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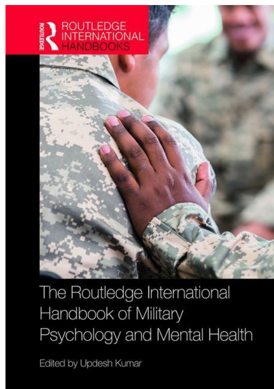

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STUDENT SERVICE MEMBERS/ VETERANS' MENTAL HEALTH ON CAMPUS

Risk and resources

Dan Nyaronga

On campus mental health risk and challenges for student service members/veterans (SSM/V)

As of 2012 at least one-half million student service members/veterans (SSM/Vs) have used their post-9/11 GI bill benefits (Sander, 2012), and these numbers are expected to increase as the United States continues to draw down its forces in Afghanistan. However, a fair number of students who matriculated into higher education post-military service are suffering from unhealed wounds of war, both physical and mental (Church, 2009), as well as dropout risk and failure to successfully complete degrees (Nyaronga & Toma, 2015). Zivin, Eisenberg, Gollust, and Golberstein (2009) report that one-third of American SSM/Vs have at least one mental health issue that persists over two years and fewer than half have received treatment. For example, research on SSM/Vs by Rudd Goudling, and Bryan (2011) found a high level of overall psychological distress among SSM/Vs, with 35% experiencing severe anxiety, 24% experiencing severe depression, and 46% reporting significant symptoms of PTS (Rudd et al., 2011). In addition, there is considerable evidence indicating that PTS commonly co-occurs with other psychiatric problems, most often with major depression, anxiety, and substance abuse (e.g., Keane & Wolfe, 1990; Rudd et al., 2011; Stewart, 1996). A study by Campbell & Riggs (2015) involving interviews with Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) veterans also found PTS and depression as common themes throughout their exploratory interviews. Furthermore, another study by Lipka (2011) indicated that half of the SSM/V population in the United States has contemplated suicide, as compared to 17% of general student population (Rudd et al., 2011). PTS, in particular, has previously been found to be associated with increased risk for suicidal thinking and suicide attempts (Jakupcak, Cook, Imel, Fontana, Rosenheck, & McFall, 2009; Sareen, Cox, Stein, Afifi, Fleet, & Asmundson, 2007). Given the mental health challenges among trauma-exposed SSM/Vs on college campus, knowledge about interference in academic performance and school dropout is critical to inform outreach and intervention strategies for university and college campuses.

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Trauma related distress and school dropout among college/university-enrolled student service members/veterans

Trauma exposure and trauma-related distress have been found to be associated with higher likelihood of dropping out of college, academic difficulties, lower GPA, low educational self-efficacy, academic motivation, and campus alienation (Bachrach & Read, 2012; Barry, Whiteman, & MacDermid Wadsworth, 2012; Boyraz, Granda, Baker, Tidwell, & Waits, 2016; Boyraz, Horne, Owens, & Armstrong, 2013; Duncan, 2000; Elliott, Gonzalez, & Larsen, 2011; Jordan, Combs, & Smith, 2014). More specifically, general anxiety was found to have a direct negative effect and a greater impact on SSM/Vs' academic adjustment and achievements. General anxiety symptoms consist of worry, sleep and concentration difficulties, irritability, feeling restless or keyed up, and fatigue (Gerdes & Mallinckrodt, 1994). The symptoms may impede study efforts, completion of coursework, and class attendance (Campbell & Riggs, 2015; Milanak, Gros, Magruder, Brawman-Mintzer, & Frueh, 2013). In addition, PTS has been significantly associated with being in a physical altercation and high-risk drinking for college-enrolled OEF/OIF veterans (Elliot et al., 2011; Ness, Rocke, Harrist, & Vroman, 2014). Furthermore, alcohol misuse is a serious issue among SSM/Vs on and off campus, especially men and those with greater combat exposure (Santiago, Wilk, Milliken, Castro, Engel, & Hoge, 2010), who may use alcohol to self-medicate their mental health issues (Bray, Marsden, & Peterson, 1991; Elliot, 2015).

