APA GUIDELINES
for Psychological Practice With Military Service Members, Veterans, and Their Families

APA COMMITTEE ON PROFESSIONAL PRACTICE AND STANDARDS (COPPS)
IN COLLABORATION WITH THE BOARD OF PROFESSIONAL AFFAIRS (BPA)

APPROVED BY APA COUNCIL OF REPRESENTATIVES
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INTRODUCTION

The role of psychology in the care of the United States (U.S.) military service members and veterans has a long and significant history and represents one of the profession's earliest concerns. Indeed, American psychology has been shaped by the provision of care to military personnel and veterans, beginning in World War I (Seligman & Fowler, 2011; Greenwood, 2017), and particularly during World War II and conflicts thereafter (Herman, 1995). Formative events include the founding of the American Psychological Association (APA) Division 19 (Society of Military Psychology), which was one of the charter divisions of APA when it was reorganized in 1945 (Benjamin, 1997); the creation of the veterans "section" in APA Division 18 (Psychologists in Public Service); and the integral function of the Veterans Administration (now the Department of Veterans Affairs [VA][1]) in the clinical training of psychologists at the predoctoral and postdoctoral levels (Sheridan, 1999), including the development of APA accreditation of such training.

Likewise, the service of approximately 700 clinical psychologists on active duty across the Army, Navy, and Air Force (Johnston et al., 2017); and the employment of over 5,400 psychologists in VA settings at the time of this writing (Department of Veterans Affairs, 2017b) indicates the importance to psychologists of providing services to military service members and veterans. Beyond specialized military or veteran settings, psychologists in the community also often work with service members or veterans. For example, among private practitioners, although only 4% frequently or very frequently provide services to military service members, 16% frequently or very frequently provide services to veterans (American Psychological Association [APA], 2017a, 2017b).

Note: Numbered superscripts refer the reader to a glossary at the end of this document providing a definition or more detail about the designated term.

These numbers do not include psychologists who sometimes or occasionally see service members or veterans and are almost certainly an underestimate, given that many providers do not routinely screen for military affiliation of their clients. Moreover, they do not account for services provided to spouses or children of service members or veterans. Thus, both historically and currently, across a range of employment settings, psychologists have contributed significantly to the care of U.S. military service members, veterans, and their family members. This document provides guidelines for psychological practice with this unique and diverse population. In the document we use the abbreviations SM, V, and F to refer to service members, veterans, and their families, respectively. The abbreviations may appear individually or in combination at different points in the text.

Like individuals in the general population, the majority of SMVF are psychologically healthy and resilient (Bonanno et al., 2012; Isaacs et al., 2017; McKibben et al., 2013; Park, 2011). However, even those who are functioning well may seek psychological services to deal with military-related or general life stressors or to improve an aspect of their lives. Additionally, those who do struggle with mental health concerns may seek psychological assessment and intervention or be referred from military treatment facilities (MTFs) for care.

According to a RAND report (Tanielian et al., 2014), addressing the mental health needs of SMVF is a national priority. The contemporary military population faces many stressors, including some that may predate military service. For example, in the current era of the all-volunteer force, individuals with military service have had a higher prevalence of adverse childhood experiences (ACEs) than those outside the military (Blosnich et al., 2014; Katon et al., 2015). Moreover, some stressors are closely or uniquely associated with military life, such as frequent moves, deployment, and exposure to potentially traumatic combat-related events (Hoge et al., 2004; Paley et al., 2013; Park, 2011; Riggs & Riggs, 2011; Seal et al., 2009), all of which may contribute to the development of mental health symptoms or disorders. In addition, there are some stressors that are experienced more often by specific subgroups, as described below in Section 3.

A significant portion of SMVF are served by the Department of Defense (DoD[2]) Military Health System (MHS) or the Veterans Health Administration (VHA[3]) within the Department of Veterans Affairs (VA). These federal agencies have promulgated clinical practice guidelines specific to their operations and service missions that apply to service members, veterans, and other beneficiaries, such as the Department of Veterans Affairs & Department of Defense (VA/DoD) Mental Health Clinical Practice Guidelines. These guidelines address such problems as substance use disorders (VA/DoD, 2015b), mild traumatic brain injury (VA/DoD, 2016a), major depression (VA/DoD, 2016b), posttraumatic stress disorder (PTSD; VA/DoD, 2017), insomnia (VA/DoD, 2019a), and risk for suicide (VA/DoD, 2019b). These are available online and may be very helpful to providers of psychological services across multiple settings. Clinical practice guidelines differ, however, from professional practice guidelines, as described below.

A limited number of service members, as well as many veterans and family members, seek services outside of DoD or VHA facilities. For example, among veterans enrolled in the VHA, access to community care is a rapidly developing topic. At the time of this writing, there were executive orders and laws (e.g., Exec. Order No. 13,625, 2012; Veterans Access, Choice, and Accountability Act of 2014; VA Maintaining Internal Systems and Strengthening Integrated Outside Networks [MISSION] Act of 2018) allowing certain VA-eligible veterans to obtain reimbursed treatment in non-VA/DoD settings. These changes in health care laws may increase the likelihood that community psychologists will see this population for services.

Some, but not all, psychologists who provide clinical services in DoD or VHA settings receive training on military culture and experiences as part of their job and/or may learn about these topics in the course of their employment, leading to increased competence working with SMVF. Psychologists within the DoD, however, may not be familiar with treatment issues or practices within the VA, and vice versa. In either group, as well as for providers without these training experiences, there remains a need for increased and ongoing cultural competency in providing services to SMVF (Tanielian et al., 2014).

Furthermore, research suggests that many mental health professionals working outside of DoD or VHA settings, as well as some within such settings, do not feel wholly competent to provide psychological treatment to SMVF (Interagency Task Force on Military and Veterans Mental Health, 2013; Exec. Order No. 13,625; Kees & Rosenblum, 2015; Paley et al., 2013; Tanielian et al., 2014). For example, only 24% of non-DoD/VHA providers in the TRICARE[3] health care network, which specifically includes service for SMVF, and only 8% of non-TRICARE providers, reported high levels of cultural competency in providing psychological treatment to SMVF, compared with 70% of VHA and DoD providers (Tanielian et al., 2014). Moreover, there is a recognized need for mental health care systems and providers to increase competence in targeted and effective services to SMVF (Interagency Task Force, 2017; Paley et al., 2013). Thus, there is demonstrated need for guidelines for psychological services with SMVF, especially for psychologists in non-VHA/DoD settings.

Purpose and Intended Users

Consistent with the APA *Professional Practice Guidelines: Guidance for Developers and Users* (2015), these professional practice guidelines were developed to provide recommendations for psychologists who provide services to SMVF, recognizing that there are varying degrees to which psychologists have received training, including when and what type of training, as well as amount of practical opportunity to reach competency for different types of work. *Psychological services* in this context refer to a broad range of activities, including but not limited to, assessment, prevention, intervention, and health-related education. Postsecondary teaching faculty and supervisors may also benefit from these guidelines since there are large numbers of SMVF engaged in education and training.

These guidelines are not intended to supplant or supersede those generated by federal agencies serving SMVF. Furthermore, the present guidelines do not provide an exhaustive review of relevant topics. Instead, the intent is to introduce psychologists to the complex practice landscape of serving SMVF and to provide a foundation for competence in military culture. In Appendix B, some potential resources for further education and training are offered. Their inclusion is not necessarily an endorsement by APA; rather, they serve as examples of the many resources available and as a potential starting point to increase knowledge and awareness in these areas.

The guidelines are intended to highlight the main issues that are relatively unique to this particular population and that would not necessarily *also* be of consideration in the civilian population. The successful application of these guidelines involves use of clinical judgment, recognition of one's own scope of practice, and an understanding of the extent to which military status is part of an individual's identity or relevant to the individual's openness to or need for psychological care.

Distinction Between Standards and Guidelines

The term *guidelines* refers to pronouncements, statements, or declarations that suggest or recommend specific professional behavior, endeavors, or conduct for psychologists. Guidelines differ from standards in that standards are mandatory and may be accompanied by an enforcement mechanism. By contrast, guidelines are aspirational in intent. They are intended to facilitate the continued systematic development of the profession and to help ensure a high level of professional practice by psychologists. They are not intended to be mandatory or exhaustive and may not be applicable to every clinical situation. They should not be construed as definitive and are not intended to take precedence over the judgment of psychologists. It is also important to note that federal and state laws supersede practice guidelines. Guidelines must also be consistent with the current APA policy and with the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017c).

Although the terms *professional practice guidelines* and *clinical practice guidelines* are often used interchangeably, APA (2015) draws a distinction between the two and encourages consistent use of terminology within the association (APA, 2015). *Clinical practice guidelines* provide specific recommendations about clinical interventions. They tend to be specific to conditions or treatments and are typically disorder-based (e.g., depression; APA, 2019). In contrast, *professional practice guidelines* consist of recommendations to professionals concerning their conduct and the issues to be considered within particular psychological practice areas.

Guideline Development Process

The Committee on Professional Practice and Standards (COPPS) drafted these professional practice guidelines with the involvement of the public and many professional and specialty-related groups who collaborated in their development and/or review. This included members of APA Division 18 (Psychologists in Public Service, Veterans Affairs Section), Division 19 (Society for Military Psychology), Division 56 (Trauma Psychology), and the VHA National Center for PTSD (Posttraumatic Stress Disorder). A full list of direct contributors is included in the Acknowledgments. The aim of these collaborations was to gather a variety of perspectives and guidance to ensure that these guidelines were comprehensive and consistent with recommendations from existing agencies and initiatives. Subject matter experts (SMEs) for each of the guidelines were recommended and identified by these groups and by the developers (see the Author Note). SMEs recommended literature to review for consideration in the guidelines. As guidelines are different from a research literature review and are not meant to provide an exhaustive list of all available literature, priority was given to the following: (1) data and information that was available in seminal works (those that provide overviews of the subject); (2) recent information (especially for rates and statistics); (3) perspectives generally agreed upon by SMEs in a certain area; and (4) material available in VA/DoD-related policies and publications. If there were many available citations to support a statement or recommendation, only a few were chosen to highlight the information, using the same criteria above. SMEs also reviewed drafts of the guidelines to ensure the information and citations were generally supported and provided additional recommendations if significant material was missing. The guidelines are organized into four broad domains: orientation to military culture, assessment and treatment, special subpopulations, and families.

Documentation of SMVF Need for Services

The total number of SMVF represents a significant part of the American population. The United States has approximately 1,295,000 active duty military service personnel in the Army, Navy, Marine Corps, and Air Force, and approximately 40,600 active duty Coast Guard members. Ready Reserve and Coast Guard Reserve comprise an additional 1,057,000 military personnel (Department of Defense, 2017). There are approximately 18.2 million living U.S. veterans, about 7% of the U.S. population aged 18 and over (Census Bureau, 2017).

Over half of active duty military members and over 40% of Reserve and National Guard members have spouses, and about 40% of each of these groups have children (National Academies of Sciences, Engineering, and Medicine, 2019). Among the veteran population, in 2016 over 1.4 million had one or more children in the home (National Center for Veterans Analysis and Statistics, 2017). Thus, the combined number of service members, veterans, and their family members is very high. Taking into consideration that most of this total group does not receive mental health services through the DoD or VHA, it is likely that the majority of practicing psychologists will provide professional services to SMVF clients at some point.

