (Byrne et al., 2021).

To screen for social anxiety disorder, mental health professionals can use the following tool:

- Mini-Social Phobia Inventory (Mini-SPIN) - A questionnaire that has three questions from the complete Social Phobia Inventory (SPIN). The questions focus on fear of embarrassment, as well as avoidance of activities (Connor et al., 2001; Rose & Tadi, 2022).

The VA also offers a tool on its website for Veterans to screen themselves for social anxiety disorder (United States Department of Veterans Affairs, 2025a).

For a diagnosis, the DSM-5-TR criteria state that the fear or anxiety about one or more social situations must be persistent for six months or more. The fear or anxiety should be related to negative judgment or humiliation by others. Social situations that cause anxiety are often avoided, but if they are attended, there is intense fear and anxiety the entire time the situation takes place. The fear and anxiety are also not proportional to the actual social situation and cause significant distress or impairment. Additionally, the fear or anxiety is not better explained by the effects of a substance, another mental health condition, or a physical issue (Barnhill, 2023a).

Specific Phobias

Specific phobias are a type of anxiety that comes with an intense, irrational fear of a situation or object that does not pose a significant threat. When thinking about facing the fear, a person may experience anxiety that can escalate into a panic attack when exposed to the fear. Therefore, a person may try to avoid the situation or object as much as possible (Barnhill, 2023b; Lawthorne-Scott & Philpott, 2013; United States Department of Veterans Affairs, 2025a).

To screen for specific phobias, generalized anxiety disorder screenings can be used. The Phobia Questionnaire (PHQ) can also be used to measure avoidance based on fear (PsychDB, 2024). Additionally, the VA offers a tool on its website for Veterans to screen themselves for particular phobias (United States Department of Veterans Affairs, 2025a).

For a diagnosis, the DSM-5-TR criteria state that the fear or anxiety about a situation or object must be persistent for six months or more. The situation or object nearly always triggers an immediate fear or anxiety response, and it is actively avoided or endured with intense feelings. The fear or anxiety is disproportionate to the actual danger, and it causes significant distress or impairment in functioning. Additionally, fear or anxiety is not better explained by the effects of a substance, another mental health condition, or a physical issue. Lastly, the diagnosis should specify if the fear is related to animals, the natural environment, blood-injection-injury, situational, or other (Barnhill, 2023b).

Depression

Feeling down or sad from time to time is a regular part of life. Though it is common, depression is different from normal sadness that people can experience. The American Psychological Association (2018b) defines depression as “a negative affective state, ranging from unhappiness and discontent to an extreme feeling of

sadness, pessimism, and despondency, that interferes with daily life" (para 1). Depression is a problem that affects people physically, mentally, and emotionally. It not only impacts sleep and/or appetite, but also affects the way people think about things and how they feel about themselves (Lawthorne-Scott & Philpott, 2013).

Risk Factors for Depression

Risk factors for depression that are unique to Veterans include deployments, combat exposure, frequent relocations, and concerns about physical and mental health (Moore et al., 2023). Stressful events (either one-time or chronic), abusing alcohol or drugs, long-term health problems, and having another mental health condition, such as post-traumatic stress disorder or anxiety, are risk factors for depression that could be related to Veterans. Additional risk factors for depression are being female, low self-esteem, low socioeconomic status, low social support, a personal and/or family history of depression, physical or sexual abuse, health problems (for example, an underactive thyroid), and certain medications (steroids or narcotics) (Mauer et al., 2018; United States Department of Veterans Affairs, 2025h).

Symptoms of Depression

Common symptoms of depression include the following:

- Feeling sad, empty, or hopeless more days than not
- Losing interest in enjoyable things and everyday activities
- Changes in appetite that cause significant weight loss or weight gain
- Decreased energy or increased fatigue
- Changes in sleep, by either sleeping too much or not enough

- Trouble concentrating and making decisions
- Slower speech or movement
- Feeling guilty or worthless
- Having thoughts of death or recurrent suicidal ideation without a plan or attempt

  (Lawthorne-Scott & Philpott, 2013; Maurer et al., 2018; United States Department of Veterans Affairs, 2025b)

Types of Depressive Disorders

According to Lawthorne-Scott & Philpott (2013), there are many different causes of depression. Specific to Veterans, “people returning from a war zone often experience painful memories, feelings of guilt, or regret about their war experiences, or have a tough time readjusting back to normal life” (p. 78). Difficulty coping with these feelings and experiences can contribute to depression.

Depression is different from being diagnosed with a depressive disorder because it is situational, and emotions often subside with time. There are various depressive disorders, including major depressive disorder (also called major depression or clinical depression) and persistent depressive disorder. The diagnosis for one or both can occur when certain symptoms are present for a specific period (Coryell, 2025).

Major Depressive Disorder

Major depressive disorder is one of the most common types of depressive disorders. It is a chronic condition that typically presents in episodes lasting weeks or months. There are subtypes of major depressive disorder, including seasonal affective disorder as well as prenatal and postpartum depression (Cleveland Clinic, 2022). This section will focus on major depressive disorder in general.

In the 2020 National Survey on Drug Use and Health in Veteran Adults, the rates of major depressive episodes in adults 26 and older have been increasing since 2017, with the highest rates in 2020. Nearly 1.8 million Veterans had a major depressive episode in the past year in 2020, compared to just over 1.1 million in 2017 (Substance Abuse and Mental Health Services Administration, 2022).

To screen for major depressive disorder, mental health professionals can use the following tools:

- Patient Health Questionnaire-2 (PHQ-2) - A short questionnaire that includes the first two questions of the PHQ-9. These questions focus on how often a person has felt little interest or pleasure in doing things and how often they have felt down, depressed, or hopeless.
- Patient Health Questionnaire-9 (PHQ-9) - If a person screens positive on the PHQ-2, they are asked the additional questions in the PHQ-9, which is the complete measure that assesses a larger range of depression symptoms.
- Beck Depression Inventory (BDI) - A 21-item self-report questionnaire to screen for the emotional, cognitive, motivational, and physiological aspects of depression.
- The Center for Epidemiologic Studies Depression Scale (CES-D) - A 20-item self-report questionnaire that measures the main dimensions of depression.

  (American Psychological Association, 2023a; United States Department of Veterans Affairs, 2024c)

The VA recommends annual screening for depression (Maurer et al., 2018). The VA website uses the PHQ-2 and PHQ-9 to screen for depression.

For a diagnosis, the DSM-5-TR criteria state that five or more of the above depression symptoms must have been present nearly every day in the same two-

week period, and one of these symptoms must be a depressed mood or loss of interest (Coryell, 2025). There should also be a change in functional status (Moore et al., 2023). An episode of mania or hypomania should be ruled out. The symptoms must also not be better explained by the effects of a substance, another mental health condition, or a physical issue (Cleveland Clinic, 2022).