Studies indicate that 30%–40% of SSM/Vs do not complete their degree programs (Cate, 2013), and they tend to have lower grade point averages (GPAs) than their non-SSM/V student counterparts (Durdella & Kim, 2012; Elliot, 2015). Also, in a comparison sample, Boyraz et al. (2016) found a significant difference in college drop-out rates between SSM/Vs who had PTS (35%) and those who did not have PTS (20.8%). In another sample of SSM/Vs, Schonfeld, Braue, Stire, Gum, Cross, and Brown (2015) revealed that 28% of enrolled SSM/Vs reported having difficulty adjusting to the college life. The adjustment problems were significantly associated with mental health challenges (Schonfeld et al., 2015). Common themes in SSM/V challenges include interpersonal difficulties in social relationships (e.g., feeling isolated or lack of connection with friends, family members, and college peers; Campbell & Riggs, 2015), difficulty in transitioning to the role of student, feeling overwhelmed, and problems concentrating on academic studies. Women who have been sexually assaulted report that, as a result of the assault, they dropped a class, changed majors, changed universities, and moved residences (Lindquist, Barrick, Krebs, Crosby, Lockard, & Sanders-Phillips, 2013). Moreover, dropping classes, changing majors, or transferring to a new institution is also associated with greater educational costs, longer completion times, and other negative consequences that may impact SSM/Vs' financial, professional, and social functioning (Artime, Buchholz, & Jakupcak, 2018).

A longitudinal study by Johnson, Graceffo, Hayes, and Locke (2014) on service utilization by SSM/Vs at college/university counseling centers from 2010 to 2012 reveals that only 2% of SSM/Vs sought treatment from college counseling services and noted no change over time in service utilization. Given the mental health challenges, the steady increase in SSM/Vs enrolled in college, the interference in academic performance among trauma-exposed SSM/Vs, and the absence of increase in treatment seeking on campus, it is critical to understand the barriers to seeking mental health services in order to develop intervention strategies for college campuses.

Barriers to seeking mental health services by student service members/veterans on college campuses

In a study by Bonar, Bohnert, Walters, Ganoczy, and Valenstein (2015) to assess barriers to seeking treatment among SSM/Vs, the most commonly reported barrier was the desire to avoid

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record of mental health treatment on their military record (43%), followed by treatment being embarrassing (31%), lack of confidentiality (29%), harmful to their career (29%), difficult to get an appointment (27%), costs too much (21%), and being seen as weak (26%) (Artime, Buchholz, & Jakupcak, 2018; Danish & Antonides, 2009).

Traditionally, institutions require students to self-identify if they have a disability and are in need of accommodations. However, unlike their non-SSM/V peers with documented disabilities who learned to seek accommodations in colleges, SSM/Vs with disabilities have less time to learn how to navigate the system (Vance & Miller, 2009). Many of their wounds are also not readily noticeable to faculty and staff. This makes self-advocacy even more important for SSM/Vs, but that is complicated by the culture they come from, a highly structured military environment, where admitting to such difficulties carries stigma and is seen as a weakness (Danish & Antonides, 2009; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Warner, Appenzeller, Grieger, Belenkiy, Breitbach, Parker, & Hoge, 2011). The military environment promotes strong beliefs and values that may benefit SSM/Vs in their college coursework. However, such an environment may also set them apart from the rest of the college and contribute to a sense of alienation and frustration (DiRamio, Ackerman, & Mitchell, 2008; Rumann & Hamrick, 2010). In particular, military culture values strength and independence, and stigma regarding mental illness is high (Kim, Britt, Klocko, Riviere, & Adler, 2011), both of which may foster an avoidant coping style in response to psychological pain.