SERVICE MEMBERS

Although active duty[5] service members generally receive their mental health care from DoD clinicians, some are referred for civilian services. Some seek care outside of a DoD setting because it is unavailable at the local DoD facility, whereas some seek it out of concern about negative career or employment impact within the DoD (Eaton et al., 2008; Mental Health Advisory Team [MHAT] 9, 2013).

Thus, it is important for civilian psychologists to be aware of the lifestyle and stressors active duty service members face, as these stressors may directly affect mental health factors. The active duty lifestyle involves moving to new military commands and installations every two to four years. It may additionally involve one or more deployments for three months to two years each, and it may require assignments to new and/or unfamiliar units or jobs (VA/DoD, 2015a). If occurring during a war or conflict, these deployments may additionally involve exposure to combat.

Unlike active duty members, members of the National Guard and Reserve (Reserve Component [RC[6]]) reside and are employed in the general community. They may live at some distance from DoD or VHA facilities. Deployments for Reserve or National Guard members may lead to stressors and major life disruptions such as leaving civilian employment that may not be guaranteed upon return; leaving personally owned businesses; and, similar to AC members, leaving their family members, neighbors, and friends.

Although some service members benefit from having services available through the VHA, many live in areas that do not have military-specific health care or supports available (Murphy & Fairbank, 2013).

VETERANS

Most, though not all, veterans are eligible to receive health care, including mental health care, at VA medical centers and outpatient clinics. Among all veterans, approximately 30% used VHA health care during the most recent year for which data are available (2017). Utilization rates of VA benefits, including health care, vary by military service era and other demographic variables (National Center for Veterans Analysis and Statistics, 2020), but overall the majority do not use VA health care.

Specific to mental health, there appear to be multiple attitudinal and practical reasons, in addition to lack of eligibility, for veterans' non-use of the VHA system, including the persisting stigma of behavioral health problems (Pietrzak et al., 2009; Rosen et al., 2011), avoidance of reminders of military service among those with posttraumatic conditions (Blais et al., 2014), distance to a VA facility for rural veterans (Brooks et al., 2012), lack of awareness of services, logistical challenges, or general concerns about seeking VHA mental health care (Government Accountability Office, 2011). Some of these barriers are not unique to veterans and have also been reported by civilian adults accessing mental health care.

Some veterans seek mental health care in the private or nonprofit sectors via referral within their medical insurance network, on their own initiative (self-pay), and through VA programs based on the MISSION Act of 2018, in which the VA pays private sector clinicians or organizations (Department of Veterans Affairs, 2019).

In addition, some veterans are also eligible for service-connected disability benefits if they suffer from a disease or injury incurred during or aggravated by their military service (Department of Veterans Affairs, 2020). Among service-connected disabled veterans, 93% were enrolled in the VHA health care system in 2017 and 89% utilized it (National Center for Veterans Analysis and Statistics, 2020).

The Veterans Benefits Administration (VBA) manages all veterans' benefits programs, including disability compensation. The VBA requires almost all veterans who file a claim for disability compensation for PTSD and other mental disorders to undergo a compensation and pension (C&P) exam. The Veterans Health Administration historically conducted the vast majority of these disability evaluations, but in recent years, private practice psychologists and psychiatrists have conducted an increasing proportion. As of early 2018, private sector clinicians conducted about 50% of C&P exams (Government Accountability Office, 2018), under contract to medical disability exam (MDE) companies, who manage and coordinate the exams on behalf of the VBA. Having a high level of competency in these C&P exams by non-VA psychologists is critical to appropriate designation, coordination, and development of care.

FAMILIES

Family members of active duty service members face unique stressors related to the military lifestyle. Such stressors can include preparing for and adjusting to frequent geographic moves to new military stations or communities and changing jobs, schools, and local support systems. Since 2001, 2.77 million military personnel have been deployed to Iraq or Afghanistan, of whom 1.3 million deployed two or more times (Wenger et al., 2018). Over half of these military personnel were married at the time, and almost half had children. More than 2 million children have experienced separation from a parent because of deployment (Cozza & Lerner, 2013). Military families may struggle with significant psychological distress before, during, and after a service member's deployment (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, 2007). For example, military families may worry about the service member's health and safety during deployment, and household duties and roles undergo transitions within the family during and after deployment. Multiple deployments during the Iraq and Afghanistan conflicts meant that some families have had to cope with an upcoming deployment as they were still adjusting following the previous deployment. As discussed in more detail in Section 4 on families, the majority of military families demonstrate resilience in response to deployment, and military branches have made efforts to foster such resilience (Cornum et al., 2011; Easterbrooks et al., 2013; Harms et al., 2013; Mental Health Advisory Team 9, 2013). Research, however, also indicates that deployment may be negatively associated with the well-being of military spouses and children. It is important for psychologists to be aware of factors related to military life and deployment that may be relevant to military family members' need for psychological care.

Expiration

While the average expiration date for most professional practice guidelines is 10 years, it is recommended that these guidelines be reviewed sooner if there are research or policy areas expected to emerge that may effect changes to practice. This document is scheduled to expire by 2031. After this date, users are encouraged to contact the APA Practice Directorate to confirm that this document remains in effect.

Author Note

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Guidelines for Psychological Practice With Military Service Members, Veterans, and Their Families

THE GUIDELINES

Overview of the Guidelines

ORIENTATION TO MILITARY CULTURE

- Guideline 1.1: Psychologists endeavor to ask all clients about past or current military status.
- Guideline 1.2: Psychologists are encouraged to understand the impact of military culture and experience on individual SMVF's views of themselves and others over the life course, and to be cognizant of the heterogeneity represented within the U.S. military.
- Guideline 1.3: Psychologists strive to consider the impact of their own personal attitudes, biases, beliefs, and knowledge about military culture and policies on their work with SMVF.

ADDITIONAL FACTORS IN PSYCHOLOGICAL ASSESSMENT, EVALUATION, AND INTERVENTION

- Guideline 2.1: Psychologists strive to be knowledgeable about common stressors faced by military personnel, veterans, and their families, and how these concerns may affect assessment and treatment.
- Guideline 2.2: Psychologists strive to become knowledgeable about mental health problems that may occur frequently among military personnel and veterans, potential differences in the experiences of those who served in different military service eras, and associated evidence-based assessment practices and interventions.
- Guideline 2.3: Psychologists make reasonable efforts to familiarize themselves with resources available through the DoD, VHA, and community agencies for SMVF, and with any legislation or policy affecting the availability of those resources.
- Guideline 2.4: Psychologists strive to understand how military culture and experience may affect both engagement in psychological services and the ability to benefit from services.

EMERGING TOPICS, CRITICAL ISSUES, AND CONCERNS REGARDING SPECIAL MILITARY AND VETERANS SUBPOPULATIONS

- Guideline 3.1: Psychologists consider the specific needs of military service member and veteran subpopulations.

WORKING WITH FAMILIES OF MILITARY SERVICE MEMBERS AND VETERANS

- Guideline 4.1: Psychologists strive to ask all clients whether they are a parent, partner, child or dependent of a service member or veteran as part of a thorough intake or assessment of needs.
- Guideline 4.2: Psychologists strive to understand the effects of military status and of deployment on SMVF.
- Guideline 4.3: Psychologists strive to understand the family context and if appropriate to involve the family system when working with military service members and veterans.

ORIENTATION TO MILITARY CULTURE

Cultural competency optimizes the ability to work effectively across cultures. As we strive to understand the importance of age, race, socioeconomic status, gender, ethnicity, sexual orientation, religion, and immigration status, among other factors, we likewise need to consider the military experience and culture as a potentially important factor in psychological practice. Understanding the impact of military experience may include, but is not limited to, consideration of a client's degree of identification with the military, Active Component versus Reserve/National Guard Component, rank (including officer versus enlisted), branch of service, occupational specialty and experiences, endorsement of military values, organizational structures and processes, as well as the demographic factors relevant for understanding non-SMVF. In this section, we explore and highlight aspects of the military experience and culture that may come into play in psychological practice.

GUIDELINE 1.1

Psychologists endeavor to ask all clients about past or current military status.

Rationale

Involvement with the military may be a factor that impacts clinical care for some military personnel, veterans, or their family members. Psychologists may be working or in contact with a client in different contexts (e.g., as a treating clinician, an assessment psychologist, a child custody evaluator) in which knowledge of military background may be an important factor to consider. Military personnel or veterans may or may not highlight their service when seeking care, and their family members may not highlight this family experience during intake, assessment, or intervention either. However, just as with any other cultural background considerations, asking about clients' experiences, perspectives, expectations, strengths, and resources as they may relate to military service can aid in conveying respect, forming the therapeutic alliance, and conducting appropriate assessment.

Application

Psychologists are encouraged to create a comfortable atmosphere that facilitates discussion of military experiences as part of assessment or therapy and to ask clients if they are SMVF. Specific details of what occurred during the military may not always be critical to understanding SMVF experiences. Additionally, civilian psychologists may not be privy to certain military details that represent confidential or classified information. Thus, psychologists are encouraged to be sensitive to gathering information only to the extent needed for clinical purposes. Psychologists also strive to avoid making immediate assumptions regarding what a particular military experience entailed based solely on the fact that an individual or family has had experiences related to military service. Rather, psychologists are encouraged to explore the extent to which the client's military experience is a core or important component in the individual's identity and/or presenting concerns. For example, symptoms may reflect an underlying service-related mental health issue, inadequate coping related to military lifestyle, or difficulty with managing life stressors unrelated to military service. Without awareness of the SMVF's specific context, the symptoms could be misinterpreted or incorrectly attributed to other causes.

Psychologists outside of the military health system who are working with clients currently in military service strive to be aware of circumstances in which service members have a duty to report receiving behavioral health care in the community. If psychologists in the community are contracted by the DoD to conduct an evaluation or provide other services, they strive to be aware of and to share with their client, any relevant limits to confidentiality.

GUIDELINE 1.2

Psychologists are encouraged to understand the impact of military culture and experience on individual SMVF's views of themselves and others over the life course, and to be cognizant of the heterogeneity represented within the U.S. military.

Rationale

The experience of military service and the impact of military culture on individual SMVF vary widely. Background, values, beliefs, and priorities of individuals in the military and veteran population cannot be assumed based on military affiliation alone. There is a vast array of backgrounds represented among those who serve or once served in the military, as well as significant pluralism in political ideology, social perspective, and faith beliefs (Dansby et al., 2001). Reasons for joining, staying in, and leaving military service vary widely across and within service eras. For example, before 1973, when the all-volunteer military was established, service members may have been drafted or may have voluntarily enlisted.

Motivations for voluntary enlistment can vary widely, including desire to serve one's country, attraction to military work roles, desire for training and further education or for improved opportunities. Motivation can be influenced by such factors as the volunteer's perception of family and parental values and culture, by racial or ethnic background, and even by the proximity of military institutional presence (Bachman et al., 2000; Kleykamp, 2006; Legree et al., 2000). Military service members may also have had different roles during their time spent in the service, including combat, support (e.g., administration, health care), and/or humanitarian assistance. Individuals may have served as officers or as enlisted personnel, in different branches of the active duty force, or in the Reserve Component.

