Assessment, Treatment, and Referrals for Military Veterans With Behavioral Health Challenges

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LESSONS LEARNED AT THE INTERFACE OF MEDICINE AND PSYCHIATRY

The Psychiatric Consultation Service at Massachusetts General Hospital sees medical and surgical inpatients with comorbid psychiatric symptoms and conditions. During their twice-weekly rounds, Dr Stern and other members of the Consultation Service discuss diagnosis and management of hospitalized patients with complex medical or surgical problems who also demonstrate psychiatric symptoms or conditions. These discussions have given rise to rounds reports that will prove useful for clinicians practicing at the interface of medicine and psychiatry.

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Have you encountered returning veterans with posttraumatic stress disorder (PTSD) and found yourself uncertain about how to intervene? Have you been undecided about how, or whether, to work with military families or to refer them to other health care providers? If you have, the following case vignettes and discussion might prove useful.

CASE VIGNETTE 1

Mr A, a 32-year-old male veteran who sustained back and knee injuries, mild traumatic brain injury (TBI), and PTSD, had a difficult transition back to work, family, and tranquility. He described being discharged from active-duty service roughly 8 months earlier, and, since then, he has felt "angry all the time." He said that he worries about yelling at his kids too much and denies abusing his children or his partner. He described having nightmares 3 to 4 times per week; however, he has difficulty remembering details of them. He is constantly vigilant for danger; loud noises make him "hit the deck," dropping to the ground in anticipation of an attack. Since he is apprehensive in crowds, functioning at work and attending part-time college classes have been difficult. He scored 4 of 5 on the Primary Care PTSD Screener 5 (PC-PTSD-5)[1] and 14 on the 9-item Patient Health Questionnaire (PHQ-9),[2] indicating probable PTSD with moderate depressive symptoms. Mr A qualifies for health care services within the Veterans Affairs (VA) and has a disability rating of 40% for his PTSD.

CASE VIGNETTE 2

Ms B, a 54-year-old female veteran, described difficulties with alcohol use and depression. She reported isolating from her family and friends and feeling hopeless, guilty, and distrustful of others. Of note, Ms B requested to leave the door open with her male provider during her initial primary care appointment and frequently became distracted whenever staff passed by in the hallway. She reported drinking primarily in the evening to help her fall asleep. She awakens at 3:00 AM most mornings and is unable to return to sleep, often spending considerable effort checking the windows and locks to be sure that they are secured. She said that she met with a mental health provider 2 or 3 times while deployed but stated that she "wasn't able to connect" and stopped going to sessions. Ms B described having ongoing difficulties with alcohol use that have led to job loss and ruptured relationships. She is a single mother with 2 young children, and it is unclear whether her alcohol use has contributed to neglect of them. She noted that she was reluctant to seek services at the VA due to her general distrust of the military.

Clinical Points

- Slightly more than one-third of veterans access VA health care services; however, the majority of veterans access health care in the community, with roughly one-third of them receiving their care entirely outside of the VA system.
- Posttraumatic stress disorder, depression, substance use, and impaired sleep are relatively common among military veterans.
- It is important to incorporate screenings of military status into standard care; if patients endorse military service, further screening can determine whether the patient is receiving care at the VA and whether the patient consents to receiving VA care.
- Providers can learn about military and veteran resources in their community and coordinate care with VA providers to facilitate effective support.

DISCUSSION

How Many Veterans Seek Care Outside of the VA?

Receiving care within the VA system is dependent on several factors (eg, time in service, status of discharge [eg, other than honorable], and income level). Thus, not all veterans qualify for VA care. Data released by the VA indicate that 37% of veterans accessed VA health care services in 2017, suggesting that the majority of veterans are apt to access health care in the community.[3] Among veterans who receive services at the VA, roughly 30%–50% indicate that they also use non-VA health care services, with estimates that roughly one-third receive their care entirely outside of the VA system.[4,5] Additionally, the passage of the Veterans Choice Program authorizes health care from a community provider when the VA is unable to provide the necessary services in a timely fashion. Veterans who seek services outside of the VA are often younger, healthier, and more likely to have private insurance.

What Kinds of Problems Prompt Returning Veterans to Receive Care?