Persistent Depressive Disorder

Persistent depressive disorder is a newer diagnosis in the DSM-5. It combines dysthymic disorder and chronic major depressive disorder. Depressive symptoms are more constant and for a longer period when compared to major depressive disorder. Suicidal thoughts and behaviors are also increased, and functional impairments are as severe or more severe than those with major depressive disorder.

To screen for persistent depressive disorder, the PHQ-2, PHQ-9, BDI, and CES-D tools mentioned above can be used. Studies have found that the Cornell Dysthymia Rating Scale (CDRS) can also be used to screen for chronic depression (Melrose, 2017).

For a diagnosis, the DSM-5-TR criteria state that a depressed mood must be present for more days than not during the same two-year period, and there must be at least two of the following symptoms:

- Lack of appetite or overeating
- Sleeping too much or not enough
- Low energy or fatigue
- Low self-esteem
- Difficulty concentrating and making decisions

- Feeling hopeless

Additionally, a person must not be without symptoms for more than two months at a time. An episode of mania or hypomania should also be ruled out. There should be a change in functional status. The symptoms must also not be better explained by the effects of a substance, another mental health condition, or a physical issue (Coryell, 2025; Patel et al., 2024).

Posttraumatic Stress Disorder

Posttraumatic stress disorder, or PTSD, is the most common behavioral health condition that comes to mind when thinking about the effects of active duty service on Veterans, as it is most often observed in people who have survived violent events, including war. PTSD can only develop after a person goes through or witnesses a life-threatening event (United States Department of Veterans Affairs, 2025c). Secondhand exposure to trauma can also lead to PTSD (Moore et al., 2023).

The American Psychological Association (2023b) defines PTSD as “a disorder that may result when an individual lives through or witnesses an event in which they believe that there is a threat to life or physical integrity and safety and experiences fear, terror, or helplessness” (para 1).

Moore et al. (2023) note that many people who have witnessed and/or experienced trauma will experience stress reactions, but their feelings typically resolve within a month. In 10% to 20% of people who have experienced trauma, the stress reaction can worsen, become persistent, and cause problems in a person’s life, which may lead to a diagnosis of PTSD.

Veterans may have witnessed a wide variety of traumatic events, including severe injuries and violent deaths, which can happen suddenly and unpredictably. They may also be adjusting to an injury of their own. There are also challenges to the

deployment environment, interpersonal violence, and physical or sexual abuse. All of these can be exacerbated in the deployment environment and may also worsen when additional stressors of post-civilian life are present. Considering all of this, PTSD can affect several aspects of a person's life, and the impact can be significant. The symptoms can disrupt functioning by impacting psychological, emotional, physical, behavioral, and cognitive aspects (Moore et al., 2023).

According to the National Center for PTSD within the United States Department of Veterans Affairs (2025d), "PTSD is slightly more common among Veterans than civilians" (para 3). In the general population, 6 out of 100 adults (or 6%) will have PTSD at some point in their lifetime, compared to 7 out of 100 Veterans (or 7%). PTSD is noted to be more common in female Veterans (13%) versus male Veterans (6%).

One large study of Veterans in the United States showed that those with PTSD varied by their service period. Out of the Veterans who served in Operations Iraqi Freedom and Enduring Freedom (also known as the Iraq and Afghanistan wars, respectively), 29% had PTSD at some point in their life, and 15% had it in the past year. Out of the Veterans who served in Vietnam, 10% had PTSD at some point in their life, and 5% had it within the past year. It is important to note that this study considered Veterans who were not deceased at the time of the study, so it is possible that PTSD was more common among Veterans of different service periods (United States Department of Veterans Affairs, 2025d).

Risk Factors for PTSD

Several risk factors for PTSD are unique to Veterans, including:

- Frequency and intensity of combat exposure, with ongoing exposure leading to a higher risk
- Firing a weapon

- Witnessing another person get wounded or killed
- Personal injury
- Multiple deployments for long periods
- Closeness to the enemy
- Having a lower rank
- Low morale or social support within a unit
- Serving in the Army
- Limited social and psychological support after deployment
- Not being aware of psychological reactions to returning to civilian life

Other risk factors include being female, being unmarried, belonging to an ethnic minority group, having a lower level of education, prior adverse life events, and pre-existing mental health conditions (Moore et al., 2023).

Symptoms of PTSD

Symptoms of PTSD fall into the following four categories:

- Intrusion symptoms
    - Intrusive thoughts and distressing memories
    - Nightmares
    - Flashbacks, which are related to past trauma, occur when a person feels as though they are reliving prior events. Flashbacks can include sights, sounds, and smells.
    - Psychological distress and physiological reactions occur when exposed to internal or external cues associated with the trauma.

- Avoidance symptoms
    - Avoiding internal things related to the trauma, including thoughts, feelings, or memories.
    - Avoiding external things that could trigger past trauma, like the anniversary date, situations, social events, activities, places, and people.
- Negative changes in thoughts and mood
    - Inability to remember important aspects of the trauma
    - Exaggerated, negative beliefs about oneself, others, or the world
    - Self-blame or blaming others based on distorted thoughts about the trauma
    - Ongoing negative emotional state (guilt, shame, despair, anger, fear)
    - Lack of interest and participation in activities
    - Distance in relationships and difficulty trusting other people
    - Ongoing inability to experience positive emotions or numbness
- Negative changes in arousal and reactivity
    - Acting aggressively, violently, and/or having a short fuse. Outbursts happen with little or no prompting and are expressed verbally or physically.
    - Reckless or self-destructive behavior
    - Hypervigilance and operating on high alert
    - Feeling on edge, tense, anxious, or startling easily
    - Difficulty concentrating

- Sleep disturbances

(American Psychiatric Association, 2013; Lawthorne-Scott & Philpott, 2013; Moore et al., 2023)

Symptoms of PTSD usually start soon after the traumatic event(s), but they may not happen until months or years later. They may also come and go over some time (United States Department of Veterans Affairs, 2025i).

Screening for PTSD

The following are some of the practical tools that mental health professionals can administer to screen for PTSD in Veterans as recommended by the National Center for PTSD (2025i). There are other screening tools on the American Psychological Association's website.

- PTSD Checklist for DSM-5 (PCL-5) - A 20-item self-report questionnaire to screen for PTSD symptoms.
- PTSD Screen for DSM-5 (PC-PTSD-5) - A 5-item PTSD screen for primary care settings.
- SPAN - A 4-item screen that assesses startle, physical upset by reminders, anger, and numbness, and how distressing these responses have been in the past week.
- SPRINT - An 8-item self-report measure that assesses the main symptoms of PTSD as well as somatic malaise, stress vulnerability, and functional impairment.
- Trauma Screening Questionnaire (TSQ) - A 10-item screen based on re-experiencing and arousal symptoms.