Military experiences can vary significantly based on these factors, as can the type

and strength of their feelings about these service experiences, in turn affecting SMVF's views of themselves, others, and the world. Veterans of different eras/cohorts also may have had very different experiences associated with such factors as differing levels of popular support for war efforts, the changing roles of women in the military, or the impact of minority status due to race, ethnicity, gender, sexual orientation, or transgender status in the military. Experiences may have also varied widely because of changes in technology and communication over time, including type of, access to, and availability of communication between deployed military service members and their families at home (Fox, A. B. et al., 2016). Some SMVF strongly identify with the military culture; others do not and might express resentment toward the military or strongly reject identification with military culture. This identification can also be fluid, ebbing and flowing across service history. Aspects of military ethos, such as selflessness, loyalty, stoicism, moral code, and high standards of excellence, may affect how SMVF manage and interpret many aspects of their lives, including health and behavioral health problems (Department of Veterans Affairs & Department of Defense, 2015b).

Application

Psychologists strive to educate themselves regarding the intersection of military experience with other client variables that impact the life of the individual seeking care, recognizing that military experience is not necessarily the most relevant or overriding factor in the client's background. Psychologists strive to remain cognizant of this fact and to avoid applying generalizations regarding those who serve or once served. Psychologists strive to familiarize themselves with cultural factors related to their SMVF clients. Asking about factors that contributed to a client joining, staying in, or leaving the military and about past military experiences will help psychologists better understand their clients' perspectives and thus to offer individualized services.

Psychologists strive to inquire about aspects of military experience, such as branch of service, rank and officer/enlisted status, primary duties and military occupational status during service, domestic and foreign deployment history and experiences, length of military career, feelings about their service, and return to civilian life. Psychologists attempt to become aware of military and government organizational culture, organizational structure, common military terms and the context in which the client uses various terms and expectations. Psychologists also strive to understand how cultural, racial, ethnic, gender, sexual orientation, and other aspects of identity (see Section 3) may have affected the SMVF's experiences and potential impact on psychological outcomes and functioning. Psychologists can become familiar with common military terms to better understand the potential effects of organizational structure and culture on their client's current functioning. In addition to asking clients directly for clarification and context, psychologists strive to educate themselves through training, reading, and other educational resources.

GUIDELINE 1.3

Psychologists strive to consider the impact of their own personal attitudes, biases, beliefs, and knowledge about military culture and policies on their work with SMVF.

Rationale

It is important for psychologists to evaluate their own attitudes, biases, beliefs, and knowledge about service members, veterans, and their family members, and about military-related issues, such as attitudes toward war, combat, and carrying weapons, knowledge and/or assumptions about mental health in military service members or in veterans, and personal political viewpoints that may affect the therapeutic relationship. Personal experience with military culture may help with therapeutic rapport-building; however, psychologists recognize that any client with military experience is considered to have had a unique experience that should be explored. Disclosure of a provider's personal experience with the military should be done judiciously, as with any self-disclosure. Psychologist self-awareness as discussed in this guideline is consistent with the APA ethical standards regarding competence (APA, 2017c).

Application

Psychologists strive to understand each individual client's experience and relationship with military culture independent of the psychologists' personal experiences of or attitudes toward military life. Psychologists are encouraged to be aware of and sensitive to their own attitudes toward military culture when providing services to SMVF, and to engage in periodic self-assessment to increase such awareness. Psychologists should be cautious about making assumptions, explore their client's unique military experience, and utilize appropriate countermeasures to diminish or eliminate potential sources of bias.

ADDITIONAL FACTORS IN PSYCHOLOGICAL ASSESSMENT, EVALUATION, AND INTERVENTION

Psychologists rely on appropriate interview methods, tests, and other assessment tools to measure and observe a client's behavior, to arrive at a diagnosis and case formulation that guides treatment. In this section, we explore military experiences and cultural factors that should be taken into account when interpreting assessment results and recommending interventions or services. We note common stressors for SMVF, common problems or diagnoses, and available services.

GUIDELINE 2.1

Psychologists strive to be knowledgeable about common stressors faced by military personnel, veterans, and their families, and how these concerns may affect assessment and treatment.

Rationale

General military-related stressors can include frequent moves, frequent job changes, separation/living apart from family of origin or support system, and lack of control over geographic moves. Unemployment is also a potential stressor for military spouses who might have difficulty obtaining and sustaining gainful employment during the course of the military cycle of moves (Blakely et al., 2012; Park, 2011).

Some service members may experience stress related to military occupational specialty (e.g., combat support [Nock et al., 2018]), work settings (e.g., submarine service [Brasher et al., 2010], detention camp service [Webb-Murphy et al., 2015]), job changes, or work dissatisfaction (Bridger et al., 2007). Service in the National Guard and Reserve entails such stressors as balancing the demands of military and civilian careers, including disruptions in civilian employment because of calls to service. Those who deploy to combat zones may experience additional combat-related stressors, raising the risk of mental health problems (Hoge et al., 2004).

Such military-related stressors can interact with or be exacerbated by stressors experienced by the whole population throughout the life course—for example, job loss, divorce, bereavement, retirement, serious illness, and facing the end of life (Schnurr et al., 2002; van Zelst et al., 2003; Wachen et al., 2014). Each of these stressors may change depending on phases of military life, including those associated with active duty in general, with the deployment cycle, and with readjusting to civilian life post-discharge.

The deployment cycle brings additional stressors on family units, including geographical separation, challenges of communicating and maintaining relationships during separation, and the various emotions associated with increased risk for the service member. These are further detailed in Section 4.

Returning home from deployment is a significant transition during which service members and their families may experience a number of reintegration challenges (Danish & Antonides, 2013). For example, typical life cycle and family changes (e.g., births and deaths of family members, birthdays, or graduations that may have occurred while the service member was on deployment) may create in the service member a sense of having missed out on major events.

Finally, the transition from military to civilian life can present challenges for some service members. Qualitative studies suggest that this transition can be experienced as a loss of a supportive social environment, a loss of purpose or structure, or as transition in an aspect of identity. Feelings of being disconnected from the military but not yet connected to civilian social organizations can occur, and shared military experiences linked to a common goal can keep SMVs connected to others who served but disconnected from family and friends upon leaving the service (Ahern et al., 2015; Binks & Cambridge, 2018; Barry et al., 2019). Finding satisfying work, experiencing family and spousal support, or having access to peer support can be helpful in this transition (Ahern et al., 2015; Black & Papile, 2010).

Of course, military experience and deployment can also be a time of growth and achievement for many SMVs. For example, some behavior patterns and interpersonal skills that are helpful and adaptive in dealing with the high-risk military setting readily transfer to civilian settings, where they are equally adaptive, such as leadership, decision-making and team-building (Wenger et al., 2017). Other coping behaviors that are adaptive in high-risk military situations may become problematic in civilian settings. For example, service members and veterans may be more meticulous, exacting, and cautious/alert to their surroundings as a result of military training and of experiences requiring vigilance (Department of Veterans Affairs & Department of Defense, 2015b). This can be adaptive in more dangerous situations that require self-protection or less adaptive when a clear danger is no longer present.

In addition to the challenges of post-military discharge reintegration into civilian life, veterans may experience stress related to finding employment or resuming their education. Veterans' employment challenges may be influenced by skill translation difficulties (i.e., employers having difficulty understanding what veterans did in the military and how those skills and experiences can benefit a company), negative stereotypes (related to potential employer concerns over possible PTSD, other mental health concerns, other disabilities, or rigidity related to military structure and hierarchy), wartime deployment history, and/or, for National Guard or Reserve service members, concerns over future deployments (Faberman & Foster, 2013; Stone & Stone, 2015).

Application

Psychologists strive to become familiar with stressors that are common in military life, including those that can be associated with clients' military occupational specialty (MOS) or work setting, with the deployment cycle, or with adjustment after military discharge. In assessing the impact of these stressors, psychologists inquire about both their potentially positive and potentially negative effects on SMVF and avoid making assumptions of whether certain experiences are considered a stressor, as some may be viewed as positive growth experiences by SMVF. Equally critical is the importance of seeking knowledge about common reactions and coping strategies related to military life stressors (Department of Veterans Affairs & Department of Defense, 2015a; Department of Veterans Affairs & Department of Defense, 2015b). Psychologists make efforts to differentiate common and adaptive military-related behaviors from those that are associated with psychopathology. Psychologists strive to become knowledgeable about and coordinate with the available VA, nonprofit, county/state, and other veteran-centered organizations committed to assisting veterans with job placement.

GUIDELINE 2.2

Psychologists strive to become knowledgeable about mental health problems that may occur frequently among military personnel and veterans, potential differences in the experiences of those who served in different military service eras, and associated evidence-based assessment practices and interventions.

Rationale

Many of the most common psychiatric diagnoses experienced by military personnel and veterans are the same as those of civilians: depression and other mood disorders, anxiety disorders, trauma-related disorders, sleep disorders, and substance use disorders (Bagalman, 2016; Government Accountability Office, 2011; Psychological Health Center of Excellence, 2019). However, as discussed in the previous section, there are specific military-related factors that may result in higher rates of mental health conditions, such as length of, number of, experiences with, and downtime between deployments; military occupational specialty (MOS); reception upon return home; and rank or officer/enlisted status (Government Accountability Office, 2011; Pickett et al., 2015; Sayer et al., 2015; Bryan, 2015).

Prevalence rates of mental health conditions change over time. Additionally, specific features of some disorders may differ between military and civilian groups or vary across military or veteran groups, including those from different service eras. For example, among SMV with posttraumatic stress disorder (PTSD), the nature of the index traumatic event may differ from those most commonly experienced by civilians with PTSD. The nature of military/occupationally-based traumas (e.g., combat) differ significantly from what are considered victim-based traumas (e.g., mugging or rape), to include all phases of the trauma experience, as well as resulting symptom constellations (Kennedy, 2020). Although the nature of treatment for trauma-based mental health conditions is essentially the same following military-related and nonmilitary-related trauma exposure, a thorough assessment of potentially traumatic military experiences is needed to inform accurate treatment planning. Index traumas linked to military experience include trauma incurred in combat, noncombat military-related trauma (e.g., being seriously injured during a training exercise on base), and sexual assault and harassment in the military (referred to as military sexual trauma (MST) in the VA; Morral et al., 2016). Assessment of combat trauma events is facilitated by more detailed awareness of combat experiences, such as involvement in hand-to-hand combat, exposure to potentially toxic environmental agents, or to explosive devices (Kennedy, 2020).

Veterans who served in different eras may have experienced different types of trauma. Also, because certain traumas may be underreported, such as sexual assault, diagnoses may be missed and effective treatments not provided.

Differences in trauma exposure and mental health diagnosis rates may also be related to age, race, ethnicity, culture, gender, and other factors (see more in Section 3). Childhood trauma and adverse experiences prior to the military are also important to assess because these exacerbate reactions to trauma exposure during military service. They increase the risk of developing combat-related PTSD (Xue et al., 2015), and even after controlling for PTSD and combat exposure, childhood trauma is associated with greater depressive symptoms and suicidal ideation in veterans (Youssef et al., 2013).

Related to life course, medical advances are allowing SMV to live longer with serious injuries—for example, spinal cord injuries, amputations (Gawande, 2004)—creating generations of veterans living with catastrophic injuries, acquired disabilities, and accelerated aging. These differences have implications for assessment and treatment planning. For example, having knowledge of a client's exposure to explosives or experience of head injury would inform the need to evaluate for potential traumatic brain injury (TBI). It is also important to consider possible effects of disability impact and medical problems on mental health disorders, including mobility and related medical treatment.