Studies suggest that avoidant coping contributes to substantial risk for dysfunction, yet SSM/Vs with this coping style may be reluctant to seek help with their difficulties from professors, mentors and academic advisors, administrators, and mental health providers because they do not want to be viewed as weak, a burden, or dependent on anyone for help (Romero, Riggs, & Ruggero, 2015). Avoidant coping is an attempt to turn away from adverse experiences and emotions and may take the form of denying or minimizing the result or effects of a specific problem or choosing not to deal with the problem (Boden, Bonn-Miller, Vujanovic, & Drescher, 2012). According to Feeny and Foa (2005), individuals with PTS use an avoidant coping style in an attempt to control their trauma-related intrusive thoughts, experiences, and emotions related to PTS. Others, like Whiteman and Barry (2011) conceptualize avoidant coping, especially among SSM/Vs, as a behavior characterized by the likelihood of consuming more alcohol than non-SSM/Vs and reluctance to seek counseling (Bonar & Domenici, 2011). Studies indicate that an avoidant coping style can aid individuals in managing their daily activities post-crisis; however, engaging in avoidant coping over an extended period of time could lead to mental health problems (Barlow, 2002; Holahan & Moos, 1987). Given the mental health challenges and interference in academic performance among trauma-exposed SSM/Vs, knowledge about available mental health services and resources is critical to inform intervention strategies on campuses.

Mental health resources and services for student service members/ veterans on college campuses

Problem-focused coping

It allows an individual to deal with the stressor causing distress (Folkman & Lazarus, 1985) and adapt or remove the source of stress via one's behavior (Lazarus & Folkman, 1984) and may be particularly useful in a military context that encourages taking swift action to resolve obstacles and minimize threats. Problem-focused coping is also adaptive in the college environment, thus allowing SSM/Vs to take responsibility to ensure their own academic success (Romero, Riggs, & Ruggero, 2015). That means SSM/Vs are encouraged to talk to campus doctors or health officials about their health status in order to initiate early intervention.

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Screening for early intervention

Screening includes being asked about military and SSM/V status, combat exposure, depression, anxiety, and posttraumatic stress symptoms. Identifying and reaching those in need is a critical first step, particularly for suicide prevention. If SSM/V-specific orientations are conducted, it would provide greater potential for mass screening efforts. Based on interviews with SSM/Vs who had served in Iraq or Afghanistan about the adjustment to college life, DiRamio et al. (2008) recommend a holistic approach for assisting SSM/Vs. The approach includes implementing a mandatory orientation, which makes use of mentors or transition coaches, especially senior SSM/V colleagues from veteran organizations on campus.

Outreach

Studies suggest the need for university disability service offices and counseling centers to ensure that SSM/Vs have a clear understanding of the help and services available at their disposal and the process by which they can receive the services. On the clinical service side, studies suggest the need for counseling centers to think in a strategic fashion about the potential for significant demand or needs from SSM/Vs, design interventions and outreach programs specifically aimed at SSM/Vs, provide access to mental health services on campus (Campbell & Riggs, 2015), offer long-lasting treatment benefits with a structured protocol, or offer appropriate referrals to a different mental health service provider. In addition, having spent so much time in a structured military environment and ascribing to military values, SSM/Vs may feel frustrated by the different values on campus and often conflicting values at institutions of higher education (Durdella & Kim, 2012), as well as by the assumptions and values of peers and faculty regarding SSM/V military service. They might also feel isolated from their non-SSM/V peers, given differences in age and experiences. As such, counseling centers and expert clinicians are encouraged to help SSM/Vs explore their pent-up emotions upon return from service to the civilian life and in navigating college life. Furthermore, studies encourage SSM/Vs to make use of the counseling center services on campus.

Cultural competency

Studies suggest the need for university officials, administrators, and primary health care and mental health service providers to be culturally competent to work with military undergraduates. In addition, studies encourage a deeper understanding of potential difficulties related to the transition from the military environment to college life, the influence of military culture and deployment experiences on the individual (pre-deployment or post-deployment), the culture and subcultures (based on the different branches and different ranks) of the military (Wurster, Rinaldi, Woods, & Liu, 2013), and possible demographic factors such as age, gender, and marital status. As such, college counseling centers are encouraged to hire service providers with first-hand experience with SSM/V issues, who can provide training on military culture and the unique challenges that the SSM/V faces. New hires with no military background are also encouraged to complete cultural competency training.