Outside of general medical needs, mental health concerns affect a significant proportion of veterans. Research indicates that 15%–20% experience clinically significant symptoms of PTSD following military service, roughly double the percentage of their civilian counterparts.[6,7] Diagnosis of PTSD requires exposure to at least 1 traumatic stressor (criterion A).[8] Symptoms are separated into 4 clusters. Criterion B symptoms reflect intrusions, including dissociative flashbacks, nightmares, and intense physical and emotional responses to these memories. Nightmares are commonly reported when veterans request medical care. Criterion C symptoms include efforts to avoid distress, both internally (eg, not thinking about the event) and externally (eg, avoiding situations [crowds, loud noises, busy areas] that evoke a threat response). Here, use of alcohol and other substances may serve as significantly impairing efforts to avoid PTSD-related distress. Criterion D symptoms reflect emotional numbness, feeling detached, and experiencing a loss of pleasure (ie, anhedonia). However, depressive symptoms are quite common (present in over 50% of patients with PTSD) as is use of substances (40%). Additionally, many veterans report a bevy of difficulties following military service, including conflict within family (couples, parenting), work, and leisure.[8]

Suicide continues to be a large concern within the veteran population, with recent rates of suicide estimated at 17.6 per day[9] and roughly 1.5 times higher among the veteran population than the nonveteran population.[9] Suicidal ideation is significantly associated with common mental health disorders, including PTSD, depression, and substance use.[9] Veterans with multiple diagnoses (eg, depression and PTSD) are more likely to endorse suicidal ideation.[10] Importantly, rates of suicide continue to decline for veterans enrolled in VA health care,[9] indicating that connecting veterans to care represents an important protective factor against suicide. Past findings indicate that risk for suicide is not necessarily related to deployment; instead, risk for suicide increases following separation from military service and in particular within 4 years of separation.[11] Thus, recently separated veterans are one of the groups at highest risk for suicide.

In addition to PTSD, depression, and substance use, impaired sleep is relatively common among military veterans. Data from a large sample of active duty service members found that nearly 1 in 5 endorsed insomnia.[12] Other research has found that the prevalence of insomnia in the military ranges from 8% to 63%, depending on how insomnia is defined.[12] Among veterans who present for their initial appointment at the VA, the majority reported having clinically significant insomnia, making insomnia more common than PTSD, depression, or substance use.[13] Those with insomnia seek care for physical health complaints or primary care more frequently than for mental health.[13]

TBI is another common complaint among veterans. As of March 2020, the US Department of Defense reported 430,720 TBIs within its ranks since 2000, with 82.4% of these classified as mild.[14] However, many veterans with mild TBI report persistent cognitive dysfunction, with difficulties in attention and information processing, memory, language, or executive functioning, as well as headaches. These complaints are still not fully understood, as there is often not an observable biological injury. Furthermore, TBI is commonly associated with exposure to psychological trauma (eg, a life-threatening explosion), and persistent cognitive dysfunction may be largely accounted for by PTSD and depression.[15] The TBI Center of Excellence recommends psychoeducation and cognitive rehabilitation for chronic or post-acute patients with mild TBI who are at high risk for chronic symptom persistence.[16] These interventions are often provided by neuropsychologists, speech language pathologists, and occupational therapists.

What Treatments Are Available for PTSD?

The most recent Department of Defense/VA guidelines[17] for the treatment of PTSD state "For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure

and/or cognitive restructuring to include prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), specific cognitive-behavioral therapies for PTSD, brief eclectic psychotherapy (BEP), narrative exposure therapy (NET), and written narrative exposure."[(p34)] They[17] further note that PE, CPT, and EMDR have the strongest research data from clinical trials that support their efficacy.

The recommendation for PE, CPT, and EMDR aligns with clinical practice guidelines from other organizations for the treatment of PTSD, with the exception that EMDR has been given a moderate recommendation by the American Psychological Association, while there appears to be a consensus of strong recommendations for PE and CPT.[18] In addition, among guidelines that have drawn a conclusion on the issue, psychotherapy is consistently identified as more effective than medication.[19]

CPT is a cognitive-behavioral treatment that addresses symptoms of trauma with a focus on cognitive restructuring.[20] A typical course of treatment lasts 12 sessions, with initial sessions focused on identifying key "stuck points." Stuck points reflect distorted beliefs related to the cause of the trauma (eg, "It's my fault for being sexually assaulted" or "I could have done more to save my friend"). These stuck points also reflect traumatic conditioning, such that patients may have developed distorted views of the world (eg, "The world is dangerous," "No one can be trusted"). Therapists who work with patients gently challenge these beliefs with Socratic questioning, psychoeducation, and homework materials that are designed to elicit conflicting evidence and result in more balanced thinking. Although initial implementation of CPT included a narrative of the trauma, recent evidence suggests that talking about traumatic events directly does not significantly improve outcomes.[21] Thus, CPT now includes the trauma narrative as an optional component.