- Hospital Mental Health Risk Screen (HMHRS) - A 10-item self-report measure that predicts mental health problems after a recent experience of trauma.

(American Psychological Association, 2025; United States Department of Veterans Affairs, 2025g)

Diagnosing PTSD

For a diagnosis, the DSM-5-TR criteria state that there must be exposure to actual or threatened death, serious injury, or sexual violence through one of the following avenues:

- Directly experiencing the traumatic event(s)
- Witnessing the event(s) in person as they happened to other(s)
- Learning that the traumatic event(s) happened to a close family member or friend. When it is actual or threatened death, the event(s) must have been violent or accidental.
- Experiencing repeated exposure to details of a traumatic event(s).

There must also be one or more intrusion symptoms, one or both of the avoidance symptoms, two or more negative changes in thoughts or mood, and two or more negative changes in arousal and reactivity, as listed above.

In addition, the symptoms must last for more than one month, there should be a change in functional status, and the symptoms must also not be better explained by the effects of a substance or a physical issue.

Furthermore, it is necessary to indicate whether a person experiences persistent or recurrent symptoms of depersonalization or derealization. Depersonalization is when a person feels detached from their body or mind. Derealization is when a

person's surroundings do not feel real, and this must not be due to the effects of a substance or a physical issue.

Lastly, there needs to be the specification of whether the PTSD diagnosis has delayed expression, which means the full diagnostic criteria are not met until at least 6 months after the event, even though some of the symptoms may start happening immediately following the traumatic event(s) (American Psychiatric Association, 2013).

Substance Use Disorders

Substance use disorder is a complex condition. The American Psychological Association (2023c) defines it as "a cluster of physiological, behavioral, and cognitive symptoms associated with the continued use of substances despite substance-related problems, distress, and/or impairment" (para. 1). Substances include several classes of drugs, from caffeine, tobacco, and alcohol to stimulants and hallucinogens.

It is common for Veterans to turn to substances to self-medicate and try to block out memories, thoughts, and feelings related to their time in the service. Veterans may also use substances to manage severe symptoms related to traumatic experiences. While this can provide short-term relief, it can also lead to more problems that tend to worsen over time and with continued use (Lawthorne-Scott & Philpott, 2013).

According to Moore et al. (2023), it is difficult to determine the prevalence of substance use disorders in Veterans because not all of them receive care through the VA, and there have been changes to the DSM criteria. However, the 2020 National Survey on Drug Use and Health in Veteran Adults showed that over 2 million Veterans had a substance use disorder, and over 5 million Veterans had a substance use disorder and a mental illness in 2020. About 1.7 million Veterans

struggled with alcohol use, about 1 million Veterans struggled with illicit drugs, and close to 300,000 struggled with both. Also in 2020, over half of Veterans aged 18 and older had used alcohol in the last month (close to 11 million), and about 1.6 million had an alcohol use disorder. For illicit drug use in 2020, marijuana was the most commonly used drug (by 3 million Veterans in the last year), followed by the misuse of psychotherapeutic drugs, including prescription stimulants, tranquilizers, sedatives, and pain relievers (by over 720,000 Veterans in the last year). The Veterans who used alcohol in the past month had higher rates of using other substances when compared to those who did not use alcohol, and those who had heavy alcohol use had higher rates of major depressive episodes and serious mental illness. Additional data confirmed that co-occurring substance use and mental illness are common (Substance Abuse and Mental Health Services Administration, 2022).

Risk Factors for Substance Use Disorders

Research by RAND (2025) showed risk factors for alcohol use disorder in Veterans include a younger age, serving after September 11th, exposure to combat, a trauma history, co-occurring mental health disorders, and having a lower income, as well as limited social support. There is some overlap between alcohol use disorder risk factors and substance use disorder risk factors for Veterans. Those who are not married and are younger than age 25 are at a higher risk for these disorders. Additionally, service-related experiences, including deployment, combat, and the challenges of adjusting to civilian life, are also risk factors for substance use disorders. Furthermore, childhood trauma and mental health conditions, including PTSD and depression, can contribute to developing a substance use disorder in Veterans (Moore et al., 2023). Family history of addiction, peer pressure, limited family support, early use, and using a highly addictive drug are additional risk factors to consider (Mayo Clinic, 2022).

Symptoms of Substance Use Disorders

Symptoms of substance use disorders fall into the following four categories:

- Impaired control
    - Taking the substance in larger amounts or over a longer time than intended.
    - Unsuccessful attempts or a continuous wanting to cut down or stop the use of a substance.
    - Spending much time to obtain, use, and recover from the effects of a substance.
    - Having ongoing cravings, a strong desire, or urges to use the substance at any time.
- Social impairment
    - Not being able to manage roles and responsibilities at work, school, or home due to substance use.
    - Continuing to use the substance regardless of recurrent social or interpersonal issues.
    - Reducing or stopping participation in social, recreational, or occupational activities due to substance use.
- Risky use
    - Continuing to use a substance even when it causes dangerous situations.
    - Continuing to use a substance despite knowing about a physical or psychological problem that is possibly being made worse by the substance.

- Pharmacological effects
    - Increasing the amount of substance being used to get the desired effect (tolerance).
    - Developing withdrawal symptoms when the use of the substance stops. These symptoms are relieved by using more of the substance.

    (Hartney, 2024; Moore et al., 2023)

Screening for Substance Use Disorders

The following are some of the practical tools that mental health professionals can administer to screen for substance use disorders in Veterans:

- Alcohol use
    - Single-Item Screening Questions for Alcohol (SISQ-Alc) - A 1-item questionnaire that asks about the frequency of consuming a certain number of drinks during a single day in the past year.
    - Alcohol Use Disorders Identification Test (AUDIT) - A 10-item questionnaire to identify those who participate in high-risk, hazardous, or harmful alcohol use.
    - Alcohol Use Disorders Identification Test-Concise Test (AUDIT-C) - A 3-item questionnaire that assesses how often a person has a drink containing alcohol, the number of drinks consumed on a typical day, and how often they have 5 (male) or 4 (female) or more drinks on one occasion.
    - CAGE - A 4-item questionnaire that identifies if people have ever felt the need to cut down on drinking, if others have been annoyed by it, if the

person feels guilt about drinking, and if they have ever needed a drink first thing in the morning to steady nerves or relieve a hangover.