Suicide is a very significant concern affecting SMV. The Department of Defense *Annual Suicide Report* for 2018 indicated that over 500 service members died by suicide that year, and that the rate of suicide increased in the Active Component over the preceding five years. When adjusted for age and sex, the military suicide rate is roughly comparable to that of the U.S. population, except in the National Guard, where it is higher (Department of Defense, 2018). The VA produces a Suicide Prevention Annual Report. The 2019 report indicated that over 6,000 veterans died by suicide each year from 2008 to 2017, and that the rate for veterans was 1.5 times that of nonveteran adults, even after adjusting for age and sex (Department of Veterans Affairs, 2019).

Application

Psychologists strive to become familiar with the symptoms, etiology, and evidence-based assessment methods and treatments available for the most common

mental health conditions experienced by military service members or veterans. Psychologists also strive to understand how these symptoms may affect the family system and consider couples or family systems approaches when relevant (see also Section 4). Further, psychologists strive to conduct careful and sensitive assessments of service members and veterans, using recommended assessment instruments, with awareness that certain traumatic experiences such as sexual assault may be underreported. Psychologists who are not familiar with available evidence-based treatments are encouraged to seek out resources such as guidelines published by the VA, the DoD, the Substance Abuse and Mental Health Services Administration (SAMHSA), and APA (e.g., clinical practice guidelines for treatment of PTSD and of depression). In addition, psychologists seek opportunities for continuing education, and consultation with knowledgeable or expert psychologists. Knowledge about prevalence and incidence rates of disorders, evidence-based and best practice assessments, and the potential for previously missed diagnoses in past eras will help psychologists provide the best care for active duty military personnel and veterans of different eras. Evidence-based practice may also require coordinating care with providers from other disciplines either within or outside of the DoD or VHA (e.g., psychiatry, physical medicine) to identify and address potential co-occurring medical disorders (e.g., cardiovascular and metabolic diseases, gastrointestinal disorders, liver diseases, viral hepatitis, HIV/AIDS, and pain). Psychologists strive to become familiar with the issue of suicide as it pertains to SMV, with the VA/DoD clinical practice guidelines for assessment and management of individuals at risk for suicide (VA/DoD, 2019b), and with the extensive suicide prevention programs developed by the DoD and VA, as well as congressional laws and presidential executive orders that have been passed to address SMV suicide. For example, at the time of this writing, the VA had implemented a comprehensive 10-year National Strategy for Preventing Veteran Suicide (Department of Veterans Affairs, 2017a), which included available internal and public resources to support the effort. Some of these programs also specifically focus on partnerships with the community as an early prevention and intervention method. Psychologists in all settings working with SMV and their families strive to become familiar with these resources. (See Appendix B for a brief list of resources than include some of this work.)

GUIDELINE 2.3

Psychologists make reasonable efforts to familiarize themselves with resources available through the DoD, VHA, and community agencies for SMVF, and with any legislation or policy affecting the availability of those resources.

Rationale

Psychologists are better able to provide a full range of support for SMVF when they have knowledge of services offered by the DoD, VHA, local government, Veterans Service Organizations (VSOs), universities, and other non-VA/DoD agencies. Such services include treatments offered in DoD or VHA settings that are tailored to the needs of service members or veterans and may not be as readily available in the community. Such settings include military treatment facilities, VA medical centers, primary care settings with integrated mental health services, community-based outpatient clinics, and Vet Centers. Veterans have found VHA health care to be of benefit in accessing specialty care that might not be available through or offered by non-VA/DoD clinicians (Wakefield et al., 2007). Veterans may also seek services through VA and non-VA settings simultaneously. Veteran clients may also benefit from targeted resources available to them in their community or educational settings.

Coordinating with other professionals can also help support the mental health of SMVF. For example, coordination of mental health and chaplaincy services within or across DoD, VHA, or civilian health care providers can better address spiritual aspects of post-deployment reintegration and recovery (Nieuwsma et al., 2014). Likewise, familiarity with resources for adapting evidence-based practices to be more relevant or culturally sensitive to military service members can improve their engagement in mental health services and result in improved outcomes (e.g., Rudd et al., 2015; Walker et al., 2017). Note that these resources are affected by sometimes rapid changes in legislation and policies and there is regional variability in access to care (availability, quality, specialty). Thus, psychologists are best equipped to help SMVF when they have knowledge of how the resources and access to those resources may change over time with changing national policies.

Psychologists working with SMVF strive to be aware of the medical benefit earned by service members specifically available to them and their spouses and children (e.g., TRICARE), which may facilitate SMVF access to care, depending on available local resources, and to be aware of their own options to become TRICARE network or nonnetwork providers. Psychologists are encouraged to contact the Transition Care Management (TCM) program at their veteran client's regional VA medical center program to obtain up-to-date knowledge of eligibility and support so their veteran client can get the care that they have earned through their service.

Application

Psychologists who understand the types of services available in DoD or VHA settings and how to navigate these systems can better help their clients to access such services to best fit their health care needs. Resources for learning about such services are included in Appendix B. They can also help to prepare their clients to anticipate potential differences in health care practices across military and civilian settings (e.g., different emphases on evidence-based interventions). Psychologists are encouraged to become aware of and to share with SMVF available DoD and VHA resources. Psychologists strive to familiarize themselves with the claims process when the VA might be identified as a good resource as part of the treatment plan. A benefits claim may help the veteran identify and access additional needed resources from the VA that they are qualified to receive.

As resources change frequently based on growing science and changes in policy, psychologists endeavor to stay abreast of these developments. In addition to being

familiar with the growing body of scientific literature and clinically focused books, psychologists strive to stay well informed about consultation groups, mobile applications, continuing education seminars, and web-based resources that can provide updated information on standards for assessment and treatment of a variety of mental health concerns in SMVF. Psychologists also strive to become knowledgeable about programs within the VHA, DoD, local government, Veteran Service Organizations (VSO), universities, and other non-VHA/DoD agencies to connect SMVF with appropriate services (e.g., local VSO to assist with submitting claims for VBA benefits). Psychologists endeavor to recognize when to make referrals for any additional services or treatments that may benefit their clients and, with their client's consent, strive to coordinate communication among health care providers and facilitate continuity of care for service members or veterans receiving help from multiple agencies. These may include mental health and medical specialty support, as well as spiritual or religious support when this is of importance to their clients.

GUIDELINE 2.4

Psychologists strive to understand how military culture and experience may affect both engagement in psychological services and the ability to benefit from services.

Rationale

Like many civilians, SMV may struggle with recognizing or seeking help for behavioral health concerns, even when these needs are significant or critical (Ben-Zeev et al., 2012). The qualities of resilience, fortitude, self-sacrifice, and priority on group mission and achievement, which are central to the military culture and ethos, may create mixed feelings about seeking help for individual problems. These mixed feelings may be related to concerns about being perceived as "weak," discomfort about prioritizing individual needs over the group mission, or beliefs that they can and should be able to manage without assistance (Elbogen et al., 2013).

Despite efforts by the military to reduce stigma related to behavioral health, help-seeking may also be affected by stigma, as well as concerns about the impact of engaging in mental health services on their military careers (Becker et al., 2014). For service members, concerns about confidentiality may inhibit them from seeking mental health services, and veterans may assume such confidentiality concerns are still relevant based on experiences during service. Further, some older veterans may not link their current symptoms with military experience/trauma exposures from long ago.

Service members may also be reluctant to identify a behavioral health problem because they want to remain fully active members of their unit, considered ready for deployment. For those in the Reserve Component of the military, additional concerns include how mental health service utilization between periods of activation might affect decisions about their readiness to serve when recalled to active duty, and thus their ability to continue in the National Guard or Reserve (Gorman et al., 2011).

On the other hand, there are many personal strengths that SMV have garnered from serving in the military. Due to work history, general training, and resiliency training, such strengths may include leadership and teamwork skills, experience with structure and discipline, adaptation to stressful working environments, increased self-confidence, resilience, and flexibility because of frequent travel and relocation (Gade et al., 1991; Harms et al., 2013; Department of Veterans Affairs & Department of Defense, 2015d). Even combat exposure or trauma can be associated with personal growth (Jennings et al., 2006; Tedeschi & Calhoun, 2004). These personal strengths can positively affect mental health treatment seeking, intervention, and outcome, serving as personal strengths to facilitate treatment when it is sought.

Application

Psychologists are encouraged to understand potential barriers such as concerns about confidentiality, career impact or stigma, or aspects of the military ethos of self-reliance as these affect help-seeking, assessment, and treatment of psychological disorders among SMV. As with other special populations that may face stigma associated with personal identity, SMV may need additional efforts to establish a therapeutic alliance and to provide specific reassurance of privacy and confidentiality. If any limitations on confidentiality are relevant in a particular situation, such as a requirement to consent to release of information pertaining to fitness for duty or readiness for deployment, providers of psychological services are aware of these limitations and discuss them during consent for services.

Special attention may need to be given to feelings of having "disappointed" themselves or others by not meeting certain expectations of stress resilience, particularly if others in the social environment are perceived (or misperceived) as not having a similar need for psychological care. Psychologists are encouraged to gather information about positive growth and resiliency factors that may improve the prognosis for treatment and serve as strengths to build upon during the treatment process. Identifying these qualities may also help with establishing trust, respect, and a therapeutic relationship with service members or veterans who may be reluctant to engage in care.

EMERGING TOPICS, CRITICAL ISSUES, AND CONCERNS REGARDING SPECIAL MILITARY AND VETERANS SUBPOPULATIONS

Subpopulations within the military often experience additional unique needs. In this section, we explore emerging topics, critical issues, and other concerns relevant to demographic or situational factors. The former include SMV of different ages or service eras; women SMV; racial or ethnic minority SMV; and sexual minority SMV. The latter include SMV involved in the disability determination process, rural SMV, veterans who are homeless, or those involved in the justice system. It is important to note that in highlighting these issues and topics, we do so to raise awareness, but our coverage is not meant to be exhaustive. APA's broader consideration of individual and cultural diversity factors includes age, disability, race, ethnicity, gender, religion/spirituality, sexual orientation, gender diversity, social class, language, and immigration status (APA, 2017d). We include some of these factors as they pertain to SMVF. The aim of this particular section is to highlight some emerging issues and to support efforts by psychologists to enhance awareness, adapt treatments to the needs of subpopulations, and improve provider competencies in working with the SMVF community.

GUIDELINE 3.1

Psychologists consider the specific needs of military service member and veteran subpopulations.

Rationale

Among SMV, specific subpopulations may have unique needs. This section focuses on ways in which SMV from different subpopulations may have different mental health concerns and may experience different barriers to care when compared with other SMV.

SMV OF DIFFERENT AGES, AND SERVICE ERAS

Age is correlated with military service era, but the two are not identical. For example, as a group, Vietnam veterans are older than veterans of the Gulf War, but the same individual may have served across both of these eras. Similarly, service members and veterans of a particular era include individuals from a wide age range. Because of changes over time in such variables as pre-recruitment characteristics of service members, combat injury survival rates, psychiatric diagnostic criteria, and clinical assessment methods, it is difficult to make comparisons in mental health problems among service members and veterans of different ages, or service eras.