PE is a cognitive-behavioral treatment that is specifically designed for PTSD. A course of treatment typically takes 8–15 sessions.[22] PE works from the perspective that the key factor maintaining PTSD is avoidance, particularly of traumatic memories or emotions and of situations or cues that have become distressing through association with the trauma (eg, crowded places, certain media content). Unhelpful beliefs may develop due to the trauma, leading to avoidance; avoidance may maintain or even reinforce these trauma-related beliefs. For example, the belief "I can't trust anyone" leads to avoiding relationships, which prevents the growth of positive experiences with others and showing that some people can be trusted. PE counters avoidance with exposure to the traumatic memory and safe situations that arouse trauma-related distress. Through exposure, patients habituate to these feared situations and receive opportunities for corrective learning. Exposures also allow for the processing of thoughts and feelings about the trauma and reevaluation of the conclusions they have drawn from it. The VA provides a helpful article on PE with videos: (https://www.ptsd.va.gov/understand_tx/prolonged_exposure.asp). Certified PE therapists by state can be found at https://www.med.upenn.edu/ctsa/find_pe_therapist.html.

EMDR is "an integrative, client-centered psychotherapy approach that emphasizes the brain's information-processing system and memories of disturbing experiences as the basis of those pathologies not caused by organic deficit or insult."[23(p68)] EMDR is more flexible than PE or CPT in that it is intended to address disturbing life events regardless of whether they meet the formal criteria of a trauma, and it does not require patients to complete homework outside of sessions. It addresses present problems as primarily reflecting on unprocessed memories of earlier experiences that are pushing the individual into inappropriate responses.[24] These connections often sit outside of conscious awareness. A course of treatment consists of 8 phases: client history, preparation, assessment, desensitization, installation, body scan, closure, and reassessment. Mechanisms of action for EMDR have been the subject of much debate, but the interventions have similarities with PE and CPT in that patients are prompted to face and process distressing memories as well as to change negative thoughts. In EMDR, this occurs while the patient tracks a visual stimulus (eg, a light, the therapist's finger) back and forth to enhance the processing. More information is available on the EMDR website (https://www.emdr.com/what-is-emdr/).

Moral Injury in the Context of PTSD Treatment

Morally injurious events, traumatic events that violate a service member's moral beliefs, often overlap with PTSD symptoms. Service members may witness or participate in events that lead to extreme guilt or shame (eg, death of a child or civilian), which also contribute to symptoms of PTSD. The frontline treatments PE and CPT have been shown to significantly reduce PTSD symptoms among veterans who experience a morally injurious event.[25,26] Emerging interventions, such as adaptive disclosure,[27] have begun to examine whether recovery from moral injury may further reduce mental health difficulties among veterans.

How Can Primary Care Providers Help Veterans Connect to Care?

An important first step for supporting military veterans is to incorporate screenings of military status into standard care. If patients endorse military service, further screening can determine whether the patient is receiving care at the VA and whether the patient consents to receiving VA care. Many veterans do not qualify for VA care, and others choose to decline VA services, perhaps out of wariness of the federal government or due to a previous negative experience. After ascertaining this information, coordination of care minimizes redundancy and misinformation. Given that violation of trust occurs frequently in the context of trauma, obtaining clearly defined releases of information (ROIs) is essential. Additionally, when contacting the VA, take note that completion of a ROI that utilizes their documentation paperwork may be required.