- Drug use
    - Single-Item Screen-Cannabis (SIS-C) - A 1-item questionnaire that asks about the frequency of cannabis use in the past year.
    - Single-Item Screening Questions for Drug Use (SISQ-Drug) - A 1-time questionnaire that asks about the frequency of illegal drug or prescription medication (for non-medical reasons) use in the past year.
    - Drug Abuse Screening Test (DAST) - A 28-item measure to identify people who are misusing drugs and the impact of the misuse.
- Substance use
    - Simple Screening Instrument for Substance Abuse (SSI-SA) - A 16-item questionnaire that examines symptoms of problematic alcohol and drug use.
    - Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) - A 4-item questionnaire that identifies how often a person has:
        - Used tobacco or other nicotine delivery products
        - Consumed 5 (male) or 4 (female) or more drinks in one day
        - Used prescription medication just for the feeling, more than prescribed, or used medications not prescribed
        - Used drugs including marijuana, cocaine, heroin, methamphetamine, hallucinogens, and/or ecstasy

(McNeely et al., 2024; Moore et al., 2023; United States Department of Veterans Affairs, 2024c)

Additionally, the VA offers an anonymous questionnaire on its website for Veterans to screen themselves if they are concerned about their substance use (United States Department of Veterans Affairs, 2025i).

Diagnosing Substance Use Disorders

For a diagnosis, the DSM-5-TR criteria state the following:

- The presence of 2 to 3 symptoms is considered a mild substance use disorder.
- The presence of 4 to 5 symptoms indicates a moderate substance use disorder.
- The presence of 6 or more symptoms indicates a severe substance use disorder.

The DSM-5-TR recognizes ten different classes of drugs:

- Caffeine
- Alcohol
- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives
- Hypnotics

- Stimulants
- Tobacco

As part of the diagnosis process, it is helpful to know which substance(s) a person is using, the frequency, the amount, and the pattern of use. It is also essential to have a comprehensive history and examination that includes physical and mental health comorbidities, as well as a review of family and social history. Mental health professionals can also administer a mental status exam to help assess psychiatric symptoms. Additionally, evaluating psychosocial factors, including living environment, employment status, financial situation, and involvement with the criminal justice system, among other things, is essential to the diagnosis process (Moore et al., 2023).

Grief

Grief is a normal emotional reaction to the losses that occur in life. It can often be a complex and unpredictable process that unfolds at its own pace. The American Psychological Association (2018c) defines grief as:

> *"The anguish experienced after a significant loss, usually the death of a beloved person. Grief often includes physiological distress, separation anxiety, confusion, yearning, obsessive dwelling on the past, and apprehension about the future. Intense grief can become life-threatening through disruption of the immune system, self-neglect, and suicidal thoughts. Grief may also take the form of regret for something lost, remorse for something done, or sorrow for a mishap to oneself"* (para. 1).

There are many different types of losses, including a person, a pet, a relationship, a role, a job, a sense of safety, meaning and purpose, identity, or physical health. There are also many different reactions to a loss, especially over time, as people grieve and adjust to what life looks like after the loss has occurred. Additionally,

there are different types of grief, including common or normal grief, anticipatory grief, and complicated grief (Lawthorne-Scott & Philpott, 2013; National Cancer Institute, 2025).

Veterans often experience numerous losses during their time in the service. These losses include the sudden deaths of their comrades, and their own physical disabilities, mental health challenges, survivor's guilt, loss of identity, and other losses that happen when returning to civilian life. Losses can be cumulative over time and cause different responses to occur as Veterans cope with their grief (Forge Health, 2020).

Grief becomes a diagnosable mental health condition called prolonged grief disorder, also known as complicated grief, when there are ongoing, severe symptoms for one year or more.

Risk Factors for Prolonged Grief Disorder

Studies have shown the following risk factors for prolonged grief disorder:

- Traumatic circumstances around the death
- Sudden, unexpected, and untimely death
- Multiple deaths
- Vulnerabilities such as low self-esteem, previous psychiatric disorders and suicidal threats or attempts, lower perceived social supports, ambivalent, dependent, or interdependent attachments to the deceased, and insecure attachment to parents in childhood.

  (Schoo et al., 2025)

Grief Symptoms

Several different symptoms can present as people are processing grief, including a wide range of emotions, impacted thoughts, physical sensations, behavior changes, somatic and psychological symptoms (Schoo et al., 2025).

Screening for Grief

The following are some of the practical tools that mental health professionals can administer to screen for prolonged grief disorder in Veterans:

- Brief Grief Questionnaire (BGQ) - A 4-item questionnaire to assess symptoms of complicated grief.
- Inventory of Complicated Grief (ICG) - A 19-item measure to assess symptoms of complicated grief

  (Schoo et al., 2025).

Diagnosing Prolonged Grief Disorder

For a diagnosis, the DSM-5-TR criteria state that the death of someone should have occurred at least one year before the diagnosis. There are ongoing, intense feelings of yearning or preoccupation with the deceased, with thoughts and memories occurring most days. There should also be three of the following leading to distress or disability for at least one month:

- Identity disruption
- Disbelief about the death
- Avoiding reminders of the fact that the person is deceased
- Intense emotional pain
- Trouble integrating back into life
- Emotional numbness

- Loneliness
- Feeling that life is meaningless

These disturbances should cause impairment in aspects of daily functioning and not be better explained by another mental health condition or substance use (Schoo et al., 2025).

Section 3 Key Terms

Risk factors are an individual's biological, psychological, social, and environmental characteristics associated with an increased likelihood of developing a condition or disorder.

Symptoms are sensations or experiences that an individual perceives as abnormal or distressing. They may not always be seen and can be challenging to measure.

Screening tools are questionnaires that help professionals quickly identify people who may have a behavioral health condition and need further assessment.

Section 3 Reflection Questions

Do you work with clients or patients who experience the behavioral health conditions described in this section? If so, what conditions do you see most often?

Is there one condition that is more challenging for you to work with when compared to others, and why?

Section 4: The Impact on Veteran Families

References: 14, 45, 49, 54, 58, 64, 71, 78

The mental health conditions described above can have a significant impact on Veterans and their families. As noted, there are over 14 million Veteran households in the United States, indicating that many people and their loved ones may be dealing with the effects of serving their country. While many people are likely coping and adjusting quite well, others may be struggling with various relationship conflicts as well as domestic violence and child abuse within their family, which are common issues impacting Veteran families.

Relationship Conflicts

It is normal for all types of relationships to have conflict. For Veterans more specifically, each of the mental health conditions outlined above can affect how the Veteran functions in their daily lives, including in their relationships. When one person in a relationship is vulnerable, traumatized, stressed, experiencing various symptoms, abusing substances, adjusting or integrating back into civilian life, the other person in the relationship, whether it be a spouse, partner, family member, or friend, is also bound to be impacted. They may be supporting, caring for, or managing the Veteran while dealing with their own physical and mental health, emotions, daily roles, and responsibilities, among other things. The other person may also share some of the same vulnerabilities as the Veteran, which can add complications.

When considering relationships with family members and friends, the following readjustment behaviors that Veterans experience can cause conflict:

- Hyperarousal can cause family members and friends to adjust their lives to reduce things that are triggering for the Veteran. They may start to live in fear. The effects of hyperarousal can cause changes in their routine or perspective on the world, while also leading to isolation, as they may begin to avoid leaving the house to attend social activities, for example.