To some extent the different problems presented by SMV of different ages mirror those of the civilian population. For example, most mental health disorders are less common in older adults as compared to younger adults, both in the general population (Kessler et al., 2005) and among veterans (Frueh et al., 2007). However, among adults with mental health disorders, comorbid medical disorders are more prevalent among older clients, indicating the need to take these into account when providing psychological services (Bartels, 2004). Vietnam veterans with chronic PTSD often have associated medical problems such as diabetes, cardiovascular problems, or immune system problems (Boscarino, 2008). Veterans in the oldest age group (80 and older) frequently present both with co-occurring physical and mental health conditions and with fewer social and economic resources than other veterans. These complex biopsychosocial needs require good coordination of care with other interdisciplinary health care providers, as well as strong clinical, advocacy, research, and educational training support from psychologists and other mental health professionals with expertise in geriatrics (Kim et al., 2001).

On the other hand, there may be differences in the characteristics of certain problems within SMV of different ages that are not identical to those within the whole population. For example, rates of PTSD and symptom presentation may vary across veteran age groups for various reasons (e.g., time since trauma, normative changes to emotion regulation with age). There are complex relationships between PTSD and risk for dementia in older veterans (Qureshi et al., 2010; Yaffe et al., 2010). Some older veterans may experience an exacerbation of PTSD-like symptoms and/or a reengagement with, rather than avoidance of, traumatic events in an attempt to integrate their life experiences, and build meaning and coherence in the context of aging-related changes and losses (Davison et al., 2016). Such reengagement may lead to positive outcomes, such as wisdom and greater life satisfaction, or to increased distress and negative psychological outcomes. Evidence also exists for late-life and end-of-life reemergence or exacerbation of PTSD symptoms for some veterans (Glick et al., 2016; Mota et al., 2016), a potential area of focus for psychologists involved in hospice and palliative care.

Service members and veterans of different service eras may present with psychological concerns related to characteristics of the conflict environment, such as differences in exposure to environmental toxins, military procedures, or medical care. For the SMV of more recent conflicts, the survival rate following casualties (90%) is much higher than it was for those who served during the Vietnam War (76%). However, current era injuries tend to be complex, with traumatic brain injury and chronic pain constituting two of the most common current era problems (Bosco et al., 2013). See Appendix B for further resources, including a VA Military Health History Pocket Card that provides guidance on topics to ask all SMV when evaluating health concerns (e.g., exposure to chemical,

biological, physical, or psychological trauma) as well as when evaluating health risks associated with specific service eras (e.g., Agent Orange exposure in Vietnam).

Psychologists are also encouraged to review the APA *Guidelines for Psychological Practice With Older Adults* (2014) as these contain recommendations that are directly relevant for work with older adult veterans.

WOMEN SMV

Among SM, the percentage of women increased from 14% in 2010 to 16% in 2017 (Department of Defense, 2017). In the veteran population, the percentage who are women depends on service era, ranging from 5% among World War II veterans to 17% among post-9/11 veterans (National Center for Veterans Analysis and Statistics, 2017). Thus, although the number of female military personnel and the scope of their roles continue to grow, women remain a significant gender minority among SMV. Such underrepresentation can contribute to negative stereotyping, discrimination, and limited social and unit support from other women, and to having to work harder to receive the same opportunities/assignments as their male counterparts (Street et al., 2008).

While sexual harassment, assault, and gender discrimination are experienced by women who work in a range of workplaces, especially those that are male-dominated and hierarchical, there is a high prevalence of sexual harassment and/or assault for women in the military. A RAND study indicated that 4.9% of women reported experiencing sexual assault and 22% reported experiencing sexual harassment in the military in the past year. Corresponding percentages for men were 1% for sexual assault and 7% for sexual harassment (Morral et al., 2016). Data from the VA's universal screening program, where every veteran seen for health care is asked about military sexual trauma (MST: the VA term for sexual assault or harassment during military service), reveal that among veterans seen for care in fiscal year 2018, 128,877 female veterans (29.1%) and 75,568 male veterans (1.6%) had reported a history of MST (Military Sexual Trauma Support Team, 2019). Regarding sexual harassment, a meta-analysis concluded that rates were higher in the military than in other work settings (Ilies et al., 2003).

Given the predominantly male makeup of the military, it is important for psychologists to be cognizant not only of the large gender difference in rates of sexual assault but also of the large absolute numbers of both men and women who experience military sexual assault. Both genders may refrain from reporting assault and harassment because of concerns about loss of confidentiality, gossip, fear of retaliation, or because of uncertainty about the reporting process (Department of Defense, 2019a).

Military sexual trauma is associated with decreased physical and mental health status in both men and women, and it often causes increased difficulties in post-military functioning (Schuyler et al., 2017). Sexual assault has been shown to be related to higher rates of psychopathology in general, especially posttraumatic stress and suicidality (Dworkin et al., 2017). There is some evidence that sexual assault or harassment during military service is even more strongly associated with such negative outcomes as PTSD or eating disorders than similar experiences before or after service (Forman-Hoffman et al., 2012; Himmelfarb et al., 2006; Luterek et al., 2011; Suris et al., 2007).

Women veterans tend to have less social and financial support than male veterans, which can present barriers to seeking treatment (Runnals et al., 2014). There may also be potential gender differences in factors that can influence post-deployment readjustment (e.g., women's roles as caregivers to their families, higher rates of divorce, lower income, more musculoskeletal pain; Haskell et al., 2012; Pierce et al., 2011; Yan et al., 2013).

Treatment interventions for service members and veterans have mainly been evaluated on male samples and, when women have been included, samples have often been too small to detect possible gender differences (Runnals et al., 2014; Washington, 2004; Yano & Frayne, 2011). Women veterans may view available health care as male-oriented or may not think they are eligible for care if they did not serve in combat (Government Accountability Office, 2011).

Finally, a growing SMV population is ethnic minority women. The current active duty female military force is significantly more racially diverse than both the United States overall and the male military force (Patten & Parker, 2011). While there is some emerging preliminary research on the specific psychological needs and experiences of minority female SMV, this remains a current gap in knowledge. Psychologists are encouraged to closely track this emerging body of literature as more consistent research becomes available in this area.

Psychologists are further encouraged to consult the APA *Guidelines for Psychological Practice with Girls and Women*, as these contain recommendations that are directly relevant for work with women SMV.

RACIAL AND ETHNIC MINORITY SMV

Racial and ethnic minority SMV can have a variety of diverse experiences, many of which are similar to those of racial and ethnic minority civilians. While the U.S. military has been historically dominated by White men (despite the often unacknowledged contributions of minorities), it was desegregated in 1948 by executive order of President Truman, and has grown more racially diverse over time since the 1990s (Department of Defense, 2014). Minority veterans who served during the Vietnam era reported greater exposure to combat and trauma as well as racial discrimination and harassment from their fellow soldiers (Dohrenwend et al., 2008; Loo, 1994). Dohrenwend et al. (2008) also found that Black and Hispanic Vietnam veterans have higher reported rates of PTSD than White veterans, which can be accounted for both by differential exposure to combat (Black soldiers were often assigned more dangerous occupations within the military) and by premilitary service factors that increase the susceptibility to PTSD. Black and Hispanic Vietnam veterans were often younger when enlisted or drafted, had lower educational attainment, were less likely to have previous military service, and were more likely to experience nonmilitary related trauma before or after their deployments.

Although Black and Hispanic veterans who were deployed to Afghanistan and Iraq after 9/11 did not report significantly different exposures to combat than White soldiers, they did report greater perceived threat during combat and more family related stress while they were deployed (Muralidharan et al., 2016). American Indians and Alaska Natives, who have long volunteered for military service at a higher per capita rate than other ethnic majority or

minority groups (McDonald, 2017), also experience PTSD diagnosis and PTSD symptoms at a greater prevalence rate than their White counterparts with combat exposure as the leading inciting event (Bassett et al., 2014).

Recently, when formal research diagnoses of PTSD were compared with diagnoses given by VA disability examiners, racial disparities were found: Among veterans with a formal research diagnosis of PTSD, Black veterans were significantly less likely to receive a PTSD diagnosis from their disability examiner than White veterans. Of importance to psychologists, this racial disparity was not found among the subgroup of veterans whose examinations had included psychometric testing (Marx et al., 2017). In their work with racial and ethnic minority SMV, psychologists are also encouraged to consult the APA *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (2017d).

SEXUAL AND GENDER MINORITY SMV

While many concerns, experiences, and mental health outcomes of lesbian, gay, bisexual, and transgender (LGBT) military service members and veterans are similar to those of LGBT civilians, some experiences are unique. This section considers several issues of potential importance to psychologists working with SMV who are lesbian, gay, or bisexual, and then issues affecting transgender SMV. It is important to note that concerns of service members may differ from those of veterans because of differences between DoD and VA policies.

Although presented as lifting the blanket ban on service by gay and lesbian military personnel that had been U.S. policy since World War II, the 1994 compromise policy referred to as "Don't Ask, Don't Tell" (DADT) prevented military health care providers from inquiring about, and LGB military personnel from openly sharing, nonheterosexual identities while in military service. This contributed to continued incidents of victimization of sexual minority service members and to reductions in reporting and help seeking (Burks, 2011). Both before and during DADT, military health care providers were required, with a few exceptions, to report evidence of same-sex sexual behavior disclosed to them by service members and this information could be used as grounds for discharge (Biddix et al., 2013).

Although DADT formally ended in 2011, its legacy remains. Stigma and secrecy about sexual orientation have continued to be a part of military culture and increase mental health risk among LGB service members. After repeal of DADT, discomfort discussing sexual orientation or health with military health care providers was still characteristic of a substantial minority of male gay or bisexual service members (Biddix et al., 2013). Sexual orientation discrimination, sexual harassment, and sexual assault remain concerns for LGBT service members (e.g., Gurung et al., 2018).

LGB veterans experience lower levels of social and emotional support and higher levels of suicidal ideation than heterosexual veterans (Blosnich et al., 2012). Studies of male gay or bisexual veterans have focused predominantly on HIV, with relatively little attention to other health factors (Mattocks et al., 2014). However, in a predominantly male sample, LGB veterans had higher rates of asthma, smoking, and activity limitations compared with heterosexual veterans, although they were less likely to have obesity or diabetes (Blosnich & Silenzio, 2013). Lesbian and bisexual women veterans have greater mental distress, higher rates of smoking and hazardous drinking, and more experiences of childhood sexual trauma and military sexual trauma than their heterosexual counterparts (Blosnich, Brown, et al., 2013; Mattocks et al., 2013). Bisexual veterans have higher rates of severe depression and of PTSD than gay, lesbian, or heterosexual veterans (McNamara et al., 2019; Mattocks et al., 2014).

Older SMVs who served prior to DADT may have experienced high rates of discrimination or may have concealed this aspect of their identity during their service. Regardless of service era, concealment of sexual orientation is a substantial source of anxiety and associated with higher rates of PTSD, depression, and alcohol use disorder (Cochran et al., 2013).

Among veterans, it is important to note that the VA did not have a DADT policy, or any exclusionary policies concerning gay, lesbian, or bisexual veterans. Current VA health care policy is inclusive and includes the provision of a LGBT Veteran Care Coordinator at every VA hospital.

Despite long-standing bans on transgender people serving openly in the military, research suggests that the percentage of transgender adults is significantly higher in the veteran population than in the general population (Shipherd et al., 2012). Transgender service members were not covered by the DADT policy. In fact, they were not permitted to serve openly between the 1960s and 2016. In 2016, government policy changed, permitting transgender individuals to enlist and to be retained in service. However, policy changed again in 2017 when multiple restrictions were imposed, effectively reversing the 2016 policy shift (Schvey et al., 2020). At the time of this writing, there were several ongoing court cases that could decide future DoD policy. Psychologists are encouraged to obtain information on current DoD policy when working with transgender clients.