For patients who decline to pursue VA services or who do not qualify, contacting military-informed community resources may be considered. Providers can search specifically for these mental health resources on the Substance Abuse and Mental Health Services Administration (SAMHSA) website (https://findtreatment.samhsa.gov/) or contact their local VA for suggested resources. Additionally, many veterans live in rural areas and may not have ready access to in-person services that they can attend on a weekly basis. When making referrals, consider that the main VA campuses are not the only military-informed resources. Other services within the VA umbrella include vet centers, small clinics available only to combat veterans, and community-based outpatient clinics that serve as outposts in less populated areas and that often have limited mental health services. Lastly, the importance of telehealth for rural veterans who have the means to access this service can be extremely high. For patients who are hesitant to engage in in-person care, telehealth may be an invaluable alternative.

In addition, when addressing the needs of military veterans it is extraordinarily helpful to become more aware of the military culture and ethos that affects the experience of mental health challenges. Pride, devotion to service, stoicism, and self-reliance are common values among service members. These characteristics confer enormous resilience as well as increase difficulty in accessing care and considering your recommendations. Consider accessing resources such as Home Base (www.homebase.org), PsychArmor (www.psycharmor.org), and the National Center for PTSD (www.ptsd.va.gov) for more information on this topic. Similarly, referring to providers with military cultural awareness may further reduce barriers to care.

What Resources Are Available to Returning Veterans and Families for PTSD, Depression, and Substance Use?

There is a range of modalities and levels of care available to veterans with PTSD, depression, or substance use. The VA is often best positioned to offer the full spectrum of services. When making a referral, the level of safety risk, substance dependence or relapse risk, and access factors (such as availability of services and transportation) should be considered. Financial considerations often play an important role in a veteran's decision making for services. Veterans may prefer to see a provider at the VA for better coverage options; indeed, many veterans routinely fill their prescriptions from non-VA providers at VA facilities to ensure affordability of their treatment.

Individual therapy. Individual therapy is a frontline intervention for most behavioral health issues, including PTSD, depression, and substance use difficulties. Cognitive-behavioral therapy (CBT), the predominant therapeutic orientation, works on changing a patient's unhelpful interpretations and assumptions, as well as on implementing more adaptive behaviors (eg, exercise, rewarding activities). Guidelines[19] recommend evidence-based, trauma-focused treatment within a CBT framework for PTSD. Most treatment protocols (eg, PE, CPT) are intended to be completed via weekly sessions, and there is recent evidence[28] showing that PTSD treatment can be just as effective when delivered in a "massed" or daily format. However, individual therapy at the VA may only be available on a less frequent basis (or after a wait) due to an imbalance between staffing levels and the demand for services.

Group therapy. Clinical practice guidelines[19] indicate that there is limited support for the effectiveness of group therapy for PTSD—individual therapy is much more strongly recommended.[10] However, this is not to say that veterans cannot benefit from group therapy. A comparison between group CPT and group present-centered therapy among veterans found large reductions in PTSD symptoms for both and superior outcomes with CPT. Evidence supports group therapy for depression as well, and substance use programs frequently include a group component.[18,29] Groups can be a resource-efficient way of providing skills and psychoeducation and may seem like a less intense or threatening first step in treatment. They can also provide a means for veterans to connect with others who have similar backgrounds and struggles, providing a source of support, comradery, and reassurance, showing that they are in good company with their challenges.

Intensive outpatient programs/partial hospitalization programs. Intensive outpatient programs typically provide a balance of structure and multimodal intervention (eg, multiple groups daily, individual therapy) with the freedom and flexibility of remaining as an outpatient and returning home in the evenings. They are often utilized in the treatment of substance use. Intensive outpatient programs should be considered for patients with high need or severe symptoms who are not at imminent risk of harm or in need of a medically supervised detox. Likewise, partial hospitalization programs allow patients to continue residing in their home while traveling to a hospital program for full treatment days, multiple days per week—typically with more structure and frequency of interventions than in an intensive outpatient program.

Inpatient. Inpatient treatment involves full-time relocation to a hospital facility, which might include the VA. It is therefore the most restrictive modality and should generally be avoided if a lower level of care can meet the patient's needs. It is typically reserved for patients with an acute/imminent risk of harm to themselves or others, substance dependence, or such poor functioning that there is concern for the patients' ability to care for themselves. Individuals may attend inpatient programs voluntarily or can be compelled to attend brief (eg, 72 hours) inpatient treatment based on state laws. Treatment in inpatient programs is highly variable and dependent on a patient's stability and ability to engage with others. Some may seek to provide a safe location for crisis intervention and medication adjustments, while others may attempt a course of trauma-focused therapy.