- Paranoia, suspicion, tenseness, and worry about potential danger on behalf of the Veteran can make others feel like they are on “pins and needles” around them. The Veteran may always be “keyed up,” making it difficult to perform everyday activities outside the home. These behaviors can impact the Veterans' trust of other people. All of these behaviors can also cause tension in relationships.

- Furthermore, anger, being quick-tempered, and yelling can make family members and friends feel on edge around the Veteran. They may start to keep things from the Veteran or avoid them. They may also begin to feel the same anger themselves.

- Depending on their rank in the service, the Veteran may start to order other people around or show authority over them, which can change relationship dynamics. The Veteran may also have very high expectations of family members and friends, putting undue pressure on them.

- Unpredictability and avoidance of people or situations on behalf of the Veteran may make family members and friends feel as though they do not care or as if they can no longer count on them.

- Not wanting to make a decision or solve a problem can make family members and friends feel frustrated, as if the Veteran is not engaged in communication with them.

- Numbness and indifference in the Veteran can make family members and friends feel like they cannot talk to the Veteran or express their feelings to them. They may feel disconnected from the Veteran and like they are being “pushed away.” Substance use can be another factor here, as the Veteran may be using substances to numb emotions (Veteran Families United, n.d.).

Partner Relationships

While all of the above behaviors can impact relationships with family members and friends, there are specific considerations for those that include spouses or partners, especially when the Veteran is living with PTSD.

The National Center for PTSD states that PTSD affects how couples get along with each other, the mental health of the Veteran's partner, and the whole family in a negative way. Veterans with PTSD tend to get divorced more often and have shorter relationships. Male Veterans living with PTSD more commonly report marriage or relationship problems, parenting issues, and inadequate family functioning when compared to Veterans without PTSD. The same problems can also occur for female Veterans.

Marriage and relationship problems can be communication-related, as Veterans with PTSD often share less of their thoughts and feelings with their partners. They may experience more negative emotions or feel numb, which can affect their behavior towards their spouse and create distance between them. There may be intimacy issues as sexual problems tend to be higher in combat Veterans with PTSD, and a decreased interest in sex can lower relationship satisfaction. There are also family violence issues. Additionally, some partners become caregivers to the Veteran due to physical or mental illness. The partner may be carrying a heavier load of responsibilities, all while trying not to trigger or stress their Veteran partner. All of these things can impact the mental health of a Veteran's partner. Studies have shown that partners of Veterans living with PTSD have lower levels of happiness and satisfaction in their lives, feel more demoralized, and often feel on the verge of a nervous breakdown (United States Department of Veterans Affairs, 2025e).

Infidelity is another issue for Veterans and their partners that can cause relationship conflicts. There are several demands placed on military couples,

including separation due to deployment. The majority of affairs are during these periods of separation (Ayson, 2024). Additionally, the issues encountered after the transition from active duty strain relationships and make people more vulnerable to infidelity. Several consequences arise after infidelity for both the Veteran and their partner, including adverse emotional effects (depression, anxiety, and PTSD symptoms) and domestic violence (Snyder & Monson, 2012).

Intimate Partner Violence

Intimate partner violence (IPV) is a type of domestic violence that includes physical, emotional, and sexual abuse as well as stalking between people who have or had an intimate relationship.

- Physical abuse is any use of physical force meant to hurt, control, or intimidate another person. Physical abuse may be visible, or there may be internal injuries.
- Sexual abuse is any attempt or completed sexual contact that happens without the other person's consent or with reproductive coercion.
- Emotional abuse damages another person's self-worth and controls them. Threats are a type of emotional abuse as they cause fear and compliance with the controlling acts.
- Stalking occurs when a person repeatedly contacts, follows, communicates with, or sends things to their partner, even when the partner does not want them to do so.

This abuse could happen with current or prior spouses, boyfriends or girlfriends, and romantic, dating, or sexual partners. People may experience one form of IPV while others may experience several. IPV often starts with infrequent, mild

behaviors that turn into more frequent and severe ones. IPV may happen one time, or it can occur on and off for many years.

IPV affects many people from all walks of life. In the general population, one in three women and one in four men experience IPV in their lives, but Veterans may be disproportionately impacted by it. Some studies have suggested that Veterans of both genders are up to twice as likely as non-Veterans to report experiencing IPV in their lifetime.

Veterans are at a greater risk for IPV because they are more likely to have been through traumatic and stressful events that increase their risk of using aggression or experiencing aggression in their romantic relationships. Aggression in intimate relationships is more common in Veterans who have PTSD, depression, substance use disorders, and traumatic brain injury. Also, the negative changes in arousal and reactivity symptoms of PTSD can cause dysregulation in mood as well as anger outbursts.

Trauma from combat and military sexual encounters, as well as PTSD, depression, and substance use disorders, also increase the risk of IPV. Furthermore, the stress of deployments and separation from families also causes tension within the Veteran and their family, putting them at higher risk for violence.

There are several effects on the person who is experiencing IPV:

- Physically, injuries and chronic health conditions can arise.
- Sexually, there may be sexually transmitted infections and HIV, reproductive coercion, as well as unplanned pregnancies or complications in them.
- Emotionally, PTSD, anxiety, depression, substance use, and suicide are more likely to develop.

- Within the family, there can be parenting issues and ongoing developmental issues in children if the couple has them.
- Financially, resources can be limited and controlled by one partner, leading to instability in housing and employment.

There are also several effects on the person who is using IPV:

- Relationally, their ability to have a healthy intimate relationship is compromised. There is often fear, mistrust, loss, lack of respect for others, and insecurity that comes with the need to use IPV.
- Emotionally, there are adverse effects on mood and behavior, which impact emotional and psychological health. These effects can include guilt, shame, feeling out of control, avoiding help, increasing mental health symptoms, and substance abuse.
- Within the family, damage can be done to children when it comes to their relationship with the person using IPV. Violence in the home can also compromise a child's emotional and physical health, and their development can be affected.
- Legally, there may be involvement from law enforcement, including arrests, and court-ordered mandates, such as classes, serving time, probation, and protection orders.
- Financially, there can be a loss of employment and legal fees associated with matters that may go to court, such as divorce, child support, and mandated classes.

Overall, there are numerous challenges for each person in a relationship involving IPV. While awareness can be helpful, safety planning, seeking support from loved ones, and working with mental health professionals can aid individuals in

addressing the various issues related to IPV (Rubin et al., 2013; United States Department of Veterans Affairs, 2024b).