A majority of transgender military service members report experiencing gender identity-related stigma in the military. Frequently reported experiences include not being permitted to wear the uniform corresponding to their gender identity, stress pertaining to bathroom use, difficulties changing their name or gender of record in military files, and overhearing colleagues gossiping about them. Greater experiences of stigma are related to worse overall mental health and greater depression (Schvey et al., 2020).

Because they are no longer in the military, transgender veterans are no longer subject to DoD policies. However, their experiences while in service can contribute to longer-term mental health problems. For example, having experienced punishment or investigation related to gender identity while in the military has been related to subsequent suicidal ideation in transgender veterans (Tucker et al., 2019). Gender dysphoria, a conflict between a person's physical or assigned gender and the gender with which they identify, is much more prevalent among veterans than in civilian populations. It is associated with an almost 20-fold increase in suicide-related events when compared with other veterans enrolled in the VHA, indicating a critical need for mental health services (Blosnich et al., 2013). Transgender veterans report high rates of military sexual assault (MSA), with 30% of transgender men and 15% of trans-

gender women experiencing MSA. MSA is associated with elevated PTSD symptoms, depression, and past-year drug use (Beckman et al., 2018).

Psychological care is critical for assessing and treating depression, anxiety, and gender dysphoria. Currently, the VHA will treat and pay for many services for transgender veterans, including transition-related care, though gender-affirming surgical interventions were not available at the time of this writing.

In light of known health and mental health disparities for sexual and gender minority individuals, (King et al., 2008), psychologists who work with SMV are encouraged to seek out training in working with LGBT clients and to provide LGBT-sensitive care (Bossarte et al., 2014). Psychologists strive to provide services that are inclusive and affirming, and to maintain awareness of current DoD and VHA policies related to their sexual minority clients. Psychologists consider routinely inquiring about sexual orientation and gender identity as part of veterans' mental health assessments to create an atmosphere of respect and inclusivity for LGBT clients and to facilitate culturally competent care (Sherman et al., 2014). However, psychologists must also recognize the limitations on confidentiality of military service members' medical records. Thus, consulting legal, ethical, and practice guidelines will help in ensuring best practices to avoid harm and provide best care.

Psychologists are also encouraged to consult APA's *Guidelines for Practice With Lesbian, Gay, and Bisexual Clients* (2012) and *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (2015), and to consult with colleague and experts in this area.

VETERANS RECEIVING SERVICE-CONNECTED DISABILITY BENEFITS

Although most veterans who receive disability benefits for injuries or illnesses sustained during military service will likely access care through the VHA as part of their benefits, some may also seek care in non-VHA settings. Psychologists working with veterans receiving disability compensation for PTSD or other mental disorders should be aware of factors that may emerge during or influence treatment. These can include the range of emotions experienced by the veteran in relation to the injury or illness or its functional impact, positive feelings about the benefits and care provided through the disability system, or stress associated with the disability claims process. There is debate about whether the VA disability system incentivizes exaggeration of symptoms or reluctance to report symptom improvement during treatment (Marx et al., 2012; McNally & Frueh, 2012). However, the VBA usually does not reduce or discontinue service-connected disability benefits for mental health disorders (Murdoch et al., 2019).–Psychologists can encourage the veteran to speak with their Veterans Service Officer for advice regarding the pros and cons of talking openly about alleviation of their mental health symptoms.

In general, psychologists are encouraged to refer to the *Guidelines for Assessment of and Intervention with Persons With Disabilities* (APA, 2012a) for further information about working with individuals presenting with disabilities.

SERVICE MEMBERS INVOLVED IN DISABILITY EVALUATIONS

Psychologists may be involved in the disability evaluation process for service members through such programs as the Integrated Disability Evaluation System (IDES) or the VA compensation and pension exams. The IDES is a joint DoD and VA evaluation process to determine if a service member is fit for continued duty and to provide appropriate disability benefits for service members (Department of Defense, 2019b). In cases involving behavioral health conditions, a psychologist's exam report might influence whether the SM meets medical retention standards for their service. Psychologists may also be asked to provide an independent evaluation as part of a rebuttal filed by an SM in response to Medical Evaluation Board conclusions. Psychologists involved in such evaluations have an understanding of the relevant fitness-for-duty definitions pertaining to the SM's branch of service and military occupational specialty; of the complete IDES process; and of the SM's legal rights.

A related population are veterans in the process of filing a claim for VA disability benefits. They might be filing an initial claim, a claim for an increase in their disability rating, or an appeal of a ratings decision. Currently, psychologists can conduct C&P exams for a medical disability examination (MDE) company that contracts with the VBA to manage disability exams in the private sector (Government Accountability Office, 2018). VA claim exams for PTSD and other mental disorders are forensic mental health evaluations. Consequently, education and training in forensic psychology core competencies will serve psychologist-examiners well (Varela & Conroy, 2012).

In addition to the required VA training, psychologists conducting veterans' disability exams—consistent with APA ethical standards—stay current with the scholarly literature in such areas as evidence-based assessment of mental disorders in general (Bornstein, 2017), and of PTSD due to combat-related trauma or military sexual trauma in particular; assessment of social, financial, and occupational functioning; VA mental health disability exams related to specific conditions and questions (e.g., Garbelman, 2017); and empirically validated methods to reduce implicit biases (e.g., Devine et al., 2012). Results of a C&P exam are documented on a Disability Benefits Questionnaire (DBQ). Completing a DBQ and submitting it to the Veterans Benefits Administration constitutes the provision of expert witness testimony (*Nieves-Rodriguez v. Peake*, 2008) in a federal legal proceeding (Veterans Health Administration, 2016).

Psychotherapy with veterans filing a claim for service-connected disability benefits

If a psychologist is seeing such a veteran for psychotherapy, the veteran might ask the psychologist to complete a DBQ in support of the veteran's disability benefits claim (Veterans Benefits Administration, 2018a, 2018b). Examples of expert witness opinions that psychologists may be asked to provide on a DBQ include whether a mental health problem is secondary to a service-connected physical injury, or to what extent a veteran's occupational impairment is due to a particular mental health disorder. Since proffering expert witness opinions constitutes the practice of forensic psychology, psychologists may consult the *Specialty Guidelines for Forensic Psychology* (APA, 2013b), and consider how their psychology licensing board(s) might evaluate the adequacy of the expert witness opinions as

provided on the DBQ form (for an example, see Ohio Board of Psychology, 2018).

Further, psychologists are reminded to consider potential conflicts of interest between the role of the therapist and the role of an evaluator and the difference between clinical and forensic services (Greenberg & Shuman, 1997; Strasburger et al., 1997). The VA cautions VHA clinicians to avoid such potential conflicts of interest. The VHA specifically discourages VA mental health clinicians from completing DBQs for their patients (Veterans Health Administration, 2019) and similar recommendations have been made to non-VA mental health providers (Worthen & Moering, 2011).

RURAL SMV

Rurality can be defined in various ways. The VHA identifies three main areas of difference between rural and urban communities, including demographic composition, social ties/capital, and infrastructure and institutional support. As of this writing, using VHA definitions, 34% of veterans enrolled in the VHA health care system are considered rural (National Center for Veterans Analysis and Statistics, 2016). Rural veterans are generally older, have lower health-related quality of life, and are more likely to be disabled than urban veterans (Weeks et al., 2004). Rural veterans are also at higher risk for suicide, even after controlling for physical distance to service locations (McCarthy et al., 2012).

As with most individuals living in rural areas, rural SMV may experience limited access to resources such as public transportation, health care facilities, or government agencies. As well, there may be limited access to improvements in technology that facilitate care. With regard to mental health care, rural residents are more likely to use psychotropic medications and less likely to receive psychotherapy, including a minimally adequate number of sessions, than are urban residents (Fortney, 2010). Challenges to receiving mental health care pertain to rural residents in general, to active duty forces in rural areas, and to rural veterans. Even military personnel who live in rural or remote areas may have to travel a considerable distance to receive mental health care at a military facility (Brown et al., 2015; Fortney et al., 1999).

Active duty soldiers in rural military installations going through the post-deployment period have indicated a strong desire for social support, such as opportunities for marriage-focused retreats, relationship-focused interventions, and assistance with child care; previous research suggests that such support from family, peers, and military officers increases resilience to the stresses of deployment and reintegration (Wright et al., 2014). For mental health services more specifically, telehealth services show great promise for enhancing service delivery to rural SMV. In a nonrandomized group comparison, active duty personnel in rural areas and their family members who received psychiatric consultation and follow-up medication management and psychotherapy via telehealth showed greater improvements in global functioning and better treatment compliance than a similar group seen in face-to-face encounters (Grady & Mercer, 2005).

Telehealth services have also proven useful in delivering mental health services, including evidence-based treatments, to veterans with PTSD, depression, substance use disorders, and chronic pain (Bumgarner et al., 2017; Fortney et al., 2015; Luxton et al., 2016). Thus, telepsychology and rapidly developing technology such as mobile apps may assist in increasing access to services and be useful for rural veterans. Psychologists are encouraged to consult the *Guidelines for the Practice of Telepsychology* (APA, 2013a) when considering use of telepsychology.

HOMELESS VETERANS

In the recent past, veterans were overrepresented in the homeless population (Department of Housing and Urban Development, 2013). However, over the past decade (2009–2019), the number of homeless veterans has declined almost 50%, as has the proportion of all homeless adults who are veterans (12% to 8%) (Department of Housing and Urban Development, 2019). Tsai and Byrne (2019) studied the VA continuum of housing programs and reported a 45% drop between 2009 and 2017 in the number of veterans who were homeless in a given night. In addition, most who used the VA homelessness programs used them only briefly.

Tsai et al. (2016) found that among veterans reporting homelessness at some point in their life, mental and physical health were poorer than for other veterans. Veterans with lifetime homelessness were also younger than other veterans and more likely to be non-White, rural, and unemployed. Veterans with alcohol or drug use disorders tend to have more extensive histories of homelessness than other homeless veterans (Tsai et al., 2014). Homeless veterans experience significantly elevated mortality risk, with mortality rates between 1.5 and 1.8 times non-homeless veteran populations, and this risk does not decrease after entry into a health care system (Kasprow & Rosenheck, 2000).

Although we discuss family issues more generally under Guideline 4, we note here that information obtained from a VA database several years ago indicated that a significant proportion of veterans with unstable housing or literal homelessness had minor children in their custody (for men, 18% of unstably housed and 9% of homeless veterans, respectively; for women, 45% of unstably housed and 30% of homeless veterans, respectively). Although homeless veterans with minor children in their custody were younger and less likely to have chronic medical or mental health disorders than other homeless veterans, 11% had psychotic disorders that can clearly affect parenting (Tsai et al., 2014; Tsai et al., 2016). The most recent Department of Housing and Urban Development Homelessness Assessment (2019), which is based on a different methodology, reported that 10% of homeless women veterans were in households with minor children.

JUSTICE-INVOLVED VETERANS

The percentage of veterans in the civilian justice system, which includes state prisons, federal prisons, and local jails, has declined over the past several decades and the percentage of male veterans who are incarcerated is lower than that of the general male population, although differences in average age of these two groups may account for some of these findings (Noonan & Mumola, 2007). Among incarcerated veterans, drug and alcohol use disorders are highly prevalent (44%–45%), and over one-quarter have mood disorder diagnoses (28%) (Tsai et al., 2014; Tsai et al., 2016). It has also been demonstrated that veterans with

mental health conditions, such as PTSD, are at increased risk for incarceration compared with veterans without mental health conditions (Greenberg & Rosenheck, 2009).