Residential/partial hospitalization programs. Residential programs offer longer-term shelter while a patient engages in treatment or rehabilitation. They are typically used when a patient has chronic impairment in his/her functioning and

needs extended support to get to the point of functioning independently. However, residential programs may offer more freedom than inpatient programs.

Alcohol/drug treatment. Alcohol/drug treatment falls into the full range of levels of care outlined previously. The Department of Defense/VA guidelines[19] recommend addressing substance use concurrently with PTSD, rather than delaying PTSD treatment.

How Can Primary Care Providers Screen for and Intervene With Someone in Crisis?

Appropriate measures/assessment. The PC-PTSD-5[1] is a 5-item measure for assessing the presence and impact of trauma. It is designed to quickly identify patients who are likely to have PTSD using only "yes/no" questions, though diagnosis requires further assessment, such as with a structured clinical interview.

The PHQ-9[2] is a 9-item, self-report rating scale for assessing depression severity. An easily computable total score provides a quick gauge of depression, ranging from "minimal depression" that likely does not warrant further intervention to "severe depression" that indicates a need for treatment.

The Alcohol Use Disorders Identification Test (AUDIT)[30] is a 10-item screener for problematic alcohol use that can be administered as an interview or as a self-report measure. Items inquire about frequency and volume of alcohol use, as well as symptoms of an alcohol use disorder, such as difficulty limiting alcohol use or failure to take care of duties because of alcohol. Each item offers multiple response choices that correspond to a range of severity. The item scores are tallied to produce an overall score with corresponding guidelines for intervention. Interventions range from alcohol education to referral for evaluation for alcohol dependence.

Ask about the impact of military/deployment experiences. Difficulties presented during your assessment may reflect longstanding issues stemming from military service. Broad questions (eg, "How has your military experience impacted your physical and mental health?") may provide important diagnostic information while avoiding detailed questions about specific traumatic events. Due to the high rates of military sexual trauma (MST) reported in veteran samples and heightened negative sequelae from this type of trauma, it is worth asking specifically about experiences of MST, perhaps by using the 2-question MST screen the VA asks of all veterans: "While you were in the military: (1) Did you receive uninvited and unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks? and (2) Did someone ever use force or threat of force to have sexual contact with you against your will?"[31] Importantly, these questions should be combined with an empathetic approach due to the sensitive subject matter.

Assess for risk. Stereotypes about "angry veterans" and the stigma around receiving care of any kind within military culture often contribute to both a reluctance to seek care and wariness toward health care providers. When considering screening and intervention for a veteran in crisis, maintain a calm, empathic tone. Follow hospital policy for de-escalation, crisis management, and involuntary care ("sectioning") for risk issues; this includes thoughts of suicide, self-harm, or hurting others.

Provide patients with the Veterans Crisis Line. For nonacute distress, the Veterans Crisis Line is a great resource to recommend to patients. Veterans can go to the website (www.veteranscrisisline.net), call the number (1–800-273–8255; press 1 for veterans), or text 838255. This resource is available 24/7. As a provider, take note of the "Signs of Crisis" resource (https://www.veteranscrisisline.net/education/signs-of-crisis), which includes helpful indicators to ask patients.

Consider whether one mental health diagnosis is masking another. PTSD is a disorder of avoidance. Avoiding intrusive symptoms may lead to difficulties with alcohol use, anger, or withdrawing from others. Patients may present with symptoms of alcohol use disorder, major depressive disorder, insomnia, or suicidal/homicidal ideation that merit further discussion to identify whether PTSD is playing a role.

What kinds of work can be done with families of returning veterans? When the individual serves, their family serves with them. Frequent moves, the disruption of the family unit, and anxiety experienced while a loved one is deployed increase risk for internalizing and externalizing difficulties among children and place significant strain on the relationship between the service member and their spouse.[32] Families may be grappling with these challenges long after military service. Additionally, mental health difficulties experienced by the veteran, such as PTSD, can have downstream effects that negatively impact the whole family. Beyond marital and parenting distress, PTSD may also contribute to symptoms of secondary traumatization among the family members.[33] If a family member presents to primary care, it is important to screen for military service to determine whether these difficulties are adversely affecting their health. Family members who are struggling with their veteran's mental health difficulties should be made aware of the VA service "Coaching Into Care" (https://www.mirecc.va.gov/coaching/), which is a free resource that provides assistance for family members to encourage their veteran to seek treatment.