Child Abuse

Similarly to children in the general population, children of Veteran families can be victims of physical, sexual, and emotional abuse as well as neglect. Since 2003, the rates of child maltreatment in military families have outpaced the rates in non-military families (The National Child Traumatic Stress Network, n.d.). One study found that the rates of child abuse in military families increase following the return from deployment when compared to rates before and during deployment (Pemberton et al., 2013).

The stressors that the whole family experiences during active duty, especially the Veteran, put families at higher risk for child maltreatment. One reason is that the family can carry stressors from active duty into the reintegration process. During this time, Veterans are adjusting to their roles and responsibilities at home. While this can be an exciting time, there are also challenges, especially if the Veteran returns home with physical or mental health conditions.

Mental health issues have been noted to increase the risk of child maltreatment, especially for very young children. PTSD, depression, and substance abuse can all impact a person's cognition, judgment, affect management, and impulse control, and can cause a Veteran to be abusive and/or neglectful to their children. These conditions can also affect their ability to function as parents, potentially leading to inconsistent discipline, inadequate supervision, and physical punishment. As a result, children and adolescents of Veteran families have higher rates of behavioral and emotional challenges, especially during times of disruption, like the reintegration process (The National Child Traumatic Stress Network, n.d.).

Section 4 Key Terms

Relationship conflict is a disagreement between people that can take the form of a difference in opinion, experience, perspective, personality, or beliefs (Scott, 2025).

Intimate partner violence is a type of domestic violence that includes physical, emotional, and sexual abuse as well as stalking between people who have or had an intimate relationship.

Child abuse is the "injury to, maltreatment of, or neglect of a child so that the child's welfare is harmed or threatened" (The Department of Defense as cited in The National Child Trauma Stress Network, n.d., p. 2). Child abuse can be physical, sexual, and emotional, as well as neglectful.

Section 4 Reflection Questions

What are the effects of trauma and stress that you see in your clinical practice?

What has your experience been like working with clients who are experiencing relationship conflicts, IPV, and/or child abuse within their family?

Section 5: Evidence-Based Interventions for Behavioral Health Treatment

References: 5, 30, 33, 37, 50, 51, 67, 68, 69, 75, 81

Several evidence-based interventions treat the behavioral health conditions outlined above. This section will focus on these practices for mental health professionals.

Anxiety

The two main types of treatment for anxiety disorders are medication and psychotherapy. Some people may benefit from a combination of both. Cognitive behavioral therapy (CBT) is the most effective form of psychotherapy to treat anxiety disorders (Mayo Clinic, 2018). The VA (2025a) describes CBT as:

> *"A short-term treatment that helps Veterans understand the anxiety they experience and address distressful thoughts and feelings. This treatment may help expose Veterans to anxiety-inducing situations to help develop response prevention strategies. CBT is focused on identifying and neutralizing unhelpful thoughts and also confronting fears through the mastery of new skills"* (para. 3).

For generalized anxiety disorder, as an example, CBT can teach the Veteran to identify their worries and manage their symptoms so that they can return to things they may be avoiding because of anxiety. As another example, if there is a specific phobia, exposure therapy may be used to help the Veteran gradually encounter the object or situation they are afraid of and learn skills to manage the anxiety caused by the trigger (Mayo Clinic, 2018).

Depression

A combination of medication and psychotherapy is the most effective treatment for depression. Mental health professionals can choose from different types of psychotherapy.

- Cognitive Behavioral Therapy for Depression (CBT-D) - A structured, time-limited therapy to help Veterans have balanced and helpful thoughts about themselves, others, and the future. A Veteran can change their thought

patterns, behaviors, and depressed mood by modifying their thought patterns and learning new skills to help them achieve their goals.

- Acceptance and Commitment Therapy for Depression (ACT-D) - This therapy can help Veterans focus on identifying their values and making choices that align with them. It can also help promote positive actions as Veterans recognize the people and things that are most important in their lives.
- Interpersonal Therapy for Depression (IPT-D) - A type of therapy that can help Veterans identify and evaluate relationship issues that may be causing depression. It also helps them develop social skills to address problems in their relationships, thereby improving their overall quality of life.
- Problem-Solving Therapy (PST) - Using this therapy, Veterans can heal from difficult situations and learn skills to support them in their daily life. It can also help them cope with life stressors and major events by having a response plan in place when these things happen.
- Behavioral Activation brings awareness to how behavior is connected to mood and teaches Veterans how to respond in a way that improves their daily lives. Similar to ACT-D, Veterans work on identifying their values and goals and how to engage in more meaningful activities that will help achieve them.

(Moore et al., 2023; United States Department of Veterans Affairs, 2025b)

Posttraumatic Stress Disorder

According to Moore et al. (2023), the first-line treatment for posttraumatic stress disorder (PTSD) is psychotherapy. Medication is considered an alternative or as an intervention prescribed alongside psychotherapy, based on the preference of the

patient and the accessibility of psychotherapy. The following are effective forms of psychotherapy for PTSD:

- Cognitive Processing Therapy (CPT) - A trauma-focused therapy that helps Veterans identify the ways that traumatic experiences have impacted their thinking. Veterans evaluate their thoughts and learn how to change them. This technique can lead to Veterans developing more balanced beliefs about themselves, others, and the world.
- Prolonged Exposure (PE) - By using this therapy, Veterans gradually approach traumatic experiences and address their memories and feelings. Facing trauma and fear directly in this way can help decrease PTSD symptoms.
- Eye Movement Desensitization and Reprocessing (EMDR) - Veterans can recall their trauma while focusing their attention on a back-and-forth movement or sound. It helps them process their trauma and make sense of it.
- Cognitive Behavioral Conjoint Therapy (CBCT) - A type of therapy used for couples to help them understand the effects of PTSD on their relationship. They can learn skills to improve their communication. They can also learn how to change their thoughts and beliefs related to their PTSD and relationship challenges.

  (United States Department of Veterans Affairs, 2025c)

Moore et al. (2023) state that the type of therapy chosen by the mental health professional should depend on the patient's primary symptoms. For example, fear and avoidance symptoms tend to benefit from exposure therapy, while a patient can address feelings of guilt and mistrust in cognitive therapy.

Substance Use Disorders

Similar to the conditions listed above, treatment for substance use disorders includes psychotherapy and medication. While psychotherapy is at the core of treating substance use disorders, medications can help manage withdrawal symptoms, reduce cravings, and prevent people from returning to using. Three types of therapy commonly used in substance use disorders are:

- Cognitive Behavioral Therapy (CBT) - CBT for these types of disorders can help Veterans with their thought and behavior patterns to manage the urge to use as well as refuse chances to use. They can learn to problem-solve and achieve their personal goals.
- Motivational Interviewing (MI) - This therapy involves the mental health professional asking questions to get to the reasons a Veteran wants to change using substances and what benefits could come from that change. It also helps people identify and strengthen their motivation to change.
- Contingency Management (CM) - In this therapy, the Veteran receives incentives for making changes and exhibiting recovery behaviors, such as negative drug screens. The incentives act as reinforcement and encourage ongoing recovery behaviors.