Given that both veteran status and incarceration can increase risk for suicide, justice-involved veterans may experience even higher rates of suicidal ideation, although data on this hypothesis are currently lacking (Wortzel et al., 2009).

Application of Awareness of Subpopulations

Psychologists are encouraged to remember that clients are complex, and when developing a treatment plan, it is important to acknowledge the multiple aspects or circumstances of a client's life that may influence the accessibility and success of treatment. An ideal treatment plan accounts for the unique strengths and risk factors of each client, and knowledge of the above subpopulations can help psychologists identify such client characteristics. Not all clients will fall into one of these subpopulation groups, and a client can belong to one or more of these and other (less studied) subpopulations. Outlining the characteristics of each of these commonly observed veteran subpopulations can make it easier for psychologists to predict difficulties their clients may be facing, but it is still important for psychologists to consider what individualized details need to be accounted for in their clients' treatment plans.

Likewise, psychologists strive to capitalize on common client strengths when applicable within subpopulations. Psychologists are encouraged to keep up to date with government and nonprofit programs that have been developed to support subpopulations of SMVF (e.g., women's health, vocational rehabilitation, VA-supported housing, veterans' courts, GI Bill, immigrant SMVF). In working with SMVF, psychologists can make use of relevant APA guidelines on working with diverse populations, including ethnic, linguistic, and cultural minorities, persons with disabilities, and transgender and gender-nonconforming people. Clinically, practicing psychologists can include an evaluation of these intersecting identities and experiences in their intake screening in order to develop a thorough and well-informed treatment intervention that takes into consideration these particular vulnerabilities.

Conducting a thorough assessment is important for treatment decisions, but psychologists also need to consider the ramifications of documenting certain demographical information, such as sexual orientation and gender identity of service members. Thus, consulting legal, ethical, and practice guidelines will help in ensuring best practices to avoid harm and provide best care. Psychologists who are involved in research can identify and address current gaps in order to move the field of intervention forward for these and other SMVF vulnerable populations (e.g., the needs of racial and ethnic minority women veterans). Psychologists who are involved in informing policy or advocacy efforts can use the above considerations in their work, for example in improving health care screenings that include these subgroup factors, and in developing prevention programs, such as those focused on preventing sexual harassment and gender discrimination.

WORKING WITH FAMILIES OF MILITARY SERVICE MEMBERS AND VETERANS

As of 2017, 52.6% of active duty military members and 44.8% of National Guard and Reserve members were married, and 38.3% and 41.5% of these respective groups had children (Department of Defense, 2017). Compared with the general U.S. population, the military population is younger, more likely to be married, and tends to start families at a younger age (Clever & Segal, 2013). Families of SMV may experience stressors that differ from those experienced by other families, and often seek psychological services outside of DoD or VHA facilities. Thus, it is important for psychologists to be aware of common sources of stress affecting these families, whether working with the parents, partners, or children of SMV or with the entire family system. Likewise, it is important for psychologists to be cognizant both of issues faced by families during the service member's active duty and of issues following discharge to veteran status, and to obtain the necessary training for working with families of service members, veterans, or both.

GUIDELINE 4.1

Psychologists strive to ask all clients whether they are a parent, partner, child or dependent of a service member or veteran as part of a thorough intake or assessment of needs.

Rationale

Families of service members or veterans who are seeking help most often rely on civilian health care providers, especially in primary care (Eaton et al., 2008; Flittner O'Grady et al., 2015) for several reasons. Family members of service members may seek help outside of the DoD because services are not available within the DoD facility, or because of their preference. Family members of veterans are generally not eligible for mental health services within the VHA unless they participate in such services for the well-being of the veteran and focus on the veteran as the identified client. Given the nonmilitary settings in which family, partner, or child mental health care is often sought, mental health service providers, including psychologists, may not be aware that a child or family member is related to a service member or veteran, or even that they may be currently involved in some phase of the deployment cycle.

Application

Psychologists strive to include in their initial interview with clients a routine question about whether the client is a family member of an active duty service member, Reserve or National Guard member, or veteran. Including this as a standard demographic question in the intake or initial interview will enable psychologists to determine whether further inquiry about military-related experiences may be relevant when providing services for the client. The most basic question that providers could ask is whether the person seeking help is a parent, partner, child, or sibling of an SMV.

GUIDELINE 4.2

Psychologists strive to understand the effects of military status and of deployment on SMVF.

Rationale

Even during peacetime, military families contend with stressors that differ from those of civilian families. Park (2011) identified these stressors as more frequent geographic moves (including possible international moves), interruption of children's peer relationships, and living with the threat of injury or death of the military service member because of dangerous duty. The average child of a military service member moves six to nine times between kindergarten and the end of high school, entailing changes in schools, health care providers, and other support systems. Children may also have to deal with multiple separations from and reunions with their loved one (National Child Traumatic Stress Network, 2014). Recent geographic moves in military families have been associated with increased mental health visits in children and adolescents, although the magnitude of the effect is small (Millegan et al., 2014). In fact, overall psychological and academic adjustment of military children is generally equal to or better than that of their civilian peers (Park, 2011). Greater social support within the military community has been associated both with better parent and with better child adjustment (Conforte et al., 2017).

The military lifestyle includes stressors that may have an impact on spouses' psychological and physical well-being or marital satisfaction as well. These include periods of separation from the military spouse, which has been linked to each of these effects; moving to a foreign country, which has been linked to poorer physical and psychological well-being; and fear for the service member's risk for injury or death (Burrell et al., 2006). For example, frequent moves can create stress for spouses of service members, through loss of employment, possible underemployment, or unemployment; and loss of an existing social network (Blakely et al., 2012). On the other hand, facing these types of changes may also yield beneficial effects related to the military lifestyle, including increased capacity for flexibility, resiliency, and a sense of meaning and purpose (Hawkins et al., 2018). Psychologists are encouraged to consider and understand both the potential positive and negative outcomes of the impact of the military lifestyle, specifically for each individual military family as these may differ for a variety of factors.

Deployment can create additional stress on families. Since the initiation of military operations in Afghanistan and Iraq, more attention has been paid to the effects

of military deployment on spouses or partners and children of deployed service members. The military deployment cycle can be conceptualized as having several different phases (i.e., pre-deployment, deployment, post-deployment and family reintegration) with various kinds of child and family stress associated with each phase (DeVoe & Ross, 2012). As just a few examples, before deployment parents must decide when and what to tell their children about the deployment while managing their own emotional reactions. During deployment family roles change to compensate for the absence of the deployed member, accompanied by bidirectional anxiety about the well-being of the service member and the non-deployed parent and children at home. In the post-deployment period, the service member must reintegrate with the family, resuming responsibilities as a parent and partner in a family system that may have of necessity changed during the deployment. Psychologists are encouraged to become familiar with these phases and how they might affect the family.

DURING DEPLOYMENT

Deployment separations can be highly stressful for couples and can be associated with relationship dissatisfaction, spousal depression, anxiety, or sleep problems, which in turn interfere with parenting (Bergmann et al., 2014; Donoho et al., 2018; Gewirtz et al., 2011). Among primary care-seeking spouses of current-era deployed service members, rates of major depression and generalized anxiety disorder were notable (12.2% and 17.4%, respectively; Eaton et al., 2008). In the Millennium Cohort Family Study, in a non-treatment-seeking sample, spousal depression was associated with SM deployment with combat experience. (Donoho et al., 2018). Longer deployments have been associated with more mental health concerns among spouses (De Burgh et al., 2011; Mansfield et al., 2010) and with marital aggression (McCarroll et al., 2000). Pre-deployment avoidant coping in couples has been associated with post-deployment mental health symptoms and relationship distress (Blow et al., 2017).

Protective factors for couples dealing with deployment include both service members' and spouses' positive evaluation of military service, greater preparation for deployment as a couple, and spouses' deployment-related benefit-finding or stress-related growth (Balderrama-Durbin et al., 2015; Renshaw & Campbell, 2017). Spouses may experience deployment as an opportunity for personal growth, development of social support, and increased self-confidence (Hawkins et al., 2018).

Research findings have been inconsistent regarding the effects of parental deployment, itself, on children of military SM. On the one hand, some evidence indicates that parental deployment may contribute to lower academic grades and test scores (Rentz et al., 2007), higher rates of child maltreatment among families with histories of child abuse (Gibbs et al., 2007), and increased anxiety among children and adolescents who are concerned about the well-being of either the deployed or the caretaker parent (Chandra, Lara-Cinisomo et al., 2010; Chandra, Martin et al., 2010; Huebner et al., 2007). In a primary care setting, childhood behavioral and stress disorders were shown to rise by 18%–19% during service member deployment, resulting in an 11% increase in outpatient mental/behavioral health visits (Gorman et al., 2010).

On the other hand, there is also evidence suggesting that deployment of a military parent (versus no deployment) is only modestly related to behavioral or emotional problems in children (Card et al., 2011) and can even be associated with positive growth, new competencies, and increased flexibility in children (Easterbrooks et al., 2013). The length of parental deployment and poorer non-deployed parent mental health have been significantly associated with a greater number of challenges for children both during deployment and during post-deployment reintegration (Chandra, Lara-Cinisomo et al., 2010; Chandra, Martin et al., 2010). Overall, the impact of deployment on children and adolescents appears to vary based on multiple factors, including the age and gender of the child, the coping and mental health of the non-deployed parent, the cumulative length of deployments, and the stress associated with varying phases of the deployment cycle (Chandra, Lara-Cinisomo et al., 2010; Chandra, Martin et al., 2010; Lester et al., 2010).

POST-DEPLOYMENT

After deployment and during the reintegration phase, some couples may experience stress related to resuming their roles within the family as partners and parents (Curry et al., 2018; Sayers, 2011). Post-deployment, a significant percentage of active duty members and veterans report significant difficulties in one or more areas of family reintegration, such as feeling like a guest in their own home or being unsure of their role in the family (Balderrama-Durbin et al., 2015; Sayers et al., 2009). Many military parents report that parenting is harder post-deployment than pre-deployment (Khaylis et al., 2011). Common experiences include the formerly deployed service member feeling that they have missed out on important events in their child's life, or being unsure how to deal with their child's emotions (Curry et al., 2018).

Returning service members with posttraumatic stress symptoms, other mental health symptoms, or injury may face additional challenges in couple and parenting adjustment. Posttraumatic symptoms have been linked to poorer couple and parenting adjustment (Gewirtz et al., 2010), parenting satisfaction (Berz et al., 2008) and child adjustment (Gewirtz et al., 2018) in families of service members or veterans. Physical injuries require families to cope with the service member's or veteran's treatment and rehabilitation and may be associated with personality changes that complicate marital and parental functioning (Holmes et al., 2013).

OTHER CONSIDERATIONS

The post-9/11 conflicts have been marked by an increased deployment of the Reserve Components. RC members and their families may face additional challenges compared to active duty forces because they have fewer sources of community and social support than do active duty members and families (Hollingsworth, 2011). RC families do not live on military bases or have access to housing and health care services on military installations. They do not receive as much pre-deployment preparation as active duty military members, and they face potential job loss and related financial consequences because of deployment (Esposito-Smythers et al., 2011).