Unfortunately, services for veteran family members can be diffuse and sometimes limited. Although the VA is mandated to provide family services, there is no mandate on the nature of these services or which services must be made available. Thus, your local VA may have a couples therapist or a family therapist, but overall most VA centers have limited capacity for these services. When making referrals for family services, one should consider whether the provider has experience working with military families. This process can be aided by the SAMHSA search tool (mentioned previously), contacting the local VA, or identifying Tricare providers, as these providers are more likely to have experience working with veterans.

What types of family therapy interventions are available? Several interventions have been designed

or tailored to address difficulties that are specific to the needs of veteran families. Parenting interventions, such as Strong Families Strong Forces, After Deployment Adaptive Parenting Tools, and Family Overcoming Under Stress all offer helpful parenting support and programming aimed at supporting reintegration into civilian life.[33–36] Similarly, resources for children, such as the book *Why Is Dad/Mom So Mad*[37] and Sesame Street for Military Families (https://sesamestreetformilitaryfamilies.org/), are helpful recommendations for parents looking for opportunities to educate and support their children on topics of mental health and military service. Beyond general couples services, therapeutic approaches that may be particularly helpful for veteran families include behavioral couples therapy for substance use and cognitive-behavioral conjoint couples therapy for PTSD.[38–40] Both forms of therapy are tailored to the unique needs of couples impacted by the stress of the respective mental health disorders.

CASE DISCUSSIONS

Case 1

Mr A's health care provider reported that the patient was experiencing significant PTSD and depressive symptoms. The provider recommended that Mr A receive mental health treatment. Mr A expressed reluctance but was encouraged after the provider gently referred to the impact of his symptoms on his family members' well-being. Mr A was referred to the VA for a neurologic evaluation of TBI complications and for PTSD treatment. The provider also completed the requisite ROI to facilitate a warm handoff with the clinician facilitating Mr A's PTSD services. Mr A completed a 12-session protocol of CPT, which allowed him to challenge his long-held beliefs about danger and threat (eg, "The world is dangerous"). Mr A's hypervigilance declined with treatment, as did his frequent anger outbursts and nightmares. With the reduction in family distress, his relationship with his wife and children improved.

Case 2

Ms B was screened for alcohol use disorders using the AUDIT, which indicated that a treatment intervention was warranted. Her childcare responsibilities prompted her provider to assess for situations when her children might be at risk of harm or neglect due to her being incapacitated by alcohol. She clarified that she only drinks when she has another adult caregiver in the home and denied other concerns for her children's safety. Her provider also asked about her military experiences, which led to disclosure of a sexual trauma that occurred one night during her deployment. This disclosure led to further explanation that she is hypervigilant at night and reluctant to fall asleep because it creates a feeling of vulnerability. She also sometimes avoids sleeping because of repeated, disturbing nightmares. Alcohol has served as a way of forcing herself to rest, as well as numbing negative emotions and blocking out intrusive memories of the assault. The PC-PTSD-5 revealed that she was experiencing symptoms suggestive of PTSD. Given her request to avoid VA services, her provider contacted the VA for recommendations for community mental health services tailored to veterans who have experienced military sexual trauma. With the additional information from the screening and the VA's recommendations, they identified a residential dual-diagnosis program to help her achieve sobriety while engaging in trauma-focused therapy. She was paired with a provider who had expertise in military sexual trauma, which improved rapport and allowed her to engage in PE. Through facing her trauma, she substantially reduced her anxiety and avoidance related to the memories and developed more helpful perspectives on the assault (eg, recognized that the perpetrator was solely to blame). As a result, her intrusive memories and nightmares became much less frequent and disturbing. In vivo exposure exercises helped her habituate to being in public without the use of hypervigilant safety behaviors. She reported feeling much safer and more relaxed. As a result of these improvements, she no longer felt the need for alcohol to help her cope and maintained her sobriety after the program. She reunited with her children and was able to enjoy taking them to the types of loud, exciting places that they enjoy.