Additionally, based on the assessment of symptoms and a provider's recommendation for the level of care that the patient needs, Veterans may benefit from the VA's Substance Use Disorder Program, which has services that vary by location. Veterans may be eligible to receive residential (or inpatient) care, as well as intensive or standard outpatient therapy through this program or others in their community.

Furthermore, there are other support programs for Veterans with substance use disorders, including Alcoholics Anonymous, Marijuana Anonymous, Narcotics

Anonymous, and SMART Recovery. Family members and friends may find benefit in attending Al-Anon or Nar-Anon groups (United States Department of Veterans Affairs, 2025i).

Grief

Some people can process their grief without seeking support from a mental health professional. For others, receiving grief counseling may be helpful.

Grief counseling can help people accept and process the loss as well as work through the emotions they are experiencing, including emotional pain, relief, sadness, and anger. Counselors can hold space as people process their pain. They can help normalize things that are common to the grief experience and intervene when things are happening that may put people at risk for developing prolonged grief disorder. Counselors can also help people learn to adapt to the loss by reintegrating into their daily activities. People may need support in moving forward and doing things like establishing a routine, developing new habits, creating rituals, and finding a different purpose or meaning in their life after losing the person or thing they loved. They may also need support as they look back and share memories or reminisce (Schoo et al., 2025; Virginia Commonwealth University, 2021).

Grief support groups can also be beneficial for individuals seeking support and establishing social connections with others who are in a similar situation. They can help people feel less alone, which can avoid feelings of isolation, which is a risk factor for prolonged grief disorder.

If a person is dealing with prolonged grief disorder, treatment can include complicated grief therapy. This type of therapy uses parts of cognitive behavioral therapy to help people accept the loss, move towards functioning without their

loved one, and find a sense of meaning in their life (American Psychiatric Association, 2022; Schoo et al., 2025).

Interventions for Family and Friends

Family members and friends of Veterans may benefit from the interventions outlined in this section. They may be living with the Veteran or be close to them, and experiencing their own stressors and behavioral health conditions. While the Veteran is receiving support and building their resiliency and coping skills, family members and friends may find it helpful to do the same.

Family members and friends may also find it helpful to prepare as much as possible for the Veteran's return home. Knowing what to expect and having a plan for dealing with change can be valuable under challenging circumstances. Additionally, assembling a support system that includes professionals and leveraging available resources can be beneficial (Lawthorne-Scott & Philpott, 2013).

Furthermore, there are family-based interventions to help those who have a parent living with depression and/or PTSD. Mental health professionals can assist with communication, education, building on family strengths, and tailoring interventions to help families develop essential skills. If there is violence in the home, mental health professionals can assess for safety and engage in safety planning (Ruzek et al., 2011). There are also community support programs for people who are experiencing IPV and child abuse in the home, and working with professionals who are skilled in this area can help people through these issues. For example, several organizations work with victims of IPV, including at the VA, and many family programs exist for children experiencing abuse.

Section 5 Key Term

Evidence-based interventions are practices that have been proven effective through research.

Section 5 Reflection Question

What types of evidence-based interventions do you use in your clinical practice?

Section 6: Suicide Prevention - Warning Signs, Risk Factors, Screening, Assessment, and Intervention

References: 2, 3, 10, 24, 41, 62, 63, 66, 76

The rates of suicide deaths among Veterans have been steadily increasing since 2001. In 2022 (most recent data available), there were 6,407 Veteran suicide deaths compared to 6,005 in 2001. Suicide was the twelfth leading cause of death for Veterans, and the second leading cause of death for Veterans under age 45 in 2022. Male Veterans have higher rates of suicide deaths (6,136) than female Veterans (271). Firearms are most common in Veteran suicide deaths (United States Department of Veterans Affairs, 2024a).

The rates of suicide among Veterans who had a documented non-fatal suicide attempt within the VA system also increased from 2017 to 2021 (United States Department of Veterans Affairs, 2024a). The majority of first suicide attempts (over 50%) happen after the Veteran has separated from the service, with the most vulnerability happening during the first three months (United States Department of Veterans Affairs, 2022).

Three terms and definitions relevant to the topic of suicide are:

- Suicide is a “death caused by self-directed injurious behavior with intent to die as a result of the behavior” (National Institute of Mental Health, 2025, para. 2).
- A suicide attempt is a “self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in death or injury” (National Institute of Mental Health, 2025, para. 2).
- Suicidal ideation refers to “thinking about, considering, or planning suicide” (National Institute of Mental Health, 2025, para. 2).

Suicide prevention includes knowing and being attentive to warning signs, understanding and assessing for risk factors and protective factors, screening, and being skilled in effective interventions.

Warning Signs

The warning signs of suicide are categorized as follows:

- If a person talks about:
  - Killing themselves or mentioning the wish to die
  - Hopelessness
  - Purposelessness/Having no reason to live
  - Being a burden
  - Feeling trapped
  - Agonizing pain
- If a person exhibits these behaviors:
  - Increased substance use

    - Looking for ways to end their life, such as seeking access to lethal means
    - Withdrawing from social activities
    - Isolating
    - Sleeping too much or too little
    - Visiting or calling loved ones and saying goodbye
    - Writing a suicide note
    - Giving away possessions
    - Aggression
    - Fatigue
    - Recklessness
- If a person displays one or more of the following:
    - Depression, including loss of interest
    - Anxiety
    - Irritability
    - Guilt or shame
    - Anger
    - Sudden improvement after consistent negative feelings/dramatic change in mood

(American Foundation for Suicide Prevention, n.d.b; Department of Veterans Affairs and Department of Defense, 2024)

Risk Factors

Risk factors for suicide in Veterans include the following:

- Self-directed violence-related thoughts or behaviors
    - Current suicidal ideation
    - Prior or current suicidal intent
    - Past suicide attempt(s)
    - Preparing to die
    - Non-suicidal, but self-directed violent behavior(s)
- Current psychiatric conditions and current or past behavioral health treatment
    - Mood disorders (for example, major depressive disorder or persistent depressive disorder)
    - Substance use disorders
    - PTSD (especially with a co-occurring depressive disorder)
    - Panic disorder
    - Psychotic disorders
    - Personality disorders (especially bipolar disorder)
    - Eating disorders
    - History of hospitalization for a psychiatric issue
- Psychiatric symptoms
    - Hopelessness

- Depressed mood
- Negativity
- Rumination
- Agitation
- Impulsivity
- Anxiety, panic, or both
- Insomnia
- Trouble solving problems
- Aggression, hostility, or both
- Withdrawing socially