Cultural competency training

In order to implement relevant, effective supports for SSM/Vs, studies encourage mental health practitioners who are in contact with SSM/Vs to understand the nature of combat-related neurobehavioral symptoms and warning signs (including PTS, depression, substance abuse, and

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suicidal ideation). In addition, they are encouraged to understand the nature of clinical problems and how the symptoms may affect learning. Furthermore, they are encouraged to respond in a caring and effective manner, hence facilitating the transition to clinical care, if needed (Rudd et al., 2011). As such, specialized training in the behavioral sequelae of TBI, PTS, and other mental health challenges is seen as relevant for campus personnel who work directly with SSM/Vs (Kennedy, Krause, & Turkstra, 2008). The training may also include education regarding military culture, the deployment cycle, and specific military related stressors, as well as screening and clinical care for SSM/Vs. Health practitioners are also encouraged to know the various resources available for SSM/Vs, including: workshops offered and educational materials provided by various organizations (e.g., the National Center for PTS, Defense and Veterans Brain Injury Center). Such trainings and resources can help prepare counselors or health practitioners to evaluate military undergraduates for clinical problems, including signs by using validated clinical assessment tools, and offer evidence-based on-campus treatment (Bonar & Domenici, 2011). Campus health and counseling officials are encouraged to utilize workshops and readings on topics such as military culture, challenges of the deployment cycle, reaction to combat trauma, and effective counseling interventions for SSM/Vs (Rudd et al., 2011). Officials should not only be equipped with knowledge regarding symptoms and treatment strategies for PTS and other SSM/V mental health challenges (Borsari et al., 2017), they should also be able to provide an extensive referral list to other health providers, including Veterans Administration hospitals. Colleges and universities are also encouraged to provide cultural sensitivity training workshops to both the student body and faculty (Nyaronga & Toma, 2015). Studies indicate that without adequate training, many students or faculty may be less equipped to identify and connect with SSM/V students. For example, identifying most veterans on campus as "wounded" or "disabled" may send a message that they are "different" and/or incapable of getting better (Bonar & Domenici, 2011).

Social support

The institutions of higher education are asked to consider implementing mechanisms to foster peer social support among SSM/Vs, such as one-on-one peer mentoring or discussion groups led by SSM/Vs themselves (Nyaronga & Toma, 2015). Emotional support from SSM/V peers also helps with academic adjustment and provides a buffer against mental health challenges (Nyaronga & Toma, 2015; Whiteman, Barry, Mroczek, & Macdermid Wadsworth, 2013). As such, institutions of higher education must be ready to enact holistic approaches to minimize the stress, isolation, and difficulties experienced by SSM/Vs (DiRamio et al., 2008). Broader strategies on reducing SSM/V mental health concerns on campuses may include having a SSM/V center within Veteran Affairs offices on campus, thus creating opportunities for SSM/Vs to network with each other for social support, participate in group therapy, or share similar experiences with friends and colleagues who served in the military (Nyaronga & Toma, 2015), that is, allowing SSM/Vs to feel more identified with their academic institutions and ensure that they are connected with SSM/V members who have similar military experiences and potentially similar social class or worldviews. Peer support has been recommended to help individuals with mental illness develop a sense of community in the process of recovery (Mead, Hilton, & Curtis, 2001). In addition, social support from peers is an established predictor of academic success among first-generation, especially ethnic minority, SSM/Vs (Dennis, Phinney, & Chuateco, 2005; Nyaronga & Toma, 2015).