CONCLUSIONS

Although some veterans and family members have access to the resources within the VA health care system, many veterans—perhaps most veterans—will at some point seek treatment from primary care providers in the community. It is important for providers to educate themselves on common challenges faced by veterans and their families and to identify resources that may best serve this population. Providers will also benefit from exploring opportunities to expand their training on military culture through psychoeducation resources. Finally, it is important for providers to be aware of military and veteran resources in their community and to coordinate care as much as possible with VA providers to facilitate effective support for this population.

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REFERENCES

1. Prins A, Bovin MJ, Smolenski DJ, et al. The Primary Care PTSD Screen for *DSM-5* (PC-PTSD-5): development and evaluation within a veteran primary care sample. *J Gen Intern Med*. 2016;31(10):1206–1211.
2. Kroenke K, Spitzer RL, Williams JBW. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16(9):606–613.
3. Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans: Cumulative from 1st Qtr FY 2002 through 3rd Qtr FY 2015 (October 1, 2001–June 30, 2015). US Department of Veterans Affairs. January 2017. Accessed July 22, 2021. https://www.publichealth.va.gov/docs/epidemiology/healthcare-utilization-report-fy2015-qtr3.pdf#
4. Hynes DM, Koelling K, Stroupe K, et al. Veterans' access to and use of Medicare and