- Social determinants of health and adverse life events
  - Barriers to care
  - Financial problems that cause food insecurity, risk of losing housing, or homelessness
  - History of abuse
  - Being separated from parents early in life
  - Living alone (especially for men)
  - Social isolation
  - Legal issues
  - Job loss

    - Relationship conflict
    - Exposure to suicide
- Availability of lethal means, especially firearms
- Medical conditions
    - Cancer (especially those with intermediate or poor prognosis)
    - Respiratory issues
    - Neurological disorders
    - Neurodegenerative disorders
    - Traumatic brain injury
- Demographics
    - Gay, lesbian, or bisexual
    - Divorced, separated, or single
    - Lower socioeconomic status
    - Unemployment
- Additional risk factors
    - Adverse childhood experiences
    - Combat exposure
    - Moral injury or participating in combat-related experiences
    - Chronic pain

- Discharge due to disability, disqualification, or misconduct, especially when the service period was less than 4 years
- Vulnerability during the transition to civilian life, especially during the first three months
- Lower levels of education that impact employment after the service
- Worsening psychosocial stressors
- Younger age when separating from the service
- Owning a firearm
- Involvement on behalf of the judicial system

(Department of Veterans Affairs and Department of Defense, 2024; United States Department of Veterans Affairs, 2022)

Screening

The VA and Department of Defense (2024) have established guidelines for screening and assessing patients at risk for suicide. The Patient Health Questionnaire-9 (PHQ-9) is the recommended screening tool in these guidelines. The PHQ-9 is a 9-item measure that assesses a range of depression symptoms, including if a person is having thoughts that they would be better off dead, or hurting themself (American Psychological Association, 2023a).

Risk Assessment

If a Veteran presents with warning signs and/or screens positive for suicide on the PHQ-9, the Department of Veterans Affairs and Department of Defense (2024)

recommend completing a suicide risk assessment. Two assessment tools can help determine risk:

- Columbia Suicide Severity Rating Scale Screening (C-SSRS) - An up to 6-item questionnaire that identifies if someone is at risk for suicide and helps mental health professionals determine the severity and immediacy of the risk as well as the level of support a person needs (The Columbia Lighthouse Project, 2016).
- Beck Suicide Intent Scale (SIS) - A 20-item measure used when a person has had a suicide attempt. The measure helps mental health professionals understand the intensity of the wish to die when a person attempted suicide (Beck et al, 1974).

The assessment should include examining the noted risk factors. It should also look at the following protective factors:

- Access to behavioral healthcare
- Connectedness to people and things in their lives
- Ability to problem-solve
- Purpose
- Physical health
- Being employed
- Social and emotional well-being

(Department of Veterans Affairs and Department of Defense, 2024)

Completing one of the above tools and/or completing a risk assessment leads a mental health professional to determine the level of risk for suicide. The acute

and chronic risk levels outlined by the Department of Veterans Affairs and the Department of Defense (2024) are categorized as low, intermediate, and high. There is a risk stratification table on the VA's website that mental health professionals can use to determine risk and identify the corresponding actions to take.

Interventions

Some Veterans who are at an intermediate acute risk and those who are at a high acute risk for suicide may require a psychiatric hospitalization. Veterans at other levels of risk may benefit from the following interventions:

- Safety planning - A collaboration between a Veteran and a mental health professional that identifies individual warning signs and lists things that a Veteran will do when they are in distress, including the following:
    - Doing activities, going places, or connecting with people who can provide a distraction
    - Verbalize their thoughts and feelings to a person who can provide emotional support and a safe place
    - Reaching out to professionals who are available for support, as well as crisis resources
    - Reducing access to lethal means, such as firearms or pills
    - Thinking about their hopes and reasons for living
- Lethal Means Counseling
    - Working with a Veteran and their family to reduce access to any lethal means in their home and determine a plan to secure these means.

(American Foundation for Suicide Prevention, n.d.a)

There are also evidence-based therapies for Veterans who are having suicidal thoughts and are exhibiting some suicidal behavior, but are at lower risk.

- Cognitive Behavioral Therapy (CBT) - This therapy helps Veterans understand how their thoughts, feelings, and behaviors interact and creates new, positive patterns.
- Dialectical Behavioral Therapy (DBT) - This type of therapy supports Veterans as they address their intense emotions and stressors by learning mindfulness, tolerance, and new skills.
- Problem-Solving Therapy (PST) - This therapy helps veterans develop skills to enhance their daily lives and manage challenging circumstances. They set goals to identify, understand, and examine their challenges and implement solutions.

(United States Department of Veterans Affairs, 2025j)

Added interventions include medication, enhancing protective factors, modifying risk factors, and addressing social determinants of health. Mental health professionals should also reassess risk at certain time points based on the level of risk (United States Department of Veterans Affairs, 2024d). In addition to offering the interventions outlined above, the VA has a Veteran Training self-help portal and mobile apps to help Veterans strengthen their protective factors (United States Department of Veterans Affairs, 2025j).

Section 6 Reflection Questions

What is your experience working with clients who are at risk for suicide? Are there specific interventions that you have found helpful in your practice?

Section 7: Case Study

Michael is a Veteran who returned from the war in Afghanistan about 5 years ago. He is married and has two children, ages 12 and 15. He also has a large extended family and many friends. He is currently employed full-time in the construction industry. Adjusting to civilian life over the last several years has been an up-and-down process for him. He has faced challenges in finding work and connecting with people and things that he once enjoyed.

For the past two years, Michael has been experiencing extreme fatigue, and he has lost a substantial amount of weight. He has difficulty making decisions at work and home, particularly when he and his spouse have to make decisions about their children. Since he returned home from war, he often feels hopeless and as if he has lost his purpose of serving his country. His day-to-day life includes working long hours, and when he returns home, he is withdrawn from his loved ones and spends most evenings watching television and drinking alcohol. He does not attend his children's school events and becomes easily irritated with them. More recently, his alcohol intake has been increasing, which his spouse relates to the recent death of his best friend from the war due to suicide. In addition to the increase in alcohol intake, Michael has been on edge, angry, and acting recklessly. He has also been hostile, withdrawn, restless, and never seems present. He went to an appointment with his primary care doctor at the VA and screened positive for having suicidal thoughts on the PHQ-9 that the nurse administered during this appointment. He agrees to speak with a mental health professional.

Section 8: Case Study Review

Michael is experiencing common issues that Veterans face when returning home from war. Meeting with a mental health professional who is knowledgeable and

skilled in these types of problems can be beneficial for him. The mental health professional will need to complete a full clinical assessment and suicide risk assessment. They will likely be considering a PTSD diagnosis with a co-occurring persistent depressive disorder and/or substance use disorder. They may consider screening Michael for these conditions with one of the tools listed above. Based on his level of risk, Michael could benefit from therapeutic interventions as well as a support program for his family. His spouse may also benefit from therapy to help her cope with the changes her husband has been experiencing since he returned from war.

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