It is important for psychologists to be

aware of potential effects of the deployment cycle on SMVF, and to be cognizant of both risk and protective factors contributing to family functioning during and after deployment. Therefore, psychologists strive to identify and understand these effects on an individual client basis when working with military and veteran families.

Application

Psychologists strive to become knowledgeable about their clients' experience with military deployments, including the length of tours of duty, support available for family members, and the challenges present before, during, and after deployments. This includes assessing the impact of military deployment on the spouses/partners and children of active duty, National Guard, and Reserve forces. Psychologists strive to conduct assessments that examine both the challenging and positive aspects of dealing with the various phases of the deployment cycle. Understanding the impact of deployment involves an appreciation of the interconnections between spousal/partner well-being, parenting, and child adjustment. Psychologists also recognize that military spouses and children are often resilient and may experience growth and positive development related to deployment challenges.

GUIDELINE 4.3

Psychologists strive to understand the family context and if appropriate to involve the family system when working with military service members and veterans.

Rationale

Understanding the needs of veterans within a mental health treatment context also includes understanding their family context across the life span, including their relationships with their partners/spouses and children, and where relevant, their caregivers. Most post-9/11 veterans report high family quality of life (Vogt et al., 2017), indicating satisfaction in relationships with spouse and children. The relationship between family functioning and military member functioning is bidirectional. Positive family functioning serves as a source of resilience for the military member, while family problems contribute to service member stress (Park, 2011). On the other hand, if the service member is experiencing mental health problems, marital and parental relationships may be adversely affected, and stress on the family members may increase. Returning military members are often concerned about their relationships with spouses/partners and with child-rearing issues (Sayers, 2011); thus, it is not surprising that some express a preference for family-based rather than individual-based mental health services (Khaylis et al., 2011).

Both intimate partner relationships and parental relationships are adversely affected by the veteran's depression or PTSD (Blow et al., 2013; Creech et al., 2016). For example, PTSD symptoms such as withdrawal, emotional numbing, anger, heightened arousal, and lack of control adversely affect family functioning (Taft et al., 2008; Samper et al., 2004). Children of veterans with PTSD can experience a range of reactions, including fear, hurt, confusion, and withdrawal (Sherman et al., 2016), and can have more behavior problems than children of veterans without PTSD (Kresic Coric et al., 2016).

INTIMATE PARTNER VIOLENCE

As is the case in civilian communities nationally, intimate partner violence (IPV) is a concern affecting some military couples. IPV occurs in heterosexual and sexual minority couples and can be perpetrated and experienced by men and women (Edwards et al., 2015; Foran et al., 2011). Both posttraumatic stress symptoms and substance abuse have been associated with IPV in veteran couples (Kelley et al., 2017). Further, among current-era women veterans, the experience of IPV is associated with greater instability in housing (Dichter et al., 2017). Both the DoD and VA have programs to assist in dealing with IPV. For example, at the time of this writing, the Family Advocacy Program works with military couples in the DoD and an IPV Assistance Program Coordinator is available at all VA hospitals.

CAREGIVERS

In families where the SMV has an enduring injury or a mental health condition requiring significant additional support from a family member or other caregiver, providers are encouraged to inquire about and coordinate with caregiver support programs and benefits, such as those through the VA Caregiver Support Program. Engaging family caregivers may be particularly important in the care of older veterans. There are 5.5 million military caregivers in the United States. Caregivers of veterans from earlier eras tended to resemble civilian caregivers, whereas caregivers for post-9/11 military-era veterans are more likely to be younger, employed, less connected to a support network, caring for veterans with a mental health or substance use condition, and using mental health resources themselves (Ramchand et al., 2014). VA Caregiver Support offers such resources as caregiver education and training, a support line, and for eligible veterans, financial support, and has been found to be highly valued by caregivers (Bruening et al., 2020). Each VA medical center has a Caregiver Support Coordinator.

Application

Psychologists strive to become knowledgeable about the mutual effects of military member, spouse or partner, and child functioning within the family system. Additionally, when working with active duty military or veteran clients or families, psychologists strive to inquire about marital or intimate partner relationships, and parenting relationships during assessments, including possible dysfunction in these relationships. Where appropriate, psychologists consider family-focused support or intervention as an aspect of caring for military or veteran clients or their partners or children. Likewise, psychologists aim to become aware of caregiver issues and the available caregiver support programs when working with families that include a caregiver. Psychologists endeavor to become familiar with and to utilize available services and evidence-based interventions to assist SMVF, including interventions that involve the family or the couple.

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APPENDIX A

Glossary

1. DEPARTMENT OF VETERANS AFFAIRS (VA)

Formerly the Veterans Administration, the VA is a Cabinet-level veterans' benefit system responsible for administering health care and other benefits to veterans, their families, and military survivors/widows. Its mission is "to fulfill President Lincoln's promise 'to care for him who shall have borne the battle, and for his widow, and his orphan.'" The VA comprises the Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration.

2. VETERANS HEALTH ADMINISTRATION (VHA)

The VHA is the VA office responsible for providing health care to military veterans. Health care delivery channels include regional medical centers, community-based outpatient clinics, community living centers (nursing homes), home health care, Vet Centers, and telehealth. The VHA mission includes significant foci on the implementation of evidence-based practice and interprofessional health care models, conducting biomedical research, and training health care professionals. The VHA provides all manner of health care and has made a particular commitment to respond to veterans' mental health needs. This includes providing specialty mental health care to Iraq- and Afghanistan-era veterans to address PTSD and TBI, the signature injuries of these conflicts.

3. TRICARE

Tricare (typically styled TRICARE) is a health care program of the Department of Defense for service members, retirees, and their dependents, as well as enrolled active status members of the Reserve Components. TRICARE is managed by the Defense Health Agency.

TRICARE providers can be found at military treatment facilities located at military installations as well as in civilian communities.

4. DEPARTMENT OF DEFENSE (DOD)

The Department of Defense is an arm of the executive branch of the federal government. It conducts all government functions related to national security and oversees the United States armed forces. Chaired by the secretary of defense, who reports directly to the president of the United States, the DoD comprises the Department of the Army, Department of the Navy (which includes both the United States Navy and United States Marine Corps), Department of the Air Force, Defense Intelligence Agency, National Security Agency, National Geospatial-Intelligence Agency, and National Reconnaissance Office.

5. ACTIVE DUTY

Active duty service members operate in full-time status and fulfill the day-to-day operations of the military services in the armed forces of the United States within the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, and U.S. Coast Guard. In relation to the Reserve Component (RC), the active duty members are sometimes referred to as the Active Component. The Coast Guard, a portion of the armed forces that deploys with the Navy during wartime, is located within the Department of Homeland Security rather than the DoD.

6. RESERVE COMPONENTS (RC)

The Reserve Components are composed of military members serving in the National Guard and Reserve who are involved in part-time work in the U.S. armed forces. The RC comprises the Army National Guard, Army Reserve, Navy Reserve, Air Force Reserve, Air National Guard, Marine Corps Reserve, and Coast Guard Reserve. The Reserves serve the federal government. The Army National Guard and Air National Guard serve individual states (and the four territories) but may also be activated into federal military service during times of need (VA/DoD, 2015a; VA/DoD, 2015b). Members of the RC generally hold civilian jobs in their communities but may be called upon to deploy in time of need.

The Individual Ready Reserve (IRR) is composed of trained service members who may be called upon, if needed, to replace soldiers in active duty, Army Reserve or Air Force Reserve units. Many of the soldiers in the IRR recently left active duty and still have a Reserve commitment (Reserve or Guard, under Section 651 of Title 10 U.S.C.). Others have chosen to remain active as Reserve soldiers but not as a unit member. The IRR is generally a mobilization asset and subject to recall in case of a national emergency or contingency.

7. VETERANS BENEFITS ADMINISTRATION (VBA)

The Veterans Benefits Administration evaluates veterans to determine health service eligibility. After being registered and determined eligible by the VBA, veterans may receive health care through the VHA. The VBA also oversees access to veteran benefits (i.e., VA Home Loan, vocational rehabilitation, GI Bills, and compensation and pension).

OEF/OIF/OND

These abbreviations represent Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn.

APPENDIX B

Selected Resources for Clinicians Working With Service Members, Veterans, and Their Families

CENTER FOR DEPLOYMENT PSYCHOLOGY
deploymentpsych.org

The Center for Deployment Psychology trains military and civilian behavioral health professionals to provide culturally sensitive, evidence-based services to service members, veterans, and their families.

MILITARY ONESOURCE
militaryonesource.mil

Military OneSource provides information on multiple services available to service members and their families, as well as resources and support.

PSYCHOLOGICAL HEALTH CENTER OF EXCELLENCE
pdhealth.mil

The Psychological Health Center of Excellence has as its mission to improve the lives of service members, veterans, and their families by advancing excellence in psychological health care, readiness, and prevention of psychological health disorders.

ABOUT VA MENTAL HEALTH
mentalhealth.va.gov

Introduction to VA mental health with links to specific services.

MILITARY HEALTH HISTORY POCKET CARD
bit.ly/va-pocketcard

The pocket card is a guide for clinicians to explore possible environmental stressors. It lists exposures relevant to any service era, and those relevant to specific service eras.

NATIONAL CENTER FOR PTSD
bit.ly/va-ptsd-professional

The National Center for PTSD is a research and educational center that offers information on assessment and effective treatments for PTSD, as well as information for veterans and family members.

VETERANS HEALTH ADMINISTRATION COMMUNITY PROVIDER TOOLKIT
bit.ly/va-mentalhealth-community-providers

This site, developed by VA clinicians at the National Center for PTSD and the Office of Mental Health Services, includes key tools and resources for working with veterans, such as easy to access information about how to screen for military experience, understanding military culture, referring to the VA, as well as tools, including mini-clinics, for working with a variety of behavioral health concerns.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA), SERVICE MEMBERS, VETERANS, AND THEIR FAMILIES TECHNICAL ASSISTANCE (SMVF TA) CENTER
samhsa.gov/smvf-ta-center

SAMHSA's SMVF TA Center serves as a national resource to support states, territories, and local communities in strengthening their capacity to address the behavioral health needs of military and veteran families.

VETERANS AND MILITARY CRISIS LINE
Telephone Support Program
veteranscrisisline.net

The Veterans and Military Crisis Line is a toll-free, 24-hour/seven days per week, confidential resource that connects service members, National Guard and Reserve, veterans, and their family members to qualified responders who are with the Department of Veterans Affairs. The crisis line, text-messaging service, and online chat provide free support for individuals in any of these categories regardless of whether or not they are registered with the VA or enrolled in VHA health care. The crisis line number is 1-800-273-8255 and then press 1. Online chat is available at veteranscrisisline.net/get-help/chat, or send a text message to 838255.

COACHING INTO CARE TELEPHONE-BASED SERVICE 1-888-823-7458
mirecc.va.gov/coaching

A telephone-based service to coach family members and relatives concerned about a veteran who may benefit from mental health care but is reluctant to seek it. This free service is not a crisis line and works over a series of telephone calls to help family members encourage and support the veteran in getting treatment for PTSD, depression, anxiety, and misuse of alcohol and drugs.

NATIONAL STRATEGY FOR PREVENTING VETERAN SUICIDE 2018–2028
bit.ly/national-strategy-for-preventing-veterans-suicide

This U.S. Department of Veterans Affairs publication describes multiple elements of a national strategy to prevent veteran suicide and includes numerous internal and public resources.

AMERICAN
PSYCHOLOGICAL
ASSOCIATION