Studies suggest that all efforts to reach out to and assist SSM/Vs should be sensitive to subgroup differences within the military or veteran population, especially in referral cases. It is critical that health officials or counselors make appropriate contact with the culture and

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subcultures (e.g., based on the different branches and different ranks) of the military and possible demographic factors such as age, gender, and marital status (Elliot, 2015). For example, Veterans Affairs (VA) or National Guard referrals may be appropriate to help SSM/V members, as the VA has a "vet-to-vet" peer-support program for veterans with serious mental illness facilitated by a peer leader, just like the National Guard with a "buddy-to-buddy" program to help members address their mental health issues (Greden et al., 2010).

Hire more health providers with clinical background, skills, and cultural competency training

Combat-related trauma requires specific treatment approaches. However, training and acquiring skills take years, especially for many clinicians at university or college campuses who may be outside the department of Veterans Affairs system, have limited exposure to the VA clinical models, and may not be up to date in terms of developing and implementing new clinical skills for supporting SSM/V members on campus. As such, there is a need to hire more health providers with clinical background, skills, and cultural competency training. These recommendations are consistent with efforts by the Department of Defense and Department of Veterans Affairs to increase the pool of mental health providers who can effectively treat service members, veterans, and their families.

Conclusion

This review gives institutions of higher learning insights into identifying and supporting SSM/V needs, especially those with mental health challenges. This may be done by accurately targeting existing resources to the more at-risk SSM/V populations on campus. These studies are not without limitations. First, a number of studies (Elliot, 2015; Nyaronga & Toma, 2015; Romero, Riggs, & Ruggero, 2015; Rudd et al., 2011) used cross sectional design, which may have introduced the potential for common-method variance and prevent causal conclusions. Second, a number of studies (Artime et al., 2018; Ness et al., 2014; Nyaronga & Toma, 2015) had small sample sizes, which in a way could have affected power and limited further analysis to detect any effects that are particularly small. Third, a number of studies (Campbell & Riggs, 2015; Elliot, 2015; Ness et al., 2014; Nyaronga & Toma, 2015; Romero et al., 2015) limited their sample to enrolled SSM/Vs in single institutions with little information from other campuses on how other colleges perceive and behave toward SSM/Vs on campus. The studies also excluded spouses of SSM/Vs, school administrators, and faculty in their samples. The relative ethnic homogeneity of a sample limits the ability to generalize to more diverse groups, thus compromising the representativeness of the overall sample. Furthermore, the studies have not assessed the length of SSM/V enrollments at their current institutions. Clearly, the amount of time in a given environment is a significant factor in the outcome or could potentially confound the results. Fourth, a number of studies (Ness et al., 2014; Nyaronga & Toma, 2015; Romero et al., 2015; Whiteman et al., 2013) have used self-report data that addresses only individual SSM/V perceptions, and not the actual risk and resource in relationship to the outcomes; as such, the findings may be inflated by common method variance (Campbell & Fiske, 1959) and the results may be a mixed bag, especially in samples where majority of SSM/V participants were nontraditional students, who tend to be older, be married, have children, and be employed. Fifth, some studies had self-selection bias (Whiteman et al., 2013; Rudd et al., 2011) and others used non-randomized samples (Eliot, 2015). In addition, some studies (e.g., Bonar & Domenici, 2011; Wurster et al., 2013) were qualitative in nature with small cases, which would not by any means cover as much as a representative sample with respect to challenges that SSM/Vs face in college campuses.

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Despite research limitations, the mentioned research/studies demonstrated the unique mental health challenges of SSM/Vs on college campuses and provided a comprehensive list of mental health services which would support retention and improved academic performance for SSM/Vs on campuses. The highlighted list of accommodations may depend on individual circumstances and needs to be determined on a case-by-case basis. As such, university or college counselors may benefit from greater coordination and collaboration with a wider network of mental health experts familiar with military-related care (Ness et al., 2014), as well as with military-undergraduate student leadership on campus, Student Affairs office, Disability Services office, and Financial Aid office to enhance the overall experience for military undergraduates on campus and play a pivotal role in the university community to reduce stressors and help SSM/Vs with readjustment challenges.

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