Veterans Affairs health care. *Med Care*. 2007;45(3):214–223.
5. Schlosser J, Kollisch D, Johnson D, et al. VA-community dual care: veteran and clinician perspectives. *J Community Health*. 2020;45(4):795–802.
6. Kessler RC, Berglund P, Demler O, et al. Lifetime prevalence and age-of-onset distributions of *DSM-IV* disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):593–602.
7. Tanielian T, Jaycox LH. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: RAND Corporation; 2008.
8. Kessler RC, Chiu WT, Demler O, et al. Prevalence, severity, and comorbidity of 12-month *DSM-IV* disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005;62(6):617–627.
9. Office of Mental Health and Suicide Prevention. 2020 National Veteran Suicide Prevention Annual Report. US Department of Veterans Affairs. 2020. Accessed July 22, 2021. https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf
10. Arenson MB, Whooley MA, Neylan TC, et al. Posttraumatic stress disorder, depression, and suicidal ideation in veterans: results from the Mind Your Heart Study. *Psychiatry Res*. 2018;265:224–230.
11. Reger MA, Smolenski DJ, Skopp NA, et al. Risk of suicide among us military service members following Operation Enduring Freedom or Operation Iraqi Freedom deployment and separation from the US military. *JAMA Psychiatry*. 2015;72(6):561–569.
12. Taylor DJ, Pruiksma KE, Hale WJ, et al; STRONG STAR Consortium. Prevalence, correlates, and predictors of insomnia in the US Army prior to deployment. *Sleep (Basel)*. 2016;39(10):1795–1806.
13. Jenkins MM, Colvonen PJ, Norman SB, et al. Prevalence and mental health correlates of insomnia in first-encounter veterans with and without military sexual trauma. *Sleep (Basel)*. 2015;38(10):1547–1554.
14. DoD TBI Worldwide Numbers. Health.mil. December 18, 2020. Accessed July 22, 2021. https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Research-and-Development/Traumatic-Brain-Injury-Center-of-Excellence/DoD-TBI-Worldwide-Numbers
15. Hoge CW, McGurk D, Thomas JL, et al. Mild traumatic brain injury in US Soldiers returning from Iraq. *N Engl J Med*. 2008;358(5):453–463.
16. Cognitive rehabilitation following mild to moderate TBI. Health.mil. Updated February 2019. Accessed July 22, 2021. https://www.health.mil/Reference-Center/Publications/2020/07/30/Cognitive-Rehabilitation-for-Following-Mild-to-Moderate-TBI-Clinical-Recommendation-Full
17. Hamblen JL, Norman SB, Sonis JH, et al. A guide to guidelines for the treatment of posttraumatic stress disorder in adults: an update. *Psychotherapy (Chic)*. 2019;56(3):359–373.
18. Resick PA, Wachen JS, Mintz J, et al. A randomized clinical trial of group cognitive processing therapy compared with group present-centered therapy for PTSD among active duty military personnel. *J Consult Clin Psychol*. 2015;83(6):1058–1068.
19. Management of Posttraumatic Stress Disorder and Acute Stress Reaction 2017; VA/DoD Clinical Practice Guidelines. US Department of Veterans Affairs. Published 2017. Accessed July 22, 2021. https://www.healthquality.va.gov/guidelines/MH/ptsd/
20. Resick PA, Monson CM, Chard KM. *Cognitive Processing Therapy for PTSD: A Comprehensive Manual*. New York, NY: The Guilford Press; 2017.
21. Resick PA, Galovski TE, Uhlmansiek MOB, et al. A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *J Consult Clin Psychol*. 2008;76(2):243–258.
22. Foa E, Hembree EA, Rothbaum BO, et al. *Prolonged Exposure Therapy for PTSD*. New York, NY: Oxford University Press; 2019.
23. Shapiro F. EMDR, adaptive information processing, and case conceptualization. *J EMDR Pract Res*. 2007;1(2):68–87.
24. Shapiro F. *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures*. Second edition. New York, NY: The Guilford Press; 2001.
25. Held P, Klassen BJ, Brennan MB, et al. Using prolonged exposure and cognitive processing therapy to treat veterans with moral injury-based PTSD: two case examples. *Cognit Behav Pract*. 2018;25(3):377–390.
26. Smith ER, Duax JM, Rauch SAM. Perceived perpetration during traumatic events: clinical suggestions from experts in prolonged exposure therapy. *Cognit Behav Pract*. 2013;20(4):461–470.
27. Gray MJ, Schorr Y, Nash W, et al. Adaptive disclosure: an open trial of a novel exposure-based intervention for service members with combat-related psychological stress injuries. *Behav Ther*. 2012;43(2):407–415.
28. Foa EB, McLean CP, Zang Y, et al; STRONG STAR Consortium. Effect of prolonged exposure therapy delivered over 2 weeks vs 8 weeks vs present-centered therapy on PTSD symptom severity in military personnel: a randomized clinical trial. *JAMA*. 2018;319(4):354–364.
29. McDermut W, Miller IW, Brown RA. The efficacy of group psychotherapy for depression: a metaanalysis and review of the empirical research. *Clin Psychol Sci Pract*. 2001;8(1):98–116.
30. Babor T, Higgins-Biddle JC, Saunders JB, et al. *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*. Geneva, Switzerland: World Health Organization; 2001:1–40.
31. Kimerling R, Gima K, Smith MW, et al. The Veterans Health Administration and military sexual trauma. *Am J Public Health*. 2007;97(12):2160–2166.
32. Lester P, Peterson K, Reeves J, et al. The long war and parental combat deployment: effects on military children and at-home spouses. *J Am Acad Child Adolesc Psychiatry*. 2010;49(4):310–320.
33. Snyder J, Gewirtz A, Schrepferman L, et al. Parent-child relationship quality and family transmission of parent posttraumatic stress disorder symptoms and child externalizing and internalizing symptoms following fathers' exposure to combat trauma. *Dev Psychopathol*. 2016;28(4pt1):947–969.
34. DeVoe ER, Paris R, Emmert-Aronson B, et al. A randomized clinical trial of a postdeployment parenting intervention for service members and their families with very young children. *Psychol Trauma*. 2017;9(suppl 1):25–34.
35. Gewirtz AH, Pinna KLM, Hanson SK, et al. Promoting parenting to support reintegrating military families: after deployment, adaptive parenting tools. *Psychol Serv*. 2014;11(1):31–40.
36. Lester P, Mogil C, Saltzman W, et al. Families overcoming under stress: implementing family-centered prevention for military families facing wartime deployments and combat operational stress. *Mil Med*. 2011;176(1):19–25.
37. Kastle S. *Why Is Dad So Mad. A Book About PTSD and Military Families*. Hays, KS: Tall Tale Press; 2015.
38. Makin-Byrd K, Gifford E, McCutcheon S, et al. Family and couples treatment for newly returning veterans. *Prof Psychol*. 2011;42(1):47–55.
39. Fals-Stewart W, O'Farrell TJ, Birchler GR. Behavioral couples therapy for substance abuse: rationale, methods, and findings. *Sci Pract Perspect*. 2004;2(2):30–41.
40. Macdonald A, Pukay-Martin ND, Wagner AC, et al. Cognitive-behavioral conjoint therapy for PTSD improves various PTSD symptoms and trauma-related cognitions: Results from a randomized controlled trial. *J Fam Psychol*. 2016;30(1):157